

MPF

ESB Staff Medical Provident Fund
27 Lower Fitzwilliam Street, Dublin 2.
Phone: 676 5831. Fax: 702 6788

INDEMNITY - OCCUPATIONAL INJURY CLAIM

TO : Trustees, ESB Staff Medical Provident Fund

MEMBER.....STAFF NO.....
WORK LOCATION.....

In consideration of the ESB Staff Medical Provident Fund, under Rule 12.7, advancing me payment to discharge the medical expenses arising out of my occupational injury on(date), I hereby agree that the advances are made strictly on the basis that:

1. I undertake to include all amounts so advanced by MPF in any claim for compensation.
2. I will be personally liable for repayment to the MPF of the total amount advanced if I fail to include the total medical expenses in any claim.
3. In the event of my recovering any monies from ESB in respect of such injury, I hereby irrevocably authorise the ESB to deduct the amounts advanced to me by the Medical Provident Fund from any settlement proceeds and to repay same direct to the MPF on my behalf.

I understand and agree to the above conditions.

MEMBER :WITNESS :
(Signed) (Signed)

ADDRESS :ADDRESS :

DATE: DATE:

SOLICITORS NAME:.....

COMPANY NAME.....

ADDRESS.....

N.B. A Copy of this signed Indemnity form will be forwarded to your Solicitor.