CLAIM FORM: DUAL EXPATRIATE AND TEMPORARY RESIDENT MEDICAL EXPENSES CLAIM FORM

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

PLEASE ENSURE

Please Ensure:

- You have fully completed every question on this form. Failure to do so will result in delay in handling your claim.
- If any question is not applicable please state 'N/A'
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- All medical receipts are submitted with this form
- All receipts are itemised and written in English or with an English translation. *A credit card slip showing payment is not sufficient.*

SECTION 1: CLAIMANT DETAILS

Name of Insured Company: _____

Name of Employee/Claimant: _____

Country of Posting: _____ Commencement Date of Posting: _____

Claimant Date of Birth: _____

Occupation/Trade or Profession: _____ Duties Undertaken: _____

Nationality: _____

Full Address of Claimant: _____

Business: _____ Home: _____

Mobile: _____

Email: _____

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS

- **I declare that** the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.
- **I authorise** any hospital, physician or other person who has attended me to furnish the claims manager Corporate Services Network (CSN) or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Signature: _____ Name (Print): _____

Date: _____ /_____ / _____

BANK ACCOUNT DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.

Please complete the following:

Currency for reimbursement: _____

Bank Name: _____

Bank Address: _____

Swift Code: _____

Account Name(s): _____

BSB Number: _____ - - - _____

Account Number: _____

SECTION 2: MEDICAL INFORMATION

Patient's Name: _____ Date of Birth: _____ /_____ / _____

Please give full details of injury/onset of illness: _____

_____

Date of Injury or manifestation of Illness: _____ /_____ / _____

When did the patient first receive medical attention for this condition? _____

_____

Is there any entitlement to compensation under workers compensation, government law or other insurance?

Yes ☐ No ☐

If YES, please give details: _____

_____

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If YES, please give details including dates of treatment and consultation: _____

_____

SECTION 3: CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

(Please keep a copy of all documents sent to CSN)

By Post: Corporate Services Network (CSN) GPO Box 4276 Sydney, NSW 2001

Email Address: claims@csnet.com.au	Fax No: +61 2 8256 1775
Phone Number: Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on: +61 (2) 8256 1770 Policy and coverage queries should first be directed to your Insurance Broker.	

PRIVACY STATEMENT:

At DUAL Australia Pty Ltd, we are committed to compliance with the Privacy Act 1988 (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services. We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2) contracted third party providers who supply us with services such as claims investigation and management companies, legal and medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains information about how you can access the information we hold about you, ask us to correct it, or make a privacy related complaint. You can obtain a copy from our Privacy Officer by telephone (+61 (0)2 9248 6300), email (reception@dualaustralia.com.au) or by visiting our website (www.dualaustralia.com.au).

By signing this claim form, you consent to the collection and use of your personal information as outlined above and in our Privacy Policy.

MEDICAL EXPENSES

Please provide full details of amounts to be claimed

Are you entitled to claim Medicare Benefits:

As an Australian Citizen ☐ Yes ☐ No

As a result of being granted or applying for permanent residency ☐ Yes ☐ No

Under a Reciprocal Health Agreement ☐ Yes ☐ No

Do you have private health insurance? ☐ Yes ☐ No

Medicare Number ☐☐☐☐ ☐☐☐☐☐ ☐

Expiry date ☐☐☐☐

	Date of Account	Type of Injury / Illness	Name / Relationship	Treatment Received	Service Provider	Amount Claimed	Currency	Paid	OFFICE USE ONLY			
									Rate	% Paid	Value Limit	Refund Due
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												

IMPORTANT: Itemise each expense/account and attach your invoices and receipts before submitting your claim.