

**PERSONAL DETAILS OF POLICY HOLDER**

Membership Number: \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Mobile Phone: (    ) \_\_\_\_\_

Preferred Email: \_\_\_\_\_

Alternative Email: \_\_\_\_\_

Place of Work: \_\_\_\_\_ Position Held: \_\_\_\_\_

**MY BANK DETAILS:**

Account Number: 

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BANK      BRANCH      ACCOUNT NUMBER      SUFFIX

**PLEASE NOTE:** All claims will be paid directly into the bank account provided by you above (Cheques are no longer issued)

**NAMES AND DATES OF BIRTH OF PEOPLE FOR WHOM REIMBURSEMENT IS BEING CLAIMED:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_      Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_      Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_      Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**DECLARATION THIS MUST BE COMPLETED IN ALL CASES**

In submitting this form I declare;

1. I am a Union member: YES  NO       Name Of Union: \_\_\_\_\_

2. The events under claim are subject to reimbursement from another source.  
(e.g. medical insurance, ACC, linked and approved HealthCarePlus Hospital Cover Provider)      YES  NO

Name of other source: \_\_\_\_\_      YES  NO   
 Payment advice received from this source is attached.

3. I understand that this claim will be treated in confidence and in accordance with the terms and conditions current at the time the events under claim occurred.

4. I consent to receiving all documentation that HealthCarePlus is required in law to give me in electronic form and I consent to HealthCarePlus communicating with me via the preferred email address specified in this claim form.

5. I confirm that I am authorised by each person named in this claim form to complete and submit on their behalf.

6. In submitting this form I declare that the information provided in this form is true and correct and I hereby authorise the Society to make further investigation if required.

**NOTE:** The claim will be returned unprocessed if any details have been omitted.

**ALL SECTIONS MUST BE COMPLETED.**

**Date:** \_\_\_\_\_

**PRIVACY ACT** Pursuant to the Privacy Act 1993 the following is brought to your attention:

- (a) This claim form and any supporting documents collect personal information about you and is collected to effect the claim you make.
- (b) In assessing and processing your claim HealthCarePlus may need to collect, disclose or use your personal information, including the collection of information from third party health service providers.
- (c) You are required to provide all information that is material to the claim. If you fail to provide this information or provide inaccurate information it may result in your claim being delayed or declined or Membership voided.
- (d) Each person in this claim form authorise HealthCarePlus to obtain from any party or organisation (including health care providers) any information reasonably required to evaluate and investigate this claim, and each person named in this claim form authorise that party or organisation to disclose such information to HealthCarePlus.
- (e) In completing and submitting this form you consent to the collection, disclosure and use of your information in accordance with the Privacy Act 1993, the Health Information Privacy Code and the HealthCarePlus Privacy Statement which is available at <http://healthcareplus.org.nz/Privacy+Statement>. You also consent to the collection, disclosure and use of your information for the purposes of the Integrity Register and as set out in the HealthCarePlus Privacy Statement.

