



LADY GROVER'S FUND

Lady Grover's Fund, Mountbarrow House,
6-20 Elizabeth Street, London SW1W 9RB

Tel: 0207 808 4180 or 0845 873 7161

Email: secretary@ladygrover.org.uk

www.ladygrover.org.uk

FORM OF APPLICATION FOR BENEFIT

IN CONFIDENCE WHEN COMPLETED

1. NAME & INITIALS OF MEMBER: (Rank, Mr, Mrs, Miss, Ms):

Date of Birth: / /

Postcode:

Email:

Bank to which you wish the Grant to be credited. SORT CODE:

A/C NUMBER:

2. BENEFICIARY for whom Application is being made. If SELF, insert SELF in Relationship

Name:

Relationship:

Date of Birth: / /

3. MEDICAL CERTIFICATE, stating the complaint, appropriate level of care and likely duration, to be completed and signed by a relevant specialist. If a specialist is not involved in the treatment, or where the GP has an earlier diagnosis from a specialist, a GP's signature is acceptable.

Signature of Doctor: _____ Practice Address: _____

4. EXPENDITURE. Please give actual dates:

(a) Nursing Home / Hospital Accommodation (*delete as applicable*)

From _____ to _____ (___ weeks ___ days) @ _____ per week

£ .

(b) Home Nursing support employed

From _____ to _____ (___ weeks ___ days) @ _____ per week

£ .

(c) Convalescence

From _____ to _____ (___ weeks ___ days) @ _____ per week

£ .

(d) Home Help

From _____ to _____ (___ weeks ___ days) @ _____ per week

£ .

TOTAL: £ .

5. EX-GRATIA PAYMENTS

If the applicant wishes to be considered for an ex-gratia payment in addition to the foregoing claim, please state on a separate sheet the nature of special circumstances constituting financial hardship.

6. OTHER INSURANCE

If benefit is being claimed under any insurance from any other source, state

(a) Name of Society or Company and Personal Reference No. if known:

(b) Amount of compensation received in respect of Nursing expenses:

DATE:

SIGNATURE OF MEMBER:

**POST THE APPLICATION
AND CONSENT FORM TO
THE SECRETARY.**



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CONSENT FOR USE OF PERSONAL AND HEALTHCARE DATA

Under the General Data Protection Regulation, Lady Grover's Fund is obliged to obtain your consent to hold and use the information we need in order to be able to fulfil the our contract with you to help you with your healthcare expenses.

Please note that without this consent we will not be able to pay your claim.

Once you have given us your consent, that consent will remain in place unless and until you let us know otherwise. We will ask you to renew this consent each time you make a claim. You may update your information at any time by letter, email or phone. When you do so, you accept that your consent remains unchanged unless you inform us to the contrary.

Both members and the dependant for whom you are making a claim will need to fill in this form as part of the claim. Please record your decision using X in the box under **YES** or **NO**.

MEMBER

I consent to Lady Grover's Fund holding and using such healthcare information about me as is required for the administration of my membership and processing of claims for my dependants.

YES	NO	NAME	SIGNATURE	DATE
<input type="checkbox"/>	<input type="checkbox"/>			

I consent to Lady Grover's Fund holding and using such personal and healthcare information about the following dependant **under the age of 18** as is required for the processing of claims on their behalf.

YES	NO	NAME	SIGNATURE	DATE
<input type="checkbox"/>	<input type="checkbox"/>			

BENEFICIARY

I consent to Lady Grover's Fund holding and using such personal and healthcare information about me as is required for the processing of claims on my behalf.

YES	NO	NAME	SIGNATURE	DATE
<input type="checkbox"/>	<input type="checkbox"/>			