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. After the initial payment you will receive a supplementary claim form which must be returned to Philip Williams and Co. together with a copy of your next pay slip.

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

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.**

HAMPSHIRE POLICE INSURANCE SCHEME
SICK PAY BENEFIT CLAIM FORM

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

FORM A

SURNAME: _____ FORENAME(S): _____

FORCE NUMBER: _____ RANK: _____

SECTION/DEPT: _____

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 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 OF 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): _____