Membership Application Form

Notes to Application

Previous/Present Health Insurance

If any of the named applicant(s) had/have Health Insurance with another Insurer in the Irish State, the following details must be provided in order to establish waiting periods/exclusions that may be applied to their MPF Cover. These details must be provided by way of letter/email from the applicable Insurer and must include the following:

1. Policy Number 2. Name of Scheme 3. Length of time that the person is/was on the policy.

Please note Renewal Notice will not suffice.

Pre-Existing Medical Conditions

Please complete the appropriate section in the following circumstances. If you are aware of any medical condition in yourself or any of the other applicants which may necessitate medical or surgical treatment. If you have a pre-existing condition, as determined on medical advice, then an exclusion period will apply before any claim will be paid relating to that condition. The exclusion period runs from the date the relevant member joined MPF.

Data Protection

In order that MPF may administer healthcare insurance, provide you with an effective service, and to comply with our legal obligations, it is necessary for us to collect and use data relating to you ("Personal Data"). This includes the name, address and contact details for you and any dependents that are included in your membership, payment data and information relating to your medical history.

We will hold, use and protect your Personal Data in accordance with data protection and privacy laws. You have significant rights in relation to the Personal Data that we hold about you. These rights include: Access to, and copies of, the Personal Data we hold about you; Correction of any Personal Data which is inaccurate; Deletion or erasure of Personal Data that we no longer require. Where necessary, we will seek your consent to specific uses of your Personal Data. Where you give that consent, you are entitled to revoke it at any time.

We may disclose your Personal Data to persons who are providing services to us under contract. We are responsible for ensuring that those persons handle and protect your Personal Data to Our standards. We may also disclose anonymised information for research or statistical purposes. Where the law requires, we may disclose your Personal Data to authorities such as An Garda Síochána.

The collection and use of your data by MPF is overseen by the ESB Group Data Protection Officer. To find out more about your rights and how we manage and protect your Personal Data please refer to our Privacy Notice, which can be found at http://www.esbmpf.ie/Privacy-Notice.html. You can get a copy by contacting us in writing. Further detail can be obtained by contacting our Data Protection Officer by email at dpo@esb.ie or by postal mail at **Data Protection Officer, ESB, Two Gateway, East Wall Road D03 A995, Dublin 3.**

ESB Staff Medical Provident Fund
PO Box 384, Rosbrien, Limerick
E: mpf@esb.ie T: 55361 for Internal Calls
061-430561 for External numbers

Application Form For Membership

Please note that this form must be completed for registration purposes.
All sections must be completed to register member(s) in the Fund.

Name of Main Member: ____**Staff No:**________________

Home Address: ____

Work Address:____

Payroll Frequency: Weekly:________ **Fortnightly:** ____________**Monthly:**___________

Email address: _______________________________________**Phone No:**________________________

Bank Details: ESB MPF makes all payments of claim by Electronic Fund Transfer. In order to facilitate such payments, please provide the following information for your nominated bank account.

BIC: ___________________________ IBAN:____.

It is your responsibility to ensure that your bank details, email and addresses are accurate and up to date. Any changes to the above information must be forwarded to the MPF office by way of email/letter .

Name	Relationship to Subscriber	Date of Birth	PPS Number	Date Cover required from	Level of Cover required MPF Intro/ MPF Premium/ MPF Premium Plus	Pre existing conditions (please see over)	Previous Health Insurance (yes/no)
Policy Holder							
Associate 1							
Associate 2							
Associate 3							
Associate 4							
Associate 5							

I declare the above statement(s) to be true and that I have disclosed all material information. I hereby authorise the ESB to deduct from my salary the contributions to the MPF at the rates prescribed.

Signature:____ **Date :** _____________________.

ESB Medical Provident Fund requires the above information to create and administer your membership.
The data controller is ESB Medical Provident Fund.
Please refer to our Privacy Notice, available at www.esbmpf.ie or we will provide a copy on request.