TFS Health Cash Plan Claim Form

Please refer to your Welcome Letter and Plan Documents to check your eligible benefits.
If you have any questions please contact the TFS Member Services team on 020 7833 2616.
PLEASE NOTE THAT CLAIMS WILL ONLY BE PROCESSED IF YOUR PREMIUMS ARE PAID UP TO DATE.

transport friendly society

1 Member's Details

Please provide your personal details (To be completed by plan holder)

Membership No		Title: Mr ☐ Mrs ☐ Miss ☐ Other _____	
First Name		Surname	
Address			
Post Code		Telephone No	
Email Address:		Workplace	
I wish to go paperless and receive all my communications by email ☐		I wish to hear about TFS products ☐	

Please note this claim form should be completed by the plan holder, even when making a claim for a Partner or Child, insured under the same plan.

2 Claim Details

Please specify the benefit, amount and person you wish to claim for

Office use

- Please enclose a copy of your child's birth or adoption certificate with their first claim
- For hospital related claims please also complete section 5 overleaf

Claimant	Benefit	Treatment	Amount Paid	Benefit Amount
			£	£
			£	£
			£	£
			£	£
Total Amount Claimed			£	£

I would like my original receipts to be returned ☐

Additional Comments

Adjustments	£
Total Benefit Paid	£
Date	Ref
Examined by	Checked by

3 Payment is made directly into your bank account. Please provide details below.

(To be completed by plan holder)

Account Holder's Name

Account Number ☐☐☐☐☐☐☐☐ Sort Code ☐☐-☐☐-☐☐

Cheque ☐ (selecting this option could significantly delay payment of your benefit)

4 Declaration

To be signed by plan holder

I declare that:

- I have read and understood the Fraud Provision on page 23 of my **TFS Health Cash Plan Claims booklet**
- The information I have provided on this claim form is true, accurate and complete
- I am aware that if any of the information I have provided is not true, accurate or correct this may affect the Society's decision to provide cover for me and may lead the Society to void my policy/policies, reject any claim and even terminate my membership

By signing this declaration I consent to the Transport Friendly Society undertaking any enquiries they consider necessary concerning this claim and I authorise the release of any information to the Transport Friendly Society.

A photocopy or scan of this authorisation shall be considered as effective and valid as the original.

Member's Signature _____ Date _____

P.T.O

5 Hospital Benefit Please ensure that all relevant information is provided to avoid any delay in processing your claim

A. To be completed by YOU (PLAN HOLDER):

1. What diagnosis has been given as the reason for the admission to hospital?
2. When did the symptoms of this condition/problem first begin?
3. When was the family doctor first consulted about them?

B. To be completed by NHS or PRIVATE HOSPITAL:

Hospital name: _____ Hospital No.: _____

Address: _____

Hospital Stamp

Ward: _____

Official's name: _____

Official's Title: _____

Signature: _____

I certify that _____ (patient's name), date of birth / /

was admitted to the hospital for the reason(s) detailed below: *(NB: maternity-related conditions and out-patient treatment are excluded)*

Nature of treatment/medical condition/procedure: _____

The patient was: (*PLEASE SELECT ONE*)

☐ **Admitted as an IN-PATIENT**

Admitted on / / Discharged on / /

Absence (NB: *Benefit is not payable for periods when patient is allowed out of hospital for any reason*)

Absence 1: from / / to / /

Absence 2: from / / to / /

OR

☐ **Admitted as a DAY PATIENT**

Patient was admitted on / /

	Please select Yes	No
Patient was allocated a bed for a period of supervised recovery	☐	☐
Patient underwent a surgical procedure using theatre facilities	☐	☐

OR

☐ **Overnight for a PARENTAL HOSPITAL STAY**

Full name of child: _____

Full name of parent accompanying child overnight: _____

No. of nights parent stayed: Dates: from / / to / /

6 Birth/Adoption of a child Please enclose your child's original full birth certificate or adoption papers

Child's full name: _____

Child's date of birth / / **OR** Child's date of adoption / /

7 Useful Checklist Please be aware that failure to comply with these requirements may cause a delay to the payment of your claim

1. Form completion and additional documentation — **please tick**

- I have stated the benefit/s and costs I am claiming for and completed all claim details as applicable ☐
- I have read the terms and conditions relevant to the benefit/s I am claiming ☐
- I have provided my personal and payment details ☐
- **Hospital claims**: The hospital has stamped and signed my claim form and I have enclosed my hospital discharge summary ☐
- **Child claims**: If this is the first claim for my child, I have enclosed their full birth certificate ☐
- **Birth/Adoption claims**: I have enclosed the original birth certificate or adoption papers ☐
- **Convalescence claims**: I have enclosed my hospital discharge summary and my convalescence receipt ☐
- I have signed the declaration box ☐

2. Attach original, official receipts, which are not more than 12 months old. *For full receipt requirements see our website.*
Do your receipts show the following: — **please tick**

- The full name and title of the patient / customer ☐
- The full name, contact details and official stamp of the practitioner ☐
- Details of the treatment provided including the date ☐
- Evidence that payment has been made in full (invoices are not accepted) ☐
- I understand that receipts will not be returned unless requested ☐

3. Please return this form, along with the appropriate receipts to us at:

Transport Friendly Society Limited, 3rd Floor, Derbyshire House, St. Chad's Street, London WC1H 8AG
T: 020 7833 2616 F: 020 7833 4426 E: claims@tfs.uk.com W: www.tfs.uk.com

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