TRANS PACIFIC ASSURANCE

FULLERTON HEALTH

AON

PNG HEALTHCARE CLAIM FORM

Important Notes:

- Ensure all applicable sections are filled out correctly and signed.
- Attach original receipts with valid stamp, invoices, prescriptions, clinical notes and test/scan results.
- Submit your claim with supporting documents to your employer or pay-master to complete the Employer's Confirmation and forward to AON.

SECTION 1 – EMPLOYEE DETAILS

Employee Name: _____ Employee Number: _____

Designation: _____ Contact Number : _____

Company Name: _____

Office Address: _____

Email Address: _____

SECTION 2 – IMPORTANT QUESTIONS

Are any of the medical or professional services claimed, resulting out of the following categories:

- Work related which entitles you to workers compensation claim? ◯ Yes ◯ No
- Related to motor vehicle accident? ◯ Yes ◯ No
- Treatment related to drug addiction, alcoholism, mental illness or aids? ◯ Yes ◯ No
- Treatment or condition that had been pre-existing prior to joining scheme? ◯ Yes ◯ No
- Are you entitled to receive reimbursement of medical expenses under any other medical insurance scheme, personal accident/sickness policy, common law entitlement or travel policy? ◯ Yes ◯ No

If the response is yes to any of the above, please give details below:

_____

SECTION 3A – TO BE COMPLETED FOR MEDICAL, OPTICAL, DENTAL & MATERNITY CLAIMS ONLY

PATIENT DETAILS

Patient Name: _____ Sex (M/F): _____

Date of Birth: _____ Relationship to Employee: _____

TREATMENT & SERVICES DETAILS

Doctor/Hospital Name	Diagnosis/Nature of Illness	Treatment Date	Amount
		Total	165.00

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SECTION 3B – TO BE COMPLETED FOR FUNERAL EXPENSE CLAIMS ONLY

Name of Deceased	Relationship to Member	Date of Death	Place of Death	Cause of Death

Is Medical Death Certificate attached? ◯ Yes ◯ No

If no, please list/state other supporting documents that you have attached:

SECTION 3C – TO BE COMPLETED FOR PERSONAL ACCIDENT CLAIMS ONLY

Date of Accident	Place of Accident	State exactly how the accident occurred	Nature of Accident/Extent of Injury(ies)	Duration of Disablement

1. Have you engaged in or attended to your business in any way since this accident? ◯ Yes ◯ No
   a) If yes, to what extent? _____
   b) If no, When do you anticipate that you will be engaged in or attend to your business in any way? _____
2. Are you confined in your bed? ◯ Yes ◯ No
3. Are you totally disabled? ◯ Yes ◯ No
4. State the name of your medical attendant? _____
5. Date of last medical attendance? _____

SECTION 4 – BANK DETAILS

Account Name: _____

Account Number: _____

Bank Name: _____

Branch: _____

BSB Number: _____

Please ensure this section is completed and submitted with Claim application to ensure efficient payment processing.

SECTION 5 – DECLARATION

I hereby claim healthcare benefits for the professional services to which this claim relates and I declare that I have incurred and paid the expenses for these services.

I do solemnly and sincerely declare that the answers in the declaration are full and true and that I have not withheld any relevant information. Further I accept the responsibility that if any information is false, Trans Pacific Assurance Limited reserves the right to repudiate the claim.

I hereby authorize any physician or any organization that has any records of my health to furnish Trans Pacific Assurance Limited with any information concerning my medical history and physical condition. I agree that a photocopy of this authorization shall be considered as effective and valid as the original.

Claimant Signature

Date

SECTION 6 – EMPLOYER'S CONFIRMATION

I certify that the above member is currently employed with our organization and is an insured person under our PNG Healthcare policy.

Employer's Name

Position

Signature

Date