ESB STAFF
MEDICAL INSURANCE

ANNUAL CLAIM FORM

ESB Staff Medical Provident Fund
P.O. Box 384, Rosbrien, Limerick
E: mpf@esb.ie **T:** 55361 for internal calls
061 – 430561 for external numbers

ESBMPF©

Annual Outpatient Claim Form

For Office use only

Membership Details

Members Name: ______________________________ Main Policy Number :______________ .

Address:____ .

Telephone No: ______________________________ Email Address:______________________ .

Family Policy: [ ] Single Policy: [ ] Claim for Calendar year: ________________ .

Please refer to the Schedule of Benefits for the appropriate year for claimable costs/limits and excesses.

Do not use this claim for Consultant or Chartered Physiotherapy receipts. Please use Benefit Claim Form for these receipts.

	A	B	C	D
Month	Pharmacy costs	GP Receipts	A & E/ Private E.R. charges	Other allowable receipts - please refer to your Schedule of Benefits
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Totals				
			Overall allowable costs (sum of A&B&C&D)	
			Less Excess Applicable for Policy	
			Nett Cost	
			Nett Refund (70% of Nett Cost)	

I declare that the attached receipts relate only to me and/or my associate members who were registered members of MPF for the period now being claimed.

Member's Signature: ______________________________________Date: ________________

ESB Medical Provident Fund requires the above information to enable us to apply the benefits as per level of cover. 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.