HealthCare
It's good to belong

Claim Form

Date Received:

PERSONAL DETAILS OF POLICY HOLDER

Membership Number:

Full Name: _____ Date of Birth: _____

Postal Address: _____

_____

Postcode: _____ Work Phone: _____

Home Phone: _____ Mobile Phone: _____

Preferred Email: _____

Alternative Email: _____

Place of Work: _____ Position Held: _____

MY BANK DETAILS:

Account Number: ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐

BANK BRANCH ACCOUNT NUMBER SUFFIX

PLEASE NOTE: All claims will be paid directly into the bank account provided by you above (Cheques are no longer issued)

NAMES AND DATES OF BIRTH OF PEOPLE FOR WHOM REIMBURSEMENT IS BEING CLAIMED:

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____ Name: _____ Date of Birth: _____

DECLARATION THIS MUST BE COMPLETED IN ALL CASES

1. I am a Union member: YES ☐ NO ☐ Name Of Union: _____
2. The events under claim are subject to reimbursement from another source. YES ☐ NO ☐
   (e.g. medical insurance, ACC, linked and approved HealthCarePlus Hospital Cover Provider)
   Name of other source: _____
   Payment advice received from this source is attached. YES ☐ NO ☐
3. I understand that this claim will be treated in confidence and in accordance with the terms and conditions current at the time the events under claim occurred.
4. I consent to receiving all documentation that UniMed is required by 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.
5. In submitting this form I certify that the surgery, treatment or procedure was performed and all particulars shown on this claim are true and correct. I authorise UniMed to obtain any further medical information they may need in connection with this claim submitted by me or my listed dependants. UniMed may disclose information related to this claim to the Integrity Register for the purposes of the detection of fraudulent and suspicious conduct.
6. I confirm that I am authorised by each person named in this claim form to complete and sign on their behalf.

SIGNATURE OF APPLICANT: _____ **DATE:** _____

PRIVACY ACT Pursuant to the Privacy Act 2020 the following is brought to your attention:

(a) This claim form and any supporting documents collect personal information about you and is collected to effect the claim you make.

(b) In assessing and processing your claim UniMed may need to collect, disclose or use your personal information, including the collection of information from third party health service providers.

(c) You are required to provide all information that is material to a claim. If you fail to provide this information or provide inaccurate information it may result in your claim being delayed or declined or Membership voided.

(d) Each person in this claim form authorises UniMed to obtain from any party or organisation (including health care providers) any information reasonably required to evaluate and investigate this claim, and each person named in this claim form authorises that party or organisation to disclose such information to UniMed.

(e) 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 contained in the UniMed/HealthCarePlus Conditions of Membership. You also consent to the collection, disclosure and use of your information for the purposes of the Integrity register.

Attach receipts/ receipted accounts here in order listed.

DETAILS OF ALL CLAIMS

☐ Receipts/Receipted accounts for all events are securely attached to this claim. These must show the date of each visit, the name of patient, and the name of the practitioner. Prescription receipts must show prescribing practitioner.

IMPORTANT: specialist fees/tests/xrays are to lead on to an operation: YES ☐ NO ☐

Receipts in order of family member please.

NOTE: Full detail of nature of illness or treatment received must be stated

DATE OF VISIT	NAME OF PATIENT	NAME OF DOCTOR ETC	NATURE OF ILLNESS OR TREATMENT RECEIVED	AMOUNT PAID	OFFICE USE ONLY

Please continue on a separate sheet if necessary

TOTAL $

PLEASE RETURN YOUR COMPLETED CLAIMS FORM AND RECEIPTS TO:-
Email: claims@unimed.co.nz
Post: UniMed, PO Box 1721, Christchurch 8140

UniMed
YOUR HEALTH INSURER