HUMBERSIDE POLICE GROUP INSURANCE SCHEME
UNSOCIABLE HOURS BENEFIT CLAIM FORM

1. The unsociable hours benefit is payable to members for any period of sickness where you were due to be working unsocial hours i.e. between the hours of 20:00 and 06:00 (subject to the 14 day excess period and applicable policy limits).
2. The benefit is payable for a maximum of 24 weeks **after** the 14 day excess period.
3. The benefit payable is £1.00 per unsocial hour up to a limit of £60 per week.
4. Please enclose a copy of your pay slips, for each month you are claiming, to confirm your hourly rate.
5. Please ensure your supervisory officer signs the appropriate declaration before you submit your claim form.

Please complete this form and return it to: - Humberside Police Federation, 1a Redland Drive, Kirk Ella, East Yorkshire, HU10 7UE

Claim Details: -

Surname: _____ Forename(s): _____

Date of Birth: _____ / _____ / _____

Rank: _____ Collar Number: _____

Home Address: _____

_____ Postcode: _____

Email Address: _____Tel Number: _____

First date of absence from duty: _____ / _____ / _____

First date of claim **(this must be after 14 days of absence):** _____ / _____ / _____

Last date of absence from duty: _____ / _____ / _____

Details of illness causing absence: _____

Declaration: -

- I declare that during the above period of sickness the total number of unsocial hours I am claiming is: -
  _____ **(Based on the hours I was scheduled to work at the time of onset of absence)**
- I confirm that as a result of not being able to work these hours I have suffered a loss of unsocial hours pay
- I have been off sick during this period and have been in receipt of Statements of Fitness to Work confirming I am not fit to work from my doctor

Insured Members Signature: _____ Date: _____

To be completed by your Supervisory Officer: -

I certify that the above was scheduled to work the unsocial hours as detailed above and has been off work during this time due to sickness.

Supervisory Officer Signature: _____ Date: _____

Please print name: _____ Rank: _____

BANK DETAILS:

When your payment has been approved we will make the payment to you directly to your bank account.

Name and Address of your bank:

_____

_____

_____

Branch Sort Code: _____

Account Number: _____

**Account Name(s):_____

****Please ensure you provide us with the exact account name as it appears on your bank account. Failure to do so will result in a delay in us processing your payment**

To be completed by a Trustee of the Scheme: -

I certify that the claimant is a member of the Scheme

Date of Joining Scheme:- _____/_____/_____

Signed: _____ Date: _____

Name: _____

DATA PROTECTION NOTICE

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