Health cover claim form



Please include all relevant documents and keep copies if required, as Australian Unity will retain originals.

Your membership details						Complet	te
Membership number	Date of birth		Pleas	e tick the type of co	over you have:		
				Health Insurance	ce	Overseas Visitors	Cover
Title Surname			First r	name			
If your contact details have changed, pleas	e complete below:						
Postal address		Subur	ъ		Stat	e Postcod	e
Email	lele	phone (home)		((mobile)		
Claim details						Complet	te
First name of patient	Date of birth	Date of service	Name (of practitioner or t	vne of service	Has the account	hoon nai
This traine of patient	Bute of Birth	Dute of service	- Tunic (or practitioner or t	ype or service	YES	NC
						YES	NC NC
						YES	NC
						YES	NC
If accounts have been paid, please complete s	ection five below.						
Hospital details					_	Complet	te
•						-	
Are you claiming medical gap claims for se	rvices received whilst a pr	ivate inpatient of a	hospital?	YES	NO		
Hospital name							
		From	D D /	M M / Y	Y To D	D / M M /	YY
Hospital address or location		Suburb			Stat	te Postcod	le
Accident declaration						Complet	te
	ent/injury for which a thire	d party may have li	ability? Or l	nave you previous	sly received any		
Is your treatment associated with an accide						VE	
Is your treatment associated with an accide compensation in relation to this injury/ailn						VE	
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