

# Claim form

## 1 Details of main member/guardian

Policy number			
Title	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):		
First name(s)			
Surname			
Date of birth	DD / MM / YY		
Postal address	Street		
	Town/city	Postcode	
Telephone	Home (     )		
	Business (     )		
	Mobile		
Email			

## 2 Refund Direct credit to member/guardian's bank account

Bank account number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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☐ I authorise information about the details of this claim to be provided to my adviser

## 3 Pre-approved claims Please complete this section if you have already obtained approval for the procedure

Pre-approval number					
Patient name					
Procedure name	Name of provider/facility	Date of procedure	Pay provider directly	Amount charged	
		DD / MM / YY	<input type="radio"/> Yes <input type="radio"/> No	\$	
		DD / MM / YY	<input type="radio"/> Yes <input type="radio"/> No	\$	
		DD / MM / YY	<input type="radio"/> Yes <input type="radio"/> No	\$	
		DD / MM / YY	<input type="radio"/> Yes <input type="radio"/> No	\$	
		DD / MM / YY	<input type="radio"/> Yes <input type="radio"/> No	\$	
Total amount charged				\$	

If you are claiming for a procedure, treatment or consultation that has not been pre-approved, then please carry on to Section 4 on the next page

Please refer to your policy certificate and the Accuro general terms and conditions for your policy exclusions.

**Important information:** To enable accurate and efficient assessment of this claim, please ensure that you have completed the following:

- ☐ Checked that the itemised account(s) includes:
  - » the date of treatment/service
  - » the name of the patient
  - » the name of the health service provider who provided the treatment/service.
- ☐ Attached a GP referral letter and/or specialist letter (if applicable).
- ☐ Attached a completed Accuro medical report form (for members/children who have had cover for fewer than five years).
- ☐ Attached the itemised account(s) and evidence that payment has been made.  
Please note that EFTPOS and credit card receipts or statements without itemised account(s) are not sufficient.
- ☐ Checked that receipts for prescription items show the name of the drug.
- ☐ Checked that the 'Full details of nature of illness or treatment received' column on this claim form has been completed with the actual condition/symptoms, e.g. chest infection.
- ☐ Checked that the main member/guardian has signed the declaration below.

Accuro Health Insurance (Accuro) is a brand owned, operated and underwritten by Union Medical Benefits Society Ltd trading as UniMed.

This claim form collects personal information about you and those covered under your policy for the purpose of evaluating your claim. The intended recipient of this information is UniMed. The information is being collected and held by UniMed, PO Box 10075, Wellington. Failure to provide the information requested may result in your claim being declined. You and those covered by your plan have the right to access and request correction of this information in accordance with the Privacy Act 2020.

This declaration must be signed in order for your claim to be paid.

I declare that all particulars shown on this form are true and correct, that this claim is made in accordance with the conditions of my membership and that UniMed is hereby authorised to obtain copies of the medical records of the person to which this claim relates that they may require. I declare that this claim is made in accordance with my policy document and the rules of UniMed.

Main member/guardian signature

Date signed: DD / MM / YY

## Details of claims

[illegible]

### Details of claims continued

[illegible]