Benefit summary

	Scheme OS1 €3.30 a week	Scheme OS2 €6.60 a week	Scheme OS3 €9.90 a week	Scheme OS4 €13.20 a week
 **Dental and Optical**	€125	€300	€450	€600
 **General Practitioner, Prescription and Emergency Department - maximum of 12 grants per 12 months**	€8	€15	€20	€25
 **Practitioner: Physiotherapy, Physical Therapy, Osteopathy, Chiropractic**	€100	€200	€300	€400
 **Wellbeing & Alternative Treatments - Acupuncture, Homeopathy, Chiropody/Podiatry**	€100	€200	€300	€400
 **Consultations**	€130	€250	€370	€490
 **Medical Tests - *Including Allergy Testing and Health Screening***	€80	€160	€240	€320
 **Birth Grant / Adoption Grant (*per child*)**	€200	€400	€600	€800
 **Day Case Surgery and Treatment (*Amounts per day*)**	€25	€50	€75	€100
 **Hospital: General and Hospice, Accident, Elderly and Mental Illness (*Amounts per night*)**	€25	€50	€75	€100
 **Recuperation – Grant after a minimum of 10 nights**	€85	€170	€250	€330
 **Personal Accident**				
Permanent Disability – up to	€10,000	€15,000	€22,500	€30,000
Accidental Death	€5,000	€7,500	€11,250	€15,000
Dental Trauma	€500	€750	€1,125	€1,500
 **Helplines - *Available on all schemes***	GP Advice Line, Virtual Doctor, Prescription Service, Counselling Service, Medical Information and Legal Advice.			

your Questions Answered

Q Can I join at any age?

A Anyone aged 18 or over may join.

Q Can I increase to a higher scheme at any time?

A Yes, subject to terms and conditions.

Q Do I have to have a medical to join?

A No. You need only complete and sign the health declaration on the application form.

Q Why do you need medical information?

A In order to explain the cover you will receive, and any restrictions which may apply.

Q Do older people pay higher premiums?

A No, all ages pay the same rates.

Q How do I pay?

A By Salary deduction.

Q Are benefits taxable?

A No. You keep all you receive from HSF health plan.

Q When can I make a claim?

A For most benefits claims will be accepted after 3 months, any exceptions are clearly indicated in the brochure.

Q How do I make a claim?

A Claim forms are available on request by telephoning the number indicated on the reverse of your certificate of cover or from our website.

Q How do I receive my money?

A By direct credit into your bank account.

Q When would my cover begin?

A Cover begins on the date printed on your certificate of cover.

How to join

1: Select the scheme which best suits your needs.
2: Complete the application form from page 25.
3: Write all the medical information requested on page 26. (This will help us to explain the cover you receive but failure to do so will not affect your registration).
4: Complete the payroll deduction form on page 27.
5: Send all completed forms to the Ennis address printed at the bottom of the payroll deduction form on page 27 or hand them to a HSF health plan Account Executive – we will do the rest.

A welcome pack will be sent to your home address and the date stated on the certificate will denote when your cover began.

Ireland Office
5 Westgate Business Park,
Kilrush Road, Ennis, Co. Clare
LoCall: 1890 473 473
Email: customer @hsf.ie
www.hsf.ie

Head Office
24 Upper Ground, London SE1 9PD
Tel: 0044 (0)20 7928 6662
Fax: 0044 (0)20 7928 0446

Application to join HSF health plan

THIS PART MUST BE COMPLETED IN ALL CASES

Date Received – HSF health plan use	Policy No. – HSF health plan use

I apply to join HSF health plan at the weekly rate indicated (net of partial Standard Rate Tax Relief at source) (PLEASE TICK)

HSF health plan AE Code **AE9NLS**

Scheme OS1	Scheme OS2	Scheme OS3	Scheme OS4
€3.30	€6.60	€9.90	€13.20

Surname

Forename

Other Initials

Mr/Mrs/Miss Ms/Other

Address

Postcode

Email

Tel: Work

Date of birth Day Month Year

Tel: Home

PPS Number

Mobile

If already covered by HSF health plan please state:

Premium	Policy No. (if known)

Payment of claims will be made direct to your bank/building society account. Please supply your details:

Your account name

Your Account Number (IBAN)

Swift BIC

HSF health plan uses the information given above for its own purposes. Any communications which you may receive are directly related to HSF health plan services and those of the Hospital Saturday Fund.

