



Prison Officers' Medical Aid Society

397e North Circular Road, Dublin 7. Phone: (01) 830 8963 Fax: 830 9420

www.pomas.ie

APPLICATION FORM

SURNAME _____ PAY NUMBER _____

CHRISTIAN NAME(S) _____ DATE OF BIRTH _____

ADDRESS _____

DATE OF JOINING SERVICE _____ STATION _____

ARE YOU CURRENTLY A MEMBER OF ANOTHER HEALTH INSURANCE SCHEME? YES / NO

IF YES PLEASE ATTACH LETTER OF CONFIRMATION FROM THE INSURANCE COMPANY

SPOUSE / PARTNER'S NAME _____ DATE OF BIRTH _____

IS HE / SHE CURRENTLY A MEMBER OF ANOTHER HEALTH INSURANCE SCHEME? YES / NO

IF YES PLEASE ATTACH LETTER OF CONFIRMATION FROM THE INSURANCE COMPANY

DEPENDANTS

	<u>NAME</u>	<u>DATE OF BIRTH</u>		<u>NAME</u>	<u>DATE OF BIRTH</u>
1.	_____	_____	2.	_____	_____
3.	_____	_____	4.	_____	_____

NOTES (1) PLEASE ENCLOSE COPY BIRTH CERTIFICATES FOR ALL THOSE NAMED ABOVE AND A COPY MARRIAGE CERTIFICATE OR COMPLETED **DECLARATION** IN RESPECT OF A PARTNER

(2) THE RULES OF THE SOCIETY PROVIDE FOR SERIOUS PENALTIES SHOULD ANY INFORMATION GIVEN HERE BE FOUND TO BE INCORRECT

DECLARATION:

(1) I WISH TO JOIN / ADD MY SPOUSE / PARTNER / DEPENDANT(S) (AS ABOVE) TO THE PRISON OFFICERS' MEDICAL AID SOCIETY AND I AGREE TO HAVE THE APPROPRIATE DEDUCTIONS MADE FROM MY SALARY

(2) I AGREE TO BE BOUND BY THE RULES OF THE SOCIETY

SIGNATURE _____ DATE _____