Prison Officers' Medical Aid Society

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

ANNUAL CLAIM FORM

Use this form for GP, Consultant and Dentist fees paid during the 12 months ended 31st December

(A) THIS (ANNUAL) CLAIM MUST BE SUBMITTED BEFORE 31st March.
(B) Receipts must be clearly marked "Paid"
(C) Photocopies of receipts will not be accepted.
(D) Original receipts cannot be returned.

Name: .....

Address: .....

.....

If this claim or part of it is in respect of dependants, they must be named in the spaces provided here.

Spouse/Partner:- .....

Children:- (1) ..... (2) ..... (3) .....

(4) ..... (5) ..... (6) .....

SECTION A

Please insert the total amount of your claim in the appropriate box below.

	MEMBER	SPOUSE/PARTNER	CHILD	NO. OF RECEIPTS
1. DOCTOR (See Note 1)				
2. CONSULTANT				
3. DENTIST (See Note 2)				
TOTALS				

Note (1) A separate receipt for each visit to the Doctor is required.
(2) Dental receipts must be itemised and priced accordingly and, where appropriate, they must be accompanied by Dental Charts.

SECTION B

Is this claim or any part of it related to:-	**Yes**	**No**
(1) General third party? e.g. motor accident.	☐	☐
(2) Personal injuries criminally inflicted? e.g. Assault on or off duty.	☐	☐
(3) Injury / Accident on duty?	☐	☐
(4) Injury, illness or disablement, directly or indirectly caused by war or civil disturbance?	☐	☐

Note carefully:

If the answer to any of the above is "YES" you must contact The Manager / Assessor ***BEFORE*** submitting this claim

THIS CLAIM WILL BE RETURNED TO YOU IF BOTH SECTIONS A & B ARE NOT COMPLETED

WARNING: *DO NOT WRITE ON RECEIPTS OR ALTER THEM IN ANY WAY. ENSURE THAT ALL DOCUMENTS IN SUPPORT OF YOUR CLAIM ARE IN ORDER AS YOU WILL HAVE TO ACCEPT RESPONSIBILITY FOR THEM.*

DECLARATION: I declare that the attached receipts relate only to me and / or my registered dependants all of whom are members of the Society and that the information supplied on / with this claim is correct

- THE RULES PROVIDE FOR SERIOUS PENALTIES FOR FRAUDULENT CLAIMS -

Signed:..... Pay No:..... Date:.....

(MEMBER)

Personnel No:..... *(If retired)*

AH1576

FOR OFFICE USE ONLY

M/S/C	CODE	NOTES	AMOUNT	CLAIM NO.	
					A

ASSESSOR'S NOTES

ASSESSED BY ..... **DATE** .....