ANZ Health Insurance
Claim form

You can fax this form (and your accounts for services) to ANZ Health Insurance on 1800 810 087 or send it to us in the envelope provided.

To ANZ Health Insurance Fax 1800 810 087

From Date / /

Number of pages (including this page)

PLEASE PRINT USING BLOCK LETTERS

Family name

Given name(s)

Membership number

Address

State Postcode

Phone Home Work

Please credit benefits to my nominated statement account

Financial institution

Address

Account name

Bank/Branch number Bank Account number

PATIENT / SERVICE INFORMATION

Given name and 2nd initial of patient	Date of service	Name of doctor/service provider
eg Paul G	01 / 05 / 10	Dr L Green
	/ /	
	/ /	
	/ /	
	/ /	
	/ /	

PRIVACY – USE AND DISCLOSURE OF PERSONAL INFORMATION

The privacy of your personal information is important to you and also to ANZ Health Insurance. The purpose of collecting information about you and other people on your membership is to assess your claim. If the information you give us is not complete or accurate, we may not be able to provide you with the full benefits of your policy.

In assessing your claim, we may need to disclose your personal information to other parties, such as independent claim assessors and doctors.

In the future, we may contact you about new products or special offers. If, at any time, you do not want to receive this information, you can opt out by telephoning 13 15 91 and quoting your ANZ Health Insurance Membership number on your customer card.

You are entitled to request reasonable access to information we have about you. We reserve the right to charge an administration fee for collating the information you request.

CLAIM DECLARATION

1. The accounts and/or documents supporting this claim are for services rendered to myself or my dependants (as defined), and I believe the information provided is true and correct. Dependants are defined as children under 17 years of age and single full time students under 25 years of age. A Family Plus membership covers the member, spouse and their single children up until their 23rd birthday.
2. Are the services claimed related to a sports injury or to any injury or ailment where there may be a right to payment of damages or compensation?

   ☐ Yes ☐ No If yes, date of accident / /

   Type of injury or ailment
3. If claiming for Medi Gap, at which hospital was treatment provided?
4. I have read and understood, and have made the other people on this membership aware of, the Privacy Disclosure Statement contained on this form (page 1). I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the persons named on this membership.

Name of member	Signature of member	Date *(dd/mm/yy)*
	✗	/ /

If you have any questions regarding your claim or our Policy on Privacy please contact ANZ Health Insurance on 13 15 91

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