Prison Officers' Medical Aid Society

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

REGULAR CLAIM FORM

NOTES:	
(1) Use this form for Out-Patient expenses only. Send the *receipts* to the Society within *3 months.* Do not include *G.P./Consultant/Dentist* receipts, as these must be held for the Annual Claim.	(2) Photocopies of receipts will not be accepted. (3) 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) .....

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

SECTION A

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

	MEMBER	SPOUSE / PARTNER	CHILD	NO OF RECEIPTS
1. **Drugs** (See Note 1 below)				
2. **Optical**				
3. **X Ray**				
4. **Laboratory Tests**				
5. **Physiotherapy**				
6. **Chiropody**				
7. **Hospital Casualty Charge**				
8. **Other** *(See Note 2 below)*				
TOTALS				

NOTE (1) PLEASE MAKE ONE CLAIM ONLY AT THE END OF THE MONTH FOR DRUGS PURCHASED DURING THAT MONTH
(2) PLEASE ENSURE THAT RECEIPTS RELATING TO **"Other"** CLEARLY INDICATE THE TREATMENT RECEIVED

SECTION B

Is this claim or any part of it related to:-	**YES**	**NO**
(1) General Third Party? eg. motor accident.	☐	☐
(2) Personal injuries criminally inflicted? eg. 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.

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 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)

AH0036

FOR OFFICE USE ONLY

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

ASSESSOR'S NOTES

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