

# Claim form

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.

## SECTION A: YOUR DETAILS

Policy number (This can be found on your card)

Surname

First name

## SECTION B: CHANGE OF ADDRESS/CONTACT DETAILS

If any of your contact details have changed, please complete appropriate details.

Unit number

Street number

PO Box number

Street name

Suburb

State

Postcode

Home phone number

Daytime phone number

Mobile phone 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 C: CLAIM DETAILS

Provider paid?

Name of service provider (eg Dr A P Jones)

Claim under Baby Bonus?

1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enclose original accounts/receipts. If a receipt is not provided, claims will be made payable directly to the provider. All accounts/receipts and any documents supporting your claim will be retained by the Fund.

## SECTION D: COST RECOVERY DETAILS

1. Can you or the patient recover any costs/damages as a result of the Condition from any other source (eg Third Party, Workers' Compensation, motor vehicle accident insurance, Repatriation, persons liable at law, school accident, etc)? Refer to 'Compensation from a third party' overleaf.

No  Yes. If yes, please explain

2. Was the patient an in-patient in hospital for any of the above services?

No  Yes. If yes, which hospital?

## SECTION E: BENEFIT PAYMENT

Please cross the box to indicate how you would like your Benefits paid to you.

Cheque  Direct credit to my bank account (only applicable if you have paid the service provider's account in full).

## SECTION F: DIRECT CREDIT DETAILS

Please complete if you wish to register for direct credit or your account details have changed.

Name of financial institution where account is held

Name(s) of account holder(s)

BSB number

Bank account number

## SECTION G: DECLARATION, ACKNOWLEDGEMENT AND AUTHORITY

Please read carefully before signing.

For important conditions concerning Benefits, please see overleaf.

I declare that the services claimed were received by the patient, and that all information on this form is true and correct.

I acknowledge that a Benefit may not be payable or may be reduced if any applicable Waiting Periods have not been served, Limits have been reached or the services claimed are Excluded Services under my Hospital Cover. Refer to 'Waiting Periods', 'Limits' and 'Excluded Service' overleaf.

I authorise the Fund to pay Benefits direct to my healthcare provider(s) where accounts are unpaid.

I authorise the Fund to obtain information from the provider for any service claimed.

Policyholder's signature

X



\*MBFA0026CLAIM\*

# How to make a claim on your health insurance Policy

## WHENEVER YOU MAKE A CLAIM, YOU MUST:

provide the original account and/or receipt from the provider of the service, or the Medicare statement if you are claiming the 'gap' Benefit for Treatment received in hospital (this will be noted on the statement). Please retain your benefit statements for your personal tax records.

## MBF ALLIANCES POLICY TERMS & CONDITIONS

The following is an outline of some of the MBF Alliances Policy Terms & Conditions relevant to payment of Benefits.

## COMPENSATION FROM A THIRD PARTY

If you have an Accident or are injured (eg in a motor vehicle accident or as a result of your employment) and have a right to receive

Compensation or damages from a third party, you are not eligible for Benefits (includes future cost of treatment). This applies whether or not you pursue the claim and whether or not MBF Alliances has made any payment. You may apply for provisional Benefits, but these must be paid back if you receive Compensation.

## EXCLUDED SERVICE

An Excluded Service is one where no Benefit is payable for any of the doctors' or hospital's charges associated with that admission.

The following applies to Insured Persons whose cover is either Hospital Select Value, under which Benefits are not payable for the following services:

- joint replacement including revisions;
- cataract and eye lens procedures;
- cardiac and cardiac related services;
- Pregnancy and Birth Related Services including assisted reproductive services\*;  
and
- renal dialysis for chronic renal failure^.

OR Hospital Select Plus, under which Benefits are not payable for the following services:

- joint replacement including revisions;
- cataract and eye lens procedures; and
- renal dialysis for chronic renal failure^.

^ Not an Excluded Service for Insured Persons who joined or transferred to Hospital Select Value or Hospital Select Plus on or before 31 March 2006.

\* Please note that most fertility treatments are Out-patient Services and therefore not covered under any levels of MBF Alliances Hospital Cover.

## LIMITS

'Limits' means the maximum Benefit in a service category per Insured Person per calendar year except in the case of life-time limits (as referred to in the Product Rules) and periodic limits (as referred to in the General Treatment Benefit Guidelines). All Limits apply from date of service/purchase.

## MINIMUM BENEFIT

The Minimum Benefit is an amount determined by the Federal Minister for Health & Ageing for basic hospital accommodation costs. It is not sufficient to cover Treatment in a private hospital. This Benefit is sufficient only to cover your stay in a shared room of a public hospital. No Benefit is paid towards the cost of theatre charges raised for these services.

## SET BENEFIT

MBF Alliances has determined a Benefit for most services you receive – called a Set Benefit. Benefits are limited to the Set Benefit, or the actual charge, whichever is less.

## TIME LIMIT ON CLAIMS

Claims must be made within two years of the date of service or Treatment, except where it is a claim for a Baby Bonus Benefit which must be lodged within six (6) months of the date of delivery of the baby.

## WAITING PERIODS

A Waiting Period applies to a Treatment covered under the Policy, no Benefits will be payable for any service, appliance or Treatment received before the relevant Waiting Period has been served. The relevant Waiting Periods are:

- Pre-existing Condition\* – 12 months
- Pregnancy and Birth Related Services – 12 months
- congenital Conditions where considered pre-existing – 12 months
- major dental – 12 months
- health management aids and appliances – 12 months (except for fully handcrafted surgical shoes – 5 years)
- Optical Appliances – 6 months
- Wellness Program – 6 months
- hearing aids – 3 years
- other Conditions – 2 months
- Treatment for Accidents which occur after joining and would normally have a 2 month Waiting Period, will have no Waiting Period.

\* except for psychiatric, palliative or rehabilitation services for which a two month Waiting Period applies.

## PRIVACY

### Your health and personal information

Information collected on this form will only be used in accordance with the Fund's Information Handling Policy and the National Privacy Principles. We will only use the information you provide to us to manage and administer your health insurance policy to you, to evaluate and pay claims and to operate an efficient and sustainable business. As part of this process, we may disclose your information to others. The information we collect may include sensitive information.

If the information you give us is not complete or inaccurate, we may be unable to provide you with the products services you request. You can ask for reasonable access to the information that we hold about you. The Fund reserves the right to charge you for retrieving and providing certain types of information that we hold about you.

To view our full Information Handling Policy, please visit <http://www.sgic.com.au/health-insurance/privacy-statement.shtml>

## MAIL-IN CLAIMS

Send your claim to:  
SGIC Health Insurance Claims  
Reply Paid 5295  
Brisbane QLD 4001  
(no postage stamp required)

## ENQUIRIES – CALL 133 234



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