UNION MEDICAL BENEFITS SOCIETY LIMITED

Claims form.

1. Member details

Any field marked by an asterisk (*) is mandatory and must be completed in all cases.
To move between fields, please use the TAB key.

Full Name*

First name(s)

Last name

Membership number

Address*

Email

Phone number

UniMed pays your claim reimbursement directly to your bank account, so...

- If you have already provided UniMed with your bank account details, tick **'Use my current bank details'**.
- Or, if your bank account details have changed please tick **'Add or Update my bank details'**.

My bank account details*

○ Use my current bank account details

○ Add or update my bank account details

Account number:

Name and date of birth of people who are claiming reimbursement:*

	Name	Date of birth (dd/mm/yyyy)
1		
2		
3		
4		
5		
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7		
8		

2. Details of all claims

Note: **Please provide full details relating to the nature of illness or treatment received. Please include the amount paid or invoiced in the column provided. Please include/attach a copy of itemised accounts (invoice) showing the name of the patient, date of consultation, description of service, qualification and GST number of the provider.***

(If you require more lines to itemise your claims, please refer to page 3)

	Date of visit (dd/mm/yy)	Name of patient (In capitals please)	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced	OFFICE USE ONLY
1						
2						
3						
4						
5						
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11						
12						
13						
14						

Total claim amount: $

3. Declaration

In completing and submitting this form you consent to the collection, disclosure and use of your information in accordance with the Privacy Act 2020, the Health Information Privacy Code and the Privacy Statement on UniMed's website.

Are the events under this claim subject to reimbursement from another Health Insurer or ACC?*

◯ Yes ◯ No

I confirm:*

☐ I understand that this claim will be treated in confidence and handled according to the terms and conditions that were in place when the events happened.

☐ I consent to receiving all documentation that UniMed is required in law to give me in electronic form and I consent to UniMed communicating with me via the preferred email address specified in this claim form.

☐ I certify that the healthcare service/s was performed and all particulars shown on this claim are true and correct. I authorise UniMed to obtain any further information they may need in connection with this claim in relation to any person listed on this claim form.

Signed:*

Full name	Signature	Date (dd/mm/yy)

Details of all claims continued

Note: Please provide full details relating to the nature of illness or treatment received.
Please include the amount paid or invoiced in the column provided.*

	Date of visit (dd/mm/yy)	Name of patient (In capitals please)	Name of doctor/ practitioner	Nature of illness/ treatment received	Amount paid/ invoiced	OFFICE USE ONLY
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UniMed, PO Box 1721, Christchurch 8140. Level 3, 165 Gloucester Street, Christchurch 8011.
P 03 365 4048 **FP** 0800 600 666 **F** 03 365 4066 **E** claims@unimed.co.nz | www.unimed.co.nz