

BENEFIT CLAIM FORM

Subject to the Benefit and General Conditions currently in force

Please return to:
WHA, 60 Newport Rd, Cardiff,
CF24 OYG Tel: 029 2048 5461



Part 1 Must be completed and signed by the person who actually pays the contributions by payroll deduction or direct to WHA.

Part 2 Must be completed and signed by an authorised person. **IN ALL CASES** the appropriate Benefit Section must be completed and certified.

Part 1 Details of Contributor

Name, address and postcode of contributor

Membership number

Date of birth --

Marital status (please tick one)

Married Widowed

Single Divorced

Legally separated

Employer

Pay/clock number

Please indicate who you are claiming benefit for . . .

A Contributor

B Contributor's spouse Name Age

C Child under 18 Name Age

D Additional member Name Age

Relationship to contributor

Marital status

Date of birth --

CONTRIBUTOR'S DECLARATION

I declare that the information given on this form is correct and true and that any fees stated have been incurred and paid either by myself or the patient and are not eligible for reimbursement from any other source. Any attempt to defraud WHA will result in legal action.

Signature _____

Date _____

SEPARATE CLAIM FORMS ARE REQUIRED FOR EACH CLAIM. NO MORE THAN ONE CLAIM PER FORM PLEASE.

Part 2 Certification of membership

Certification of membership should be by an authorised person at the place of employment. Direct subscribers should ignore this section.

Employer name

Date contributor joined

Date contributions paid up to

EMPLOYER'S CERTIFICATION

I certify that the above named is a regular contributor at the rate of £ . per week / mth / qtr (circle one)

Signature _____

Position held _____

Date _____

Sections 1 & 2 Hospital inpatient & outpatient (excluding maternity - see section 3)

To be certified on discharge/completion of a 90 day stay or, for outpatient, of four attendances in a continuous period of six months

Patient's name First Last DOB --

Medical classification Accident Emergency Psychiatric Geriatric Ante/postnatal Other

1st **INPATIENT** hospitalisation
Name of hospital (official stamp)

Admitted -- Discharged --
or still in hospital

Signature and position of hospital officer

Date --

2nd **INPATIENT** hospitalisation
Name of hospital (official stamp)

Admitted -- Discharged --
or still in hospital

Signature and position of hospital officer

Date --

OUTPATIENT attendances
Name of hospital (official stamp)

Attendance dates
(minimum of four)

1st --

2nd --

3rd --

4th --

Signature and position of hospital officer

Date --

Section 3 Maternity benefit (hospital or home birth)

To be completed by doctor, midwife or hospital officer.

Name of mother

Where confined

Date of confinement

Male/female child

If twins or more, state number of children here and enclose birth certificates

Period in hospital (if applicable) Admitted

Discharged

Name of hospital (official stamp)

I certify that a confinement took place after not less than 28 weeks of pregnancy. Signature of doctor, midwife or hospital officer.

Signature

Status/qualification

Date

WHA may request that birth certificate/s be submitted

Section 4 Convalescent home

If you want WHA to arrange your admission to a convalescent home, your General Practitioner must complete the section below.

Doctor's recommendation: I recommend (insert patient's name)

Who is recovering from (insert nature of condition)

for a stay in a convalescent home, if considered eligible.

Nature of any disability

Signed

Date

Qualifications

Section 5 Optical (spectacles, lenses and contact lenses)

To be completed by the optician. The patient must attach a receipt of payment to this claim form.

Name of patient

Details/description of lenses

Date of supply

Prescription/test date

Value of NHS vouchers £ . (if any)

The optician must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box opposite.

Section 6 Dental (including dentures)

To be completed by the dentist. The patient must attach a receipt of payment to this claim form.

Name of patient

Details / description of treatment

Date of treatment from to

The dentist must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

Section 7 Personal accident benefit

Personal accident benefit is for the contributor only and is not applicable to Personal 145 and Partners 145 schemes.

Please send me an application form for personal accident benefit (tick)

Details of injury suffered

Section 8 Complementary treatments

For physiotherapy, osteopathy, chiropractic, acupuncture and chiropody benefit claims. To be completed by the qualified practitioner. The patient must attach a receipt of payment. SEE SECTION 2 FOR NHS PHYSIOTHERAPY CLAIMS.

I certify that (patient's name)

suffering from

has received (tick one) Physiotherapy Chiropractic
 Osteopathy Acupuncture Chiropody

date of treatment from to

Number of treatments Cost per treatment £

The practitioner must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

Section 9 Specialist consultation

To be completed by the consultant (receipt to be attached). SEE SECTION 2 FOR NHS CONSULTATION CLAIMS.

I certify that (patient's name)

has attended for a consultation in respect of (nature of condition):

The practitioner must certify this claim by stamping and completing the PRACTITIONER'S CERTIFICATION box below.

PRACTITIONER'S CERTIFICATION

Full name

Signature

Qualifications

Date

Amount Paid £ .

Amount paid in words (pounds only)

pounds

Official stamp including name and address