ESB STAFF
MEDICAL INSURANCE

INDEMNITY FORM - OCCUPATIONAL INJURY CLAIM

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

INDEMNITY FORM OCCUPATIONAL INJURY CLAIM

TO: Trustees, ESB Staff Medical Provident Fund

Member…… Staff No……

Work Location…… Tel. No. ……..

In consideration of the ESB Staff Medical Provident Fund, under Rule 13.7,advancing me payment to discharge the medical expense arising out of my occupational injury on ……(date), I hereby agree that the advances are made strictly on the basis that:

1. **I undertake to include all amounts so advanced by MPF in any claim for compensation.**

2. **I will be personally liable for repayment to the MPF of the total amount advanced if I fail to include the total medical expenses in any claim.**

3. **In the event of my recovering any monies from ESB in respect of such injury, I hereby irrevocably authorise the ESB, or the Solicitor acting on my behalf, to deduct the amounts advanced to me by the Medical Provident Fund from any settlement proceeds and to repay same, direct to the MPF on my behalf.**

4. **I will keep the MPF informed of progress and outcome of claim when finalised.**

I understand and agree to the above conditions.

Member:……Witness:……..
(Signed) To Signature :(Signed)

Address:…… Address:……

Date:…… Date:……..

Solicitor's Name(s):……

Company Name:……

Address……

N.B. A copy of this signed Indemnity Form will be forwarded to your Solicitor

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