BENEFIT CLAIM FORM

MPF

ESB Staff Medical Provident Fund

P.O. Box 384, Rosbrien, Limerick
Phone: 061-430 474 / 430 506 / 430 586
Fax: 061-430 500
Email: MPF@esb.ie

(For all claims other than Maternity & Annual Outpatient Claim)

Please ensure that you complete both sides of this claim form.

For office use only

Membership Details

Name & Address of Member	**Patient Name**
	Relationship to member
	Telephone Number
	STAFF NUMBER

Ordinary Scheme ☐ **Extra Benefits Scheme** ☐

Injury Section

THIS SECTION MUST BE COMPLETED IN ALL CASES WHERE A THIRD PARTY/OCCUPATIONAL INJURY IS BEING PURSUED (See Section 9 of Members Guide to Benefits)

Date & Place of Injury: ______________________

Brief Description of Injury: ______________________

Do you intend to make a Claim? ______________________

Name & Address of Solicitor: ______________________

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In consideration of the MPF discharging my medical expenses, to the extent of my cover limits, I/We undertake to the MPF to include these expenses as part of my claim against a third party(ies), I hereby irrevocably authorise the solicitor(s) representing me in making a claim to furnish to MPF an undertaking in the following words:
"In consideration of the MPF discharging the medical expenses of my/our client(name). I/We hereby undertake to include as part of my/our client,s (name) the monies so paid out by the MPF (details of which are supplied to us by MPF) and subject to any order to the contrary, to repay to MPF out of the proceeds that come into our hands the new amounts recovered in respect of such payments made by the MPF"

Signature: ______________________ Date: ______________________
Please sign here if injury is involved

I declare that to the best of my knowledge the foregoing statements are true in every respect and I authorise the doctors/hospitals to supply the information requested.

DECLARATION AND SIGNATURE

(Please ensure all above sections are completed to facilitate prompt payment)

Member's Signature: ______________________ Date: ______________________

P ______________ **V** ______________ **A** ______________

MPF

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Nature Of Illness

This section must be completed in relation to each invoice/receipt submitted.
Please give Clinical description - as broad terms like 'Back Problem', 'Injury' or 'See Previous Claims' are not sufficient.

	Details/Description & Date	Nature of illness	Third Party/ Occupational Injury related (Yes/No)*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Please Refer to the Current Schedule of Benefits for entitlements and conditions of cover.

All invoices and receipts should be attached to this claim. Please ensure that all invoices that you have paid are clearly marked paid to ensure reimbursement will be issued to you.

A separate claim form must be used for each Claimant.

Please remember:

-- Photocopies of receipts/invoices will not be accepted.

-- Original receipts/invoices cannot be returned.
Please retain counterfoil of cheque for any MED1 submissions.

-- Claims cannot be accepted later than two years after treatment date.

-- Do not write on receipts/invoices or alter them in any way.

****Please see front of form for details that should be submitted.***

This form must be completed in full before you make a submission

Non completion will result in Claim Forms being returned and will delay reimbursement/payment.

DATA PROTECTION NOTICE – The information you provide becomes part of the personal data held by ESB Staff Medical Provident Fund and is automated. It is confidential and will be used for the payment of claims and for the provision and administration of health insurance products and related services.

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