

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:

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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

In submitting this form I declare;

1. I am a Union member: YES NO Name Of Union: _____

2. The events under claim are subject to reimbursement from another source.
(e.g. medical insurance, ACC, linked and approved HealthCarePlus Hospital Cover Provider) YES NO

Name of other source: _____ YES NO
Payment advice received from this source is attached.

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 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.

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 submit on their behalf.

Date: _____

PRIVACY ACT Pursuant to the Privacy Act 1993 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 the 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 1993, 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.

