Accident & Health
International Underwriting
Pty Ltd (AHI)
GPO Box 4213
Sydney NSW 2001

ABN: 26 053 335 952
AFS Licence No: 238621

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E. claims@ahiinsurance.com.au

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# Claim Form Expatriate/ Inpatriate Medical Expenses

**Important: Please read before you complete this form**
• Exchange rates and currency conversions will be taken from those listed on OANDA www oanda com

**Please ensure all items below are completed prior to returning form.**
1. All receipts are itemised and written in English or with an English translation (credit card slip showing payment is not sufficient)
2. All relevant sections on claim form are complete.
3. Verified that your international banking details are correct.
4. Completed Medicare declaration for any medical expenses incurred within Australia.
5. Itemised receipts must show all services separately, e.g. medical and pharmacy amounts shown separately.

## 01. Your Details

Compulsory

Policy Number

Name of Insured Company

Name of Insured Person

Residential Address

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Nationality

Country of Expatriation

## 02. Payment Details

Compulsory

Please note we are not liable for any bank processing fees incurred by the beneficiary

Direct/EFT Payment

Account Holder’s Name

BSB Number (6-Digits)

Account Number

Bank

Alternatively supply a deposit slip noting the following information

Foreign Account

SWIFT CODE / SORT CODE

IBAN Number

Account Number

Bank Name

Bank Address

Account Holders Name

Account Holders Residential Address

Account Holders International Phone Number

Account Currency

Tax I.D. (if applicable)

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**Important Declaration for ANY Treatment/Expense incurred in Australia**
(Please note, under the Health Insurance Act s128a fines apply for false or misleading information)

Medicare Number

Expiry Date

Do you have private health insurance? Yes No

Are you entitled to claim Medicare Benefits:

As an Australian Citizen Yes No

As a result of being granted or applying for permanent residency Yes No

Under a Reciprocal Health Agreement Yes No

## Schedule of claimed Expenses

| | Date of Account | Type of Injury / Illness | Name / Relationship | Treatment Received | Service Provider | Amount Claimed | Currency | Paid |
|---|---|---|---|---|---|---|---|---|
| *EG* | *10/4/2018* | *Eg. Sore Throat* | *Trevor / Son* | *consultation* | *Dr Smith* | *$100.00* | *USD* | *Y* |
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

**Important: Itemise each expense/account and attach your invoices and receipts before submitting your claim.**

**Dispute Resolution Statement**
AHI underwrite the policy on behalf of Insurance Australia Limited trading as CGU Insurance.

CGU is a subscriber to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to AHI, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within 15 business days.

If you still remain dissatisfied after proceeding with the above , our process includes advising you on how to contact the insurance industry's external independent complaints scheme. Access to this scheme is free of charge to you .

**Privacy Declaration**
I/we agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

**Declaration:**
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy including for the processing of this claim.

**Authority**
I authorise any hospital and/or physician who has treated me to provide AHI with copies of medical records or of my past medical history, as requested.

Signature

Date