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 ______

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?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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 D D / M M / Y Y Y Y To D D / M M / Y Y Y Y

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 D D / M M / Y Y Y Y

 Australian Unity Health Limited ABN 13 078 722 568 | 271 Spring Street, Melbourne VIC 3000

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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 D D / M M / Y Y Y Y

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.

Contact us

13 29 39
australianunity.com.au