SOUTH WALES POLICE FEDERATION
HOSPITALISATION BENEFIT
CLAIM FORM

☐ Serving Member ☐ Entry Level Member ☐ Police Staff Member

Claimant Details:

Full Name:____

Rank:______________________ Force Number:_______________________________

Division:___________________ Section/Dept:______________________________

Home Address:____

____

_______________________________Post Code:_______________________

Telephone Number:___________________________________

Claim Details:____

I was a hospital in-patient at (Name of hospital and ward) ______________________

____

Telephone Number: ____________________________

For the period: ________________________Totalling:__________________nights
(maximum payable 5 nights)

Suffering from: ____

Date and Details of accident (if applicable): ______________________________

____

Name of Consultant: _______________________________________

Please indicate below if your admission was unplanned or planned:-

☐ Accident/incident/emergency admission

☐ Planned admission (benefit payable after first 3 nights)

Member Declaration:

I declare that the above statements are true and complete and that I remained in a hospital bed in a ward or intensive care unit **between midnight and seven o'clock in the morning** for each night claimed.

I attach a copy of the hospital admission and discharge certificate.

Signed: ____ Date:__________________

Trustee Declaration:

I certify that the details stated above are correct and that the claimant is a subscribing member of the South Wales Police insurance scheme and submit this claim on behalf of the trustees.

Signed: ____ Date:__________________

Name: ____

Bank Details:

When your claim has been approved we will make the payment to you directly into your bank account.

This payment method is both speedier and safer than payment by cheque. Please complete the following:-

Name and Address of your bank:

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Branch Sort Code: ______/_______/_______

Account Number: _______________________

Account Name (s): ______________________