SOUTH WALES POLICE FEDERATION
HOSPITALISATION BENEFIT
CLAIM FORM

☐ **Serving Member** ☐ **Police Staff**

Claimant details:

Full Name: _____

Rank: _____ Force Number: _____

Division: _____ Section/Dept.: _____

Home Address: _____

_____

_____ Postcode: _____

Email: _____

Telephone Number: _____ Date of Birth :_____

Claim details:

I was a hospital in-patient at: **(Name of hospital and ward)** _____

_____

Telephone Number: _____

For the period: _____ Totaling: _____nights
(maximum payable 5 nights)

Suffering from: _____

Date and details of accident (if applicable):_____

_____

Name of consultant: _____

Please indicate below if your admission was:-

☐ Accident / Incident / Emergency Admission (unplanned)

☐ 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** 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 Federation Insurance Scheme** and submit this claim on behalf of the Trustees.

Signed: _____ Date: _____

Name: _____

BANK DETAILS:

When your payment has been approved we will make the payment to you directly to 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:

_____

_____

_____

Branch Sort Code: _____

Account Number: _____

Account Name(s):_____