

Health Cover Claim form



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

1. Membership details

Your Membership Number Type of Cover Health Insurance Overseas Visitors Cover

Title Date of birth Sex M/F

Surname First Name

If your contact details have changed, please complete below:

Postal address (no PO Box)

Suburb State Postcode

Phone (home) Mobile

Email

2. Claim details

First name of patient	Date of birth	Date of service	Name of practitioner or type of service	Has the account been paid?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If accounts have been paid, please complete Section 5 below.

3. Hospital details

Are you claiming medical gap claims for services received whilst a private inpatient of a hospital? Yes No

From / / To / /

Hospital name

Hospital address

Suburb State Postcode

4. Accident declaration

Is your treatment associated with an accident/injury for which a third party may have liability? Or have you previously received any compensation in relation to this injury/ailment? This includes: transport or vehicle, workers' compensation, domestic or sporting accidents?

Yes No

Nature of your ailment or injury

5. Claim payment

Australian Unity pays your claims directly into your nominated financial institution account. You only need to complete this section if your account details are different from the details we already hold.

Name and branch of financial institution

Name of account holder

BSB No. - Account number

Signature of policy holder Date / /

Please turn over page >

6. Declaration Note

I declare the information on this claim to be true and correct. I agree to assist Australian Unity obtain all information relevant to this claim, authorise the doctors, practitioners or other relevant authorities to provide access to any records relevant to this ailment/injury to Australian Unity (including date, type of services and relevant clinical information), and consent to the release of all relevant information to a medical referee, as determined necessary by Australian Unity, for the purpose of assessment of this claim.

Signature Date / /

Benefits are payable on claims submitted **no more than two years** after the date of service and only for periods during which a membership is financial (fully paid).

We handle your personal information in accordance with our Privacy Policy available at australianunity.com.au/privacy or by calling 13 29 39.



Return by post

Australian Unity Health
Reply Paid 91943, Melbourne VIC 3000
(No stamp is required)



Online

Send in an electronic claim via Online Member Services at australianunity.com.au/memberservices



Email

customerservice@australianunity.com.au



Apps

Download our iPhone or Android application to submit your claim electronically. Available on most covers.



Call us

Call our TeleClaims team to process your claim over the phone on **1800 807 144**.

Contact us



13 29 39



australianunity.com.au