

Wellness Programs and gym membership fees approval form

Please complete this form using **black ink** and print well within the boxes in **CAPITAL LETTERS**. Please complete all questions, tick boxes and sign where appropriate. Leaving a question blank may delay the processing of this form.

FOR CUSTOMER(S) WITH A LEVEL OF EXTRAS COVER THAT INCLUDES WELLNESS PROGRAMS AND GYM MEMBERSHIP FEES

To be eligible to receive this Benefit, the gym membership fees, yoga or Pilates program must be a health management program or a chronic disease management program.

A health management program is a program that is intended to ameliorate a persons specific health condition.

A chronic disease management program is a program that is intended to:

- a) Either reduce complications in a person with a diagnosed chronic disease; or prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease; and
- b) Requires the development of a written plan
- c) Is coordinated by a person who has accepted responsibility for:
 - i. Ensuring the services are provided according to the plan and
 - ii. Monitoring the patient's compliance with the agreed goals and activities specified in the plan.

This form should be completed by your GP or Fund Recognised Provider including a physiotherapist, chiropractor or occupational therapist confirming that the Program is a health management program or a chronic disease management program. Each approval is valid for a maximum of 12 months from the date the approval is signed. Please note that GP consultations are not covered by the Fund.

Please provide the original gym membership, yoga or Pilates account or receipt with this approval form and mail to:

SGIC Health Insurance Claims, GPO Box 5295, Brisbane QLD 4001

SECTION A: CURRENT DETAILS

Policy number

Surname

Given name(s)

Initial

Title

Date of birth

Age

SECTION B: FUND RECOGNISED PROVIDER DETAILS

Provider number (if known)

Provider speciality

Provider name

Address of provider

Unit number

Street number

PO Box number

Street name

Suburb

State

Postcode

Contact phone number

Name of Hospital

SECTION C: TREATMENT DETAILS

SECTION D: DECLARATION

I certify that the gym/yoga/Pilates (please circle as appropriate) program is intended to be either a health management program or a chronic disease management program for the customer/s listed above and all the information on this form is true and correct.

Recognised Provider/General Practitioner signature



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