



Plaza 255, Blanchardstown Corporate Park 2, Ballycoolin Rd., Dublin 15. Tel: 01 899 1604. Fax: 01 899 1707. E-mail: customerservice@medicalaid.ie Website: www.medicalaid.ie

M.A.3 Members Claim Form OFFICE USE

Empty rectangular box for office use.

Registered Number _____ Name _____

Address _____

Station _____

If the claim or part of it is in respect of a child or children, the name and date of birth must be given.

Name: 1 _____ 2 _____ 3 _____ 4 _____ 5 _____

Date of Birth: _____

Does any part of this claim refer to expense incurred as a result of a Road Traffic Accident, Injury on Duty, Sporting Injury or were you referred for a Consultation/Treatment by the Chief Medical Officer of the Force?

Please tick Yes [] No []

If yes please indicate which part of claim so refers.

Must be answered before claim can be assessed.

You are asked to retain your receipts and submit your claim on a three monthly basis. In the case of financial hardship claims can be submitted more frequently. Please group receipts together i.e. drugs, doctor, dental etc. and place in date order.

Electronic Payments into your Garda Credit Union/Bank Account (not necessary if previously provided)

If you sign up for this service, you will save money and bank charges and also having to visit your credit union or bank to lodge your cheque. Your claim will be paid at least 5 days earlier than payments by cheque. To sign up and gain these benefits please supply the following details:

Credit Union / Bank Name Credit Union / Bank Sort Code Credit Union / Bank Account Number

I certify that the information and documentation submitted in support of this claim are correct in every way.

Signed: _____ Mobile No. _____

Dated: _____ Email: _____

(In case we need to contact you re claims etc.)

OFFICE USE

DATE RECEIVED

Empty box for date received.

TOTAL PAYMENT



Empty box for total payment.