MEDICAL SCHEME

Gloucestershire

REGISTRATION FORM ☐

PLEASE COMPLETE ALL DETAILS :- (BLOCK CAPITALS, BLACK INK)

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Support Staff ☐ Officer ☐ Student Officer ☐
Transferee from another force ☐

Members Name.. **Collar No**..................................

Home Address ....

....

Post Code.. **Home Telephone No**..

Date of Birth....................... **Date of Joining Force** .... **Date of Joining Fund** ....

Member of the Welfare Fund / Flint House? **Yes ☐ No ☐**

Pre-existing condition - No ☐ Yes ☐ IF YES, PLEASE GIVE BRIEF DETAILS

....

....

....

(CONTINE OVERLEAF IF NECESSARY)

DETAILS OF DEPENDANTS TO BE COVERED:

Full Names	Relationship to Subscriber	Date(s) of Birth
1..	....	......../....../..........
2..	....	......../....../..........
3..	....	......../....../..........
4..	....	......../....../..........
5..	....	......../....../..........

NOTE 1: Dependants eligible for inclusion as members of the Fund are:- 1. Spouse/Residential Partner 2. Children/Step-Children (Children must be under 21 years of age at date of joining).

NOTE 2: If any dependant has a pre-existing condition, please give brief details, with dates, on a separate sheet and attach it to this form.

NOTE 3: The information you have entered on this form will be held by the Trustees of TriCare Health Fund on a computerised database. TriCare Health Fund is registered under the Data Protection Act.

N.B. PLEASE SIGN FORM ON REVERSE

Tricare Health Fund Office, United House, Unit 1 de Salis Drive
Hampton Lovett, Droitwich, WR9 0QE
Tel 01905 796682 Fax 01905 796072

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MEMBERS DECLARATION

1. I apply to join the TriCare Health Fund. I confirm that the details on this form are true and correct to the best of my knowledge and belief.

2. I understand that benefits are granted at the discretion of the Management Committee and I agree to be bound by the rules of the Health Fund, and accept that the decisions of the Management Committee shall be final.

3. Pre-existing Conditions:

   a. I understand that in addition to any other exclusions under the Rules of the Fund, during the first 24 months of membership, benefit will not be payable to me (or my Dependants) for any injury, illness or condition:-

      i) for which medical advice or treatment has been received, or
      ii) of which I (or my Dependants) were aware, or ought reasonably to have been aware, and for which medical advice was not sought, before my confirmed date of joining the Fund.

   b. If I (or my Dependants) require treatment for a Pre-existing Medical Condition then, in addition to the restrictions in 3a, no benefit will be paid for such condition (or related condition) until 24 continuous months have elapsed without further medical advice or treatment, including drugs and/or medication.

4. I understand that subscriptions will be collected on behalf of the Fund by means of Direct Debit under the BACS scheme (and a signed Direct Debit mandate is attached).

Signed .... **Date** ....

DETAILS OF PRE-EXISTING CONDITIONS (continued from page 1)

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