# WEST MERCIA POLICE FEDERATION
# TRANSFEREE GROUP INSURANCE APPLICATION
## £29.95 per calendar month

This form must be completed and returned within ONE MONTH of joining
Double Indemnity Clause – you cannot be a Member and a Spouse on our policies

FULL NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____ POSTCODE: _____

RANK & COLLAR NO: _____ DATE JOINED WMP: _____

☐ **MEMBER ONLY COVER**
Please attach a wage slip from your previous force to confirm you were a member of their Group Insurance Scheme, up until the date you left.

☐ **MEMBER AND PARTNER COVER**
Name of Partner: _____ Date of Birth: _____
Please provide written proof from your previous Federation confirming the Spouse insured including their full name and date of birth.

EXPRESSION OF WISH

I understand that in the event of my death, the benefit will be paid to my next of kin at that time, unless I have declared in writing to the contrary.

You can nominate more than one person, charity club or society. Please ensure that you keep this updated regarding any changes in circumstances.

I understand that this request is not binding on the Trustee. In the event of my death I would like the Trustee to consider making payment of any benefits under the Rules of the Scheme to the following:

| Name & Relationship | Date of Birth | Address | £ or % |
|---|---|---|---|
| | | | |

I authorise West Mercia to deduct the required subscription from my salary at source each pay period.

SIGNED: _____ DATE: _____

May 2024