HAMPSHIRE POLICE FEDERATION INSURANCE SCHEME
SICK PAY BENEFIT

1. The sick pay benefit is only payable to members who are notified by the Force that their pay is to be reduced because of absence due to sickness or injury.

2. If you have been notified that your pay is to be reduced please complete this form and return it to the Federation Office.

3. Payment of the benefit will be paid into your nominated bank account on a monthly basis in line with the policy terms and conditions (including the required sickness absence period).

4. Benefit ceases after the period determined by the Insurance policy or on earlier return to duty, or on earlier resignation or retirement from the Force.

5. The benefit may be terminated if you turn down any reasonable recuperative duties.

6. In order that your claim can be correctly reviewed and paid each month Philip Williams and Co must be advised if: -

   - You return to work / retire / resign
   - You receive a change in salary
   - You are reduced to nil pay
   - You are reinstated to full pay for any reason
   - You change any personal details (e.g. address, email, bank account)

7. Your Statutory Sick Pay will cease at week 28 of sickness. It becomes your own responsibility to make a claim to the Department of Work and Pensions for Employment Support Allowance.

SERVING OFFICER / POLICE STAFF / SPECIAL CONSTABLE* (Delete as applicable)

SURNAME: _____ FORENAME(S): _____

COLLAR NUMBER: _____ RANK: _____

HOME ADDRESS: _____

_____

_____ POSTCODE: _____

TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

I have been absent from duty since (date): _____

Suffering from (condition): _____

And as a result I have been notified that my pay is to be reduced with effect from (date) _____

I have returned to work on (date):_____

I am being considered for Medical Retirement: **Yes / No**

I attach a copy of the Force Notification regarding the Half Pay decision together with copies of my last monthly full pay-slip and a copy of the first monthly reduced pay-slip.

I claim benefit under the scheme and I will notify the underwriters should I return to work, retire or resign. If I am reinstated on full pay I will inform Philip Williams and Co immediately. If I receive full pay from the force for any period for which I have been paid benefit under the scheme by the insurers, I undertake to refund the benefit paid in full.

Signed: _____ Date: _____

FOR FEDERATION USE:

I certify that the details stated above are correct and that the claimant is a subscribing member if the Group Insurance Scheme

Signed: _____ Date: _____

On behalf of the Trustees

BANK DETAILS

When your claim has been approved we will make the payment to you directly to your Bank Account.

Please complete the following: -

Name and address of your Bank: Branch Sort Code: **_____/_____/_____**

_____ Account Number: _____

_____ Account Name(s): _____

DATA PROTECTION NOTICE

Philip Williams & Company Insurance Management collects and uses your data in accordance with current data protection law (which includes, from 25 May 2018, the General Data Protection Regulation (Regulation (EU) 2016/679)) ("data protection law"). We maintain records in regard to policy claims on computer and/or paper files. Information will only be disclosed to third parties in whatever format is considered appropriate by us. By signing this form, you consent to Philip Williams & Company Insurance Management using your data and the information you have provided to process the claim. Further information can be found in our Privacy Policy at https://www.philipwilliams.co.uk