MEDISAN APPLICATION FORM

Section A- must be completed by all applicants

Name_____ Grade_____Staff No. _____

Address _____ Work Location___ _____ Mobile number_____

Date of Birth ___/____/____Employment Start Date___/___/___email_____

Work phone number _____Line Manger _____

VHI Plan_____ Last Date of Assistance (From Fund)___/___/___

Section B This section only to be completed if on sick leave and reduced income
Income assistance applications must be accompanied by a doctor's report

Pay Frequency in Euros: **W**eekly/ **F**ortnightly : ☐

Full Pay: From:_____ To_____

1/2 Pay: _____ From:_____ To_____

Pension:or NIL Pay:_____From:_____ To_____

Social Welfare/Health Board Benefit_____

I hereby declare that I have not received income continuance benefit from the CWU in the past twelve months. I declare also that I am not in receipt of benefit from any other source.

_____

Postmaster /Welfare Officer/ EAP Support Officer

Section C- must be completed by all applicants

I declare that the information given on this application is true and I authorise the Hon. Secretary of the Fund to make any further enquiries relating to this application

_____ _____

Signature of Applicant Date

Section D- Checklist for all applications

1. Current payslip ☐
2. Medical evidence of illness ☐
3. Signed undertaking (see over) MUST accompany each INITIAL application ☐

(Please ensure these documents are included to ensure successful application)

Summary of Consultation & Drug Claims

(all receipts must be attached with the application)

	Doctor	Hospital	Drugs
Qtr 1			
Qtr 2			
Qtr 3			
Qtr 4			
Total £			

UNDERTAKING

I,

Name..... **Staff No**.....

Address..... **Grade**.....

..... **Employer**.....

In consideration of the Executive Committee of the Medisan Fund, ('The Fund') providing benefits out of the Fund to me pursuant to my application made herein for such benefits. I hereby undertake on my own behalf and on behalf of my heirs and executors and administrators to repay the full amount of such benefits to the Trustees of the Fund in the event that I receive compensation from any source in respect of the losses incurred by me which gave rise to my receiving the benefits from the Executive Committee of the Fund.

PROVIDED ALWAYS that at its absolute discretion the Executive Committee of the Fund may waive in whole or in part any repayments due to it hereunder.

Dated: _____ **Signed:** _____ **Witnessed:** _____

Please Note:

1. This document in no way indicates the likelihood or otherwise of any applicant receiving payment
2. All correspondence to: Grainne O Boyle, Medisan, PO Box 222, An Post Delivery Unit, Mullaghboy Industrial Estate, Navan, Co Meath, C15 AY 95
3. In cases of Drugs refund members must disclose if they are receiving a refund for same under Company doctor or medical refund schemes and must disclose the amount of same
4. Applicants are advised that matters in relation to the **Revenue Commissioner** are the sole responsibility of the applicant.
5. In cases of financial assistance, members **must disclose** if they are in receipt of benefit from any the following:
   - Union income continuance fund
   - Department of Social Community and Family Affairs payment

Members Electronic Funds Transfer Details

Account Details (Bank/ Building Society/ Credit Union? An Post Smart Account)

Name of Institution:_____(Please Print)

Name on Account: _____(Please Print)

IBAN

Account Number_____ Sort Code _____

Data Protection – the information collected here will only be used for the purposes of processing your claim with the Medisan Benefit Fund and will not be shared with any third party. If you consent to the use of your data for this purpose please sign the form below

Signed_____ Date_____