Uni-Care Claim Form



Please complete clearly in English

Policy Holder Details						
Given Name:		Family Name:				
Date of Birth: dd / mm / yyyy		Your Policy Number:				
Email:						
Telephone:		Mobile:				
Name of Education Provider (if	fapplicable):					
Claim Payment (Please comp	olete details of New Zealand Bank	k Account)				
Name of Account Holder:						
Account Number: Bank	- Branch	- Account Num		Suffix	Please note enter credit details	
Claim Details (Please complet	te for the sections you are claimin	ng for)				
What policy sections are you cl	laiming under:	O Medical O	Luggage	Other		
MEDICAL & RELATED EXI	PENSES (Section 1 of Policy Wo	ording)				
Date of Medical Consultation:	dd / mm / yyyy C	ost Claimed: \$	O Pay Po	olicy Holder	O Pay Medio	al Provider
				·	,	
When was the medical condition	on first treated? dd / mm / yy	yyy When was th	ne medical condition l			
		When was the syou first came to New Zealand		ast treated? dd / r		
	ou wearing optical aids when	you first came to New Zealand		ast treated? dd / r	mm / yyyy	
If this is a optical claim, were yo	ou wearing optical aids when	you first came to New Zealand		ast treated? dd / r	mm / yyyy	
If this is a optical claim, were your LUGGAGE - PERSONAL ER	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy	you first came to New Zealand	? • Yes	ast treated? dd / r	mm / yyyy	
If this is a optical claim, were year • LUGGAGE - PERSONAL EP Date of Loss, Damage or Theft Description of what happened	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy :	you first came to New Zealand	ecation of loss:	ast treated? dd / r	mm / yyyy	
If this is a optical claim, were year • LUGGAGE - PERSONAL EP Date of Loss, Damage or Theft Description of what happened	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy :	n you first came to New Zealand: icy Wording) Country & Lo	execution of loss:	ast treated? dd / r	Mm / yyyyy O No *Proof or	f ownership ached
If this is a optical claim, were you LUGGAGE - PERSONAL ER Date of Loss, Damage or Theft Description of what happened Description of property lost/da	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy : amage/stolen (please use a se	n you first came to New Zealand: icy Wording) Country & Lo	expocation of loss: ary) Purchase price:	ast treated? dd / r	Mm / yyyyy O No *Proof or	f ownership
If this is a optical claim, were you • LUGGAGE - PERSONAL EP Date of Loss, Damage or Theft Description of what happened Description of property lost/da Describe Property:	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy : amage/stolen (please use a se	eperate sheet of paper if necessad: Date purchased	execution of loss: Purchase price:	Replacement cost:	*Proof or att	f ownership ached
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If this is a optical claim, were yet • LUGGAGE - PERSONAL EI Date of Loss, Damage or Theft Description of what happened Description of property lost/da Describe Property: 1. 2.	ou wearing optical aids when FFECTS ETC. (Section 2 of Pol : dd / mm / yyyy : amage/stolen (please use a se	country & Lo Country & Lo Peperate sheet of paper if necessa d: Date purchased dd / mm / yyyy dd / mm / yyyy	expocation of loss: Purchase price:	Replacement cost:	*Proof or att. O Yes O Yes	f ownership ached O No O No

Important: If the loss is due to theft or burglary, a police complaint acknowledgement form must be provided

*Please supply proof of ownership for all claimed items such as receipts, manuals or credit statements. If you are supplying a credit card statement as proof of payment, please blank out the credit card number for your own security.

6.

O No

O Yes



Please complete clearly in English

OTHER CLAIM CATEGORIES (Section 3-7 of Policy Wording)	
What are you claiming for?	When did it happen? dd / mm / yyyy
Where did it happen?	Cost Claimed: \$
Description of what happened:	

Claimants Declaration

Declaration

I do solemnly and sincerely declare that the particulars contained in this form are true and correct in every detail and I agree that if I have made, or in any further declaration in respect of the above said claim shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Furthermore

In consideration of QBE Insurance (Australia) Limited, ABN 78 003 191 035 - Incorporated in Australia ("QBE") agreeing to meet payment of this claim I/we hereby agree to discharge QBE from any further liability, claims or demands in respect of this claim. Any property which is the subject of this claim will be owned by the Insurer by virtue of the claim having been settled in respect of such property.

Privacy Act

I acknowledge that QBE require this personal information from me before it will decide whether to accept this claim. This information will be retained and held by QBE. I understand that the Privacy Act entitles me to have access to and require correction of this information. I authorise QBE to disclose this information to its advisers, other insurers, to reinsurers and other parties. I further authorise QBE to obtain information about me held by any other party that is in its view relevant to this claim.

Medical authority

I hereby authorise any hospital, physician or other person who has attended me to furnish to QBE or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and all copies of hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective as the original.

I/We consent to QBE Assist recording all calls to the assistance service provided under the Travel Insurance for quality assurance, training and verification purposes.

Signature	Da	te
	do	d / mm / yyyy

Sending this Form

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We require original receipts, invoices and estimates to be provided in support of this claim. If you are supplying a credit card statement as proof of payment, please blank out the credit card number for your own security.

Post, fax or scan & email your claims and original receipts to:

="	Uni-Care Claims Service, Crombie Lockwood (NZ) Limited, P.O. Box 496, Wellington, New Zealand.
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+64.4.385.7865 (a) claims@crombie.co.nz

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