HEALTHCARE - MEDICAL
CLAIM REPORT

Please answer all questions. This will help us process your claim quickly. If you need more space to answer any of the questions, please use a separate sheet of paper. Any attachments will form part of this claim report and the declaration will include them.

GENERAL INFORMATION

1. Company name

Member no.

2. Member name

Occupation

3. Date of birth

Sex: M/F

Date joined

4. Address

Postcode

Private telephone no.

Business telephone no.

Fax no.

Email address

DECLARATION

5. Are any of the medical or professional services claimed, resulting out of the following categories:

- Work related which entitles you to workers compensation claim? Yes No
- Related to motor vehicle accident? Yes No
- Treatment related to drug addiction, alcoholism, mental illness or aids? Yes No
- Treatment or condition that had been pre-existing prior to joining scheme? Yes No

6. If response is **YES** to any of the above, please give details below:

7. Are you entitled to receive reimbursement of medical expenses under any other medical insurance scheme, personal accident/sickness policy, common law entitlement or travel policy?

No Yes ➡ If Yes, give details below

TO BE COMPLETED FOR HEALTHCARE CLAIMS ONLY

PROFESSIONAL MEDICAL TREATMENT AND SERVICE DETAILS

Patient's name	Relationship to member	Date of Birth	Doctor or Hospital	Details of illness	Date treated	Amount

Total:	K

TO BE COMPLETED FOR FUNERAL EXPENSE CLAIMS ONLY

Name of deceased	Relationship to member	Date of death	Place of death	Cause of death

Is the medical death certificate attached?

No Yes If No, please list/state other supporting documents that you have attached

TO BE COMPLETED FOR PERSONAL ACCIDENT CLAIMS ONLY

Date of accident	Place of accident	**State exactly how the accident occurred**	Nature of accident/extent of injury(ies)	Duration of disablement

8. Have you engaged in or attended to your business in any way since the accident occurred? No Yes

Yes To what extent?

No When do you think you would be able to engage or attend to you business?

9. Are you confined to your bed? No Yes

10. Are you totally disabled? No Yes

11. State name of your medical attendant

Date of last medical attendance

PAYMENT DETAILS

Would you like the funds deposited to your Bank Account by electronic transfer? Yes No

Bank name

BSB

Account name

Account number

IMPORTANT NOTES

- Original receipts with valid stamp must be attached to the claim form
- Persons declared in the original proposal application form can be included for a claim
- Ensure that all claim forms are properly filled including the declaration section

I / We hereby claim healthcare benefits for the professional services to which this claim relates and I declare that I have incurred and paid the expenses for these services.

I / We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld.

I / We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I / We hereby authorise any physician or organization that has any records of my health to furnish Niugini Assurance Group Limited with any information concerning my/our medical history and physical condition.

Signature

Date