CLAIM FORM

Head Office
17 The Quadrant Mall
PO Box 915
Launceston 7250
abn 81 009 479 618

MEMBERSHIP DETAILS

Member's Surname | First Name and Initial | Membership No.

Address | Postcode | Phone Home | Work

Do you want this recorded as your permanent address YES ☐ NO ☐

CLAIM DETAILS

Name of Patient	Provider's Name	A/C Paid Yes/No	Name of Patient	Provider's Name	A/C Paid Yes/No	Name of Patient	Provider's Name	A/C Paid Yes/No

STATEMENT BY CLAIMANT

1. If adding a dependant: Name

Date of Birth / / | Relationship

2. Was the service incurred whilst in hospital? .... YES ☐ NO ☐

If yes, name of hospital

Period in hospital from / / to / /

3. Was the patient aware of the symptoms of the condition before joining St.LukesHealth or upgrading to a higher level of cover? .... YES ☐ NO ☐

If yes, please supply details

4. Is there any entitlement to claim benefit for this health care service under Repatriation, Worker's Compensation, MAIB, persons liable at law or from any other source? .... YES ☐ NO ☐

If yes, please supply details

I hereby declare and warrant that all the above information furnished in connection with this claim is true and correct. I authorise the hospital, medical or any other authorities or practitioners concerned with my hospitalisation, injury, disease or ailment or the treatment or diagnosis thereof or any matter arising therefrom to supply all relevant information to St.LukesHealth, if required.

Further, I consent to the collection, use and disclosure of my personal information by St.LukesHealth for any reasonable purpose associated with its businesses as a health insurer or for any purpose identified in the St.LukesHealth Privacy Policy, and I have authority to provide and consent to the release of personal information on behalf of the dependants referred to in this document.

Signature of Claimant | Date / /

ELECTRONIC FUNDS TRANSFER (EFT) OF BENEFIT

If you have previously registered for EFT Benefit Payments, it is not necessary to complete this section again, unless your account details have changed.

Do you want the benefit for this claim and all future claims to be deposited directly into a financial institution account via Electronic Funds Transfer (EFT)? (This option is only available for paid accounts.) YES ☐ NO ☐

Name the account is held in

BSB number (6 digits in total) ☐☐☐ - ☐☐☐

Financial institution account number (up to 9 digits only) ☐☐☐☐☐☐☐☐☐

If you are unsure of the BSB number please contact the financial institution where the account is held

Financial institution | Branch

Signature of Claimant | Date / /

AGENT'S AUTHORITY

Please complete this section to authorise another person to collect benefits on your behalf. Must be completed prior to lodging your claim.

AGENT'S SIGNATURE .... CLAIMANT'S SIGNATURE ....

RECEIVED BY CASH THE SUM OF $ .... Signature of Claimant or Authorised Agent ....

CLAIM No.

OFFICE USE ONLY

Comment:

Override authorisation: Authorised by Initial: