Ambulance claim form

1. Please complete this form using **black ink** and write within the boxes in CAPITAL LETTERS.
   Mark appropriate answer boxes with a cross. Start at the left of each answer space and leave a gap between words. PLEASE DO NOT STAPLE.
2. Please complete all details that are relevant to you on both sides of this form.
3. Read the declaration and sign all the signature panels you need to.

SECTION A: YOUR DETAILS

Policy number

Surname

First name Initial Title

Unit number Street number PO Box number

Street name

Suburb

State Postcode

Home phone number

Daytime phone number

Mobile phone number

Fax number

Email address: if you would like to be kept up-to-date via email with the Fund's news and services when available, please fill in your email address below.

SECTION B: AMBULANCE SERVICE DETAILS

Do you have a subscription with an ambulance service? X Yes X No

Ambulance subscription number

Are you a Department of Social Security beneficiary (other than a Seniors Card holder)? X Yes X No

If yes to the above question, please provide Pension number

Health Care card number

SECTION C: TRANSPORTATION DETAILS

Date and time of ambulance transportation

D D / M M / Y Y AM/PM

Name and address of where journey commenced *(e.g. hospital name and address)*

Unit number Street number

Street name

Suburb

State Postcode

Name and address of destination *(e.g. hospital name and address)*

Unit number Street number

Street name

Suburb

State Postcode

Were you admitted to the above hospital? X Yes X No

Purpose/reason for transportation i.e. medical condition or nature of medical treatment which necessitated ambulance transportation

If you we're taken to hospital, how long were you there?

H H hours D D days W W week/s

Name of Medical Practitioner who treated you in hospital

Transport organised by *(e.g. yourself, doctor, relative etc)*

Has this account been paid by you? X Yes X No

Please ensure you have attached all invoices needed to process this claim

Are all invoices attached to this form? X Yes X No

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Provided by

Ambulance claim form

Your Policy number

SECTION D: ADDITIONAL DETAILS

Please complete the following sections where applicable.

1. Are you entitled to compensation from any other source? ☐ Yes ☐ No
2. Did the need for Ambulance Transportation occur at work? ☐ Yes ☐ No
3. Did the need for Ambulance Transportation occur going to or from work? ☐ Yes ☐ No
4. Has a claim been lodged with your employer? ☐ Yes ☐ No
5. If No, do you intend to lodge a claim with your employer? ☐ Yes ☐ No
6. What is your occupation?
7. Are you self-employed? ☐ Yes ☐ No
8. Did the transport accident occur whilst travelling to or from work? ☐ Yes ☐ No
9. Do you intend to lodge a claim with the Transport Accident Commission or a Third Party Insurer? ☐ Yes ☐ No
10. Was the accident/injury the result of negligence or violence by another person? ☐ Yes ☐ No
11. Do you intend to lodge a claim against the Crimes Compensation Tribunal? ☐ Yes ☐ No
12. Do you intend to pursue a common law/personal injuries claim? ☐ Yes ☐ No

SECTION E: DECLARATION

I authorise the Fund to contact any necessary persons if information is required to establish my entitlement to benefits.

I declare that information provided on this form is true, correct and complete and I will notify the Fund of any changes.

I agree to be bound by the Fund Rules.

Signature of Policyholder

✗

D D / M M / Y Y

MAIL TO: GPO Box 9809, Brisbane QLD 4001.

The Fund will only collect your personal information in order to respond to your enquiry and not disclose it to others. You may request access to this information.

For our Privacy Policy please call 133 234

Insurance Australia Limited ABN 11 000 016 722 trading as SGIC distributes SGIC Health Insurance.
SGIC Health Insurance is provided to you by the insurer MBF Alliances Pty Ltd ABN 89 075 799 236.
As the insurer, MBF Alliances Pty Ltd is referred to as the 'Fund'.

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