



# UNI-CARE CLAIM FORM

COMPLETE IN ENGLISH - Please write clearly

Your policy number .....

## Policy Holder Details:

Given Name: ..... Family Name: ..... Date of Birth: ..... / ..... / .....

Telephone: ..... Mobile: ..... Email: .....

Claim payments to: .....

Name of Education Provider (if applicable): .....

Claim payments are made directly to your New Zealand Bank Account. Please complete your details below.

## Full New Zealand Bank Account Details

Name of Account: ..... Account Number: .....

What policy section are you claiming under: ☐ Medical ☐ Luggage ☐ Other

## MEDICAL & RELATED EXPENSES (Section 1 of Policy Wording)

Describe the Illness or Injury you are claiming for and treatment you have received: .....

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Date of Medical Consultation ..... Cost Claimed \$ ..... ☐ Pay Policy Holder ☐ Pay Medical Provider

When was the medical condition first treated? ..... / ..... / ..... • When was the medical condition last treated? ..... / ..... / .....

If optical claim enter date of first consultation ..... / ..... / ..... • If the claim is for a change in vision, please advise:

**A:** Previous prescription ..... **B:** New prescription ..... **C:** Change in dioptries: .....

## LUGGAGE - PERSONAL EFFECTS etc (Section 2 of Policy Wording)

Date of Loss, Damage or Theft: ..... / ..... / ..... Country & Location where it happened: .....

Describe Property\*\* .....

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Date Purchased ..... / ..... / ..... From ..... Cost \$ ..... Repair or Replacement cost \$ .....

Description of what happened: .....

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**IMPORTANT If the loss is due to theft or burglary the police should have been informed and a police report must be provided.**

\*\* Please supply proof of ownership for all claimed items, such as receipts, manuals or credit card statements.

## OTHER CLAIM CATEGORIES (Sections 3-7 of Policy Wording)

Claim Category: ..... Date of Event: ..... / ..... / ..... Country & Location: ..... Cost Claimed: \$ .....

Description of what happened: .....

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DECLARATION: I/We declare that:

1. to the best of my/our knowledge, all information provided on this claim form is accurate in every respect.

2. the amount claimed is NOT covered by another insurance policy, health or medical scheme.

PRIVACY ACT: I/We authorise American Home Assurance or their representatives or agents to obtain personal information (including medical information) about me/us from any other party and to release that information to other parties if requested. A photocopy of this authorisation shall be considered as effective and valid as the original.

SIGNATURE: ..... DATE: ..... / ..... / .....

**We require original receipts, invoices and estimates to be provided in support of this claim.**

Post, fax or scan and email your claims and original receipts to: The Uni-Care Claims Service, P.O. Box 496, Wellington, New Zealand.

Phone toll free in New Zealand: 0800 864 227 (0800 UNICARE); in Australia: 1800 864 227 (1800 UNICARE)

Outside New Zealand and Australia call: +64-4-381 8166 (collect), Fax: +64-4-385 7865. Email: claims@crombie.co.nz