

Global Healthcare Claim Form

Post or fax to: Global Healthcare, PO Box 8672, Symonds Street, Auckland, New Zealand
Facsimile +64-9-309 4119. Telephone +64-9-309 2119

IMPORTANT NOTE: Please return this form as soon as possible. For prompt payment you must attach the following: 1. Police or Local Authority/Airline/Carrier reports. 2. Original doctor's certificates and/or receipts. 3. Original purchase receipts for old and new items and replacement quotes. 4. For Loss of Deposits claims – a copy of your original itinerary from your travel agent. 5. If none of these are available please state why:

Sections of this policy are subject to deductibles and these will be deducted from the amount of the claim.

Member No:	Period of Cover from: DD / MM / YY to: DD / MM / YY
First Name:	Surname:
Postal Address:	
Nationality:	
Occupation:	Date of birth: DD / MM / YY Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home phone: ()	Work phone: () Home fax: () E-mail:

Important: Were any special conditions, terms or endorsements applied to this policy? Yes No If 'Yes' please state:

Please complete this section if your claim relates to any of the following: In-patient/Out-patient – Dental – Hospital Cash benefit – Post hospital services – Home nursing – Ambulance charges – Loss of income – Maternity care – Organ transplant – Repatriation/Local burial – Emergency evacuation – Return travel – Death by accident – Legal expenses

Name of the person treated:		Date of birth: DD / MM / YY
Date: DD / MM / YY	Time: <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> night	Country:

Please advise what you are claiming for:

Please declare type of treatment received and final diagnosis:

Were you suffering or receiving treatment for this illness before purchasing this Insurance? Yes No. If YES, when and which type of treatment had you received?

Did you contact First Assistance for this claim? Yes No

Name and address of your usual doctor:	Doctors phone: ()
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Are these expenses recoverable from any other Medical Plan or Insurance Policy? Yes No

If YES, declare the name and address of the Medical Plan or Insurer:

REIMBURSEMENT: How do you wish payment of your claim to be made? Cheque (please state currency)

<input type="checkbox"/> Bank account - Bank:	Branch, name and country:
Account number:	Account holder's name:
<input type="checkbox"/> Credit card - Card number: <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/>	Expiry: Card Type:
Cardholders name:	

Type of treatment — complete the appropriate sections being claimed and circle relevant treatment	Have you paid this account	Date(s)	Amount claimed
In-patient treatment/Travel health extension	Yes / No		
Out-patient treatment/Specialist out-patient	Yes / No		
Dental	Yes / No		
Post hospital treatment/Hospital cash benefit	Yes / No		
Home nursing/Local ambulance charges/Organ transplant	Yes / No		
Loss of income/Return travel	Yes / No		
Maternity care benefit/Emergency maternity care	Yes / No		
Repatriation/Local burial/Emergency medical evacuation	Yes / No		
Death by accident/Legal expenses	Yes / No		

Important: You must provide invoices and receipts to support your claim AND you must sign this declaration before sending to Global Healthcare. Global Healthcare is not liable for any bank charges incurred in settling your claim.

Declaration: Please read and sign. 1. I declare that all the above information is true. 2. I agree that if I have made any false statement, or fraudulent claim or suppress or conceal any information that this policy will be invalid and all rights of recovery will be forfeited. 3. I declare that I do or I do not (please tick applicable) have any claim with any other insurance company covering this loss. 4. I declare that I have not had any previous claim declined. 5. I authorise Global Healthcare Insurance Services to obtain any medical or other information from any other source, doctor or specialist that will assist in the process of this claim. 6. I agree to provide the Insurer or its' Representative any relevant information regarding current or past claims and to the Insurer or its' Representative releasing claims information to any other party.

Signed:	Dated: DD / MM / YY
Name of Person who has completed this form:	

