

Claim Form

Expatriate and Temporary Resident Medical Expenses Insurance



The issue of this form is not an admission of liability

PLEASE ENSURE

- You have fully completed every question on this form including Appendix A. Failure to do so will result in delay in handling your claim.
- If any question is not applicable please state 'N/A'
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- All medical receipts are submitted with this form
- All receipts are itemised and written in English or with an English translation. A credit card slip showing payment is not sufficient.

Section 1

Claimant Details

Insured Name: _____ Policy number: _____

Name of Employee /Claimant: _____

Date of Birth: _____ Nationality: _____

Address: _____

Business Phone: _____ Mobile Phone: _____

Email: _____

Section 2

Medical Information

Patient's Name: _____ Date of Birth: _____ / _____ / _____

Please give full details of injury/onset of illness: _____

Date of Injury or manifestation of Illness: _____ / _____ / _____

When did the patient first receive medical attention for this condition? _____

Is there any entitlement to compensation under workers compensation, government law or other insurance? Yes [] No []

If YES, please give details: _____

Has the patient ever suffered with this or any similar condition before the present episode? Yes [] No []

If YES, please give details including dates of treatment and consultation: _____

Section 3 Payee Bank Details

When the claim has been approved the payment will be credited direct to your Bank Account.

Please complete the following:

Currency for reimbursement: _____

Bank Name: _____

Bank Address: _____

Swift Code: _____

Account Name(s): _____

BSB Number: _____ - - - _____

Account Number: _____

Section 4 Declaration

Claim Lodgement Details

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

(Please keep a copy of all documents sent to CSN)

Postal Address:

Corporate Services Network
GPO Box 4276
Sydney, NSW 2001

Email Address:

claims@csnet.com.au

Fax No:

+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:
+61 (2) 8256 1770

Policy and coverage queries should first be directed to your Insurance Broker.

Privacy Collection Statement:

At DUAL Australia Pty Ltd, we are committed to compliance with the *Privacy Act 1988* (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services. We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2) contracted third party providers who supply us with services such as claims investigation and management companies, legal and medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains more information about how to access and correct the information we hold about you and how to make a privacy related complaint, including how we will deal with it. By providing us with your personal information, you consent to its collection and use as outlined above and in our Privacy Policy. Ask us for a copy of our Privacy Policy via email at privacy@dualaustralia.com.au or access it via our website using the following [link](#).

Declaration and Authorisation Complete for all Claims

- **I declare that** the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.
- **I authorise** any hospital, physician or other person who has attended me to furnish the claims manager Corporate Services Network (CSN) or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Full Name: _____

Position: _____

Signature: _____ Date: / /

Appendix A - Medical Expenses

Please provide full details of amounts to be claimed

Are you entitled to claim Medicare Benefits:

As an Australian Citizen? Yes [] No [] Do you have private health insurance? Yes [] No []

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

Under a Reciprocal Health Agreement? Yes [] No []

Medical Number

Expiry Date

| | | | | | | | | | OFFICE USE ONLY | | | |
|----|-----------------|--------------------------|---------------|--------------------|------------------|----------------|----------|------|-----------------|--------|-------------|------------|
| | Date of Account | Type of Injury / Illness | Claimant name | Treatment Received | Service Provider | Amount Claimed | Currency | Paid | Rate | % Paid | Value Limit | Refund Due |
| 1 | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | |

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