CLAIM ON ESB MEDICAL BENEFIT SCHEME

**OPTICAL/ HEARING AID**

**IMPORTANT NOTE:**

* This section is to be completed and signed by the applicant.
* The optician should completed the form overleaf. A separate optical receipt is essential stating the **Price of the Examination**, **Type of Spectacles or Contact Lenses** carried out, as this is all that can be claimed back. (Photocopy not accepted)
* A separate aural receipt is essential stating the cost of hearing aid/s, as this is all that can be claimed back. (Photocopy not accepted)
* Claims should be submitted no later than **3 Months** after treatment.
* FOR OFFICE USE ONLY section should be left blank.

**All Benevolent fund members are required to provide an additional copy of their claim for forwarding to relevant benevolent fund.**

Send completed forms to: **ESB Medical Benefits, 39-43 Merrion Square East, Dublin 2**

**To be completed by applicant**

Name of ESB Employee / Pensioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In Superannuation Scheme from (Date, if Known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone No: \_\_\_\_\_\_\_\_\_\_\_\_

Location/Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This section should be completed if the claim is being made on behalf of a spouse/civil partner or a child**

**dependant. A SPOUSE/CIVIL PARTNER who is in employment must FIRST apply to the Department**

**of Social Protection, and if not covered by the Social Welfare scheme must submit their written reply.**

Name of person for who benefit is claimed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to ESB employee or pensioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** If separated or divorced please advise address to where correspondence should be sent.

**SPOUSE/CIVIL PARTNER:** Is your spouse/civil partner paying full Pay Related Social Insurance now

or has he/she in the past?

If applicable, please give details of commencement and cessation of employment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILD:** Date of Birth of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(N.B Only children under 16 years are eligible)**

Have you or your spouse/civil partner received or are you entitled to receive benefit form Social Welfare or any other medical scheme in respect of all or any of the items covered by this application? If so, please give particulars:

Do you or your spouse/civil partner have a medical card? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I declare the information I have given is true and complete to the best of my knowledge.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This claim form should be completed and returned to the appropriate **paying office\*** together with

whichever of the following documents are relevant:

**Optical Benefit:** Itemised receipt indicating the price of examination and/ or services provided.

Or

The Optician should complete, sign and stamp this side of the form.

**Hearing Aid:** Receipt and certificate from Doctor recommending the purchase of hearing aid(s).

**TO BE COMPLETED BY OPTICIAN**

**Examination Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Sight Examination: € \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supply or Repair of Spectacles**

1 pair Distance **€ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1 pair Reading **€ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bi-focal/ Varifocal spectacles/ or repairs thereto €** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact lenses**

(once off payment, unless there is a change in prescription**) € \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOTAL** € **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

2/2

**FOR OFFICE USE**

Amount : €

Type of Benefit : Optical/Aural

Wk/ Month Paid :

Cheque No. :

Certified :

Approved :

**ESB Medical Benefits, 39-43 Merrion Square East, Dublin 2**