By completing health information on the reverse of this form you will assist us in the administration of your policy. Failure to do so will not affect the registration.

TEAR ALONG PERFORATION

Declaration

This application is made on behalf of myself (the policyholder). I confirm that no advice has been received regarding this application from HSF health plan. I agree to HSF health plan and Chubb holding data relevant to my scheme registration. I agree to abide by HSF health plan rules and conditions and the right of the Board of Directors to vary them and the range or rates of benefits or premiums if deemed necessary, with notice. I declare that all the information I have given on this application form is true and complete to my knowledge and belief and that if found to the contrary I understand that HSF health plan may need to impose some restrictions on my cover.

Signature ✗	Date

How did you hear about HSF health plan?

Medical information

Your cover has to be based on the information you supply on the whole of this application form. You must be satisfied that it is correct to the best of your knowledge and belief. To withhold or fail to disclose relevant facts (or to knowingly give false information) about the health and / or treatments could affect the benefits we are able to offer or could seriously influence your cover in the event of a claim. To give false information could be considered to be a fraudulent act and lead to termination of cover.

Please tick the boxes below for any long term / chronic / congenital conditions even if at present under control. If any condition is not listed please complete the 'Other' section, stating conditions in full and avoiding abbreviations.

☐ Transferring from another insurer? PLEASE SUPPLY DETAILS	

Condition/Illness	Date symptoms began
☐ Arthritis PLEASE STATE PART(S) OF BODY AFFECTED BELOW ..... ☐ Asthma/Chest problems ☐ Diabetes ☐ Epilepsy ☐ Kidney disease ☐ Liver disease ☐ Raised blood pressure/Angina ☐ Congenital (conditions from birth) PLEASE STATE ..... ☐ Clinical Obesity	

Please list other illnesses / operations, either current or in the past (stating conditions in full and avoid abbreviations). Also list any medication being taken currently and state the condition / illness requiring the treatment.

Any other Condition/Illness	Date symptoms began
Signature ✗	Date

Authority for deduction from pay for HSF health plan

Policy No. – HSF health plan use

This is the scheme I wish to join and have the weekly amount indicated deducted from my pay/pension (net of partial Standard Rate Tax Relief at source) (PLEASE TICK)

Scheme OS1	Scheme OS2	Scheme OS3	Scheme OS4
€3.30	€6.60	€9.90	€13.20

Employer

Surname

Forename

Other Initials

Mr/Mrs/Miss Ms/Other

PLEASE COMPLETE THE SECTIONS BELOW WHICH ARE APPLICABLE TO YOUR PARTICULAR EMPLOYER

Departments / Branch / Location

PPS Number

Pay No. / Pension No.

Pay / Pension Office

This authority replaces the existing authority for deductions of € C

New deduction € C

Company premium (if applicable) € C

Pay frequency PLEASE TICK

Weekly ☐ Fortnightly ☐ Four weekly ☐ Monthly ☐

I authorise my employer to deduct from my pay / pension the above sum (or such future amounts as apply for my cover), and remit to HSF health plan. If my pay / pension is not paid for any reason any premium arrears should be deducted when my income resumes.

Signature ✗ Date

Your pay department will commence deductions as soon as possible after receipt of this mandate form from HSF health plan.
Your pay advice should be checked to ensure that this request has been correctly applied.

Recorded in Wages Dept.	Initials	Date

TEAR ALONG PERFORATION

To: HSF HEALTH PLAN
FREEPOST
5 Westgate Business Park
Kilrush Road
Ennis
Co Clare

Ireland Office

5 Westgate Business Park,
Kilrush Road, Ennis, Co. Clare

Tel: 1890 473 473

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HSF health plan®

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