StudentCare Claim form

Please send your completed claim form to:
StudentCare Claims, PO Box 4513, Auckland 1010, New Zealand.

Fax: +64 9 309 4119
Tel: +64 9 309 2119 Email: claims@studentcare.biz

Please complete this form if your claim relates to any of the following:

Doctor or Specialist fees	**Public Hospital Services**	**Private Hospital Services**	**Pharmaceutical**	**Medical/Dental Emergency**
Ambulance Services	**Physiotherapy**	**Rehabilitation**	**Repatriation**	**Emergency Dental Treatment**
Maternity Services	**Medical Evacuation**	**Funeral Expenses**	**In-hospital Cash**	**Family Assistance/Travel Expenses**

PLEASE ANSWER ALL SECTIONS IN CAPITALS

Policyholder Details Section

Membership number: SC …………………

Policy dates: from dd/mm/yyyy ***to*** dd/mm/yyyy

First name:	*Last name:*
Date of birth:	*Postal address:* ………………………………………………
Gender:	
Date you arrived in your country of study: dd/mm/yyyy	*Email address:*
Nationality:	*Home fax:* ( )
Home phone: ( )	*Mobile phone:* ( )

Important: How would you prefer us to contact you? (Please circle) **Email** **Fax** **Post**

Claim Details

Name of Person Treated:	*What treatment/medication did you receive and what was the final diagnosis?* ***(This question must be answered before your claim can be processed.)*** ……………………………………………… ………………………………………………
Date injury/illness happened or began: dd/mm/yyyy	
Date of first consultation: dd/mm/yyyy	
Did you contact First Assistance? Yes / No	
Why did you visit the doctor? What was wrong with you? What were your symptoms? ……………………………………………… ………………………………………………	*Are these expenses recoverable from any other Medical Plan or Insurer?* Yes / No *If 'Yes', please give the name and address of your Medical Plan or Insurer:* ………………………………

Name of Doctor/Dentist, Pharmacy, Hospital or Provider	Date of Treatment/Consultation	Amount Charged (include currency)	Paid
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Payment Details & Checklist

Bank Name: ………………………………………………

Bank Address: ………………………………………………

Account Name: ………………………………………………

Account Number: ………………………………………………

IBAN/Swift Code: ………………………………………………

Important: Have you done the following? (Please tick the boxes when completed.)

- Completed all questions on your claim form in full and signed the declaration? ☐
- Has your Georgetown Representative collected your evidence/receipts in support of this claim? ☐
- Has your Georgetown Representative stamped this form as confirmation of receipt of your evidence? ☐
  (Evidence can be; original receipt/s, medical report/s and supporting documentation for your claim.)

Declaration: Please read and sign. 1. I declare that all the above information is true. 2. I agree that if I have made any false statement, or fraudulent claim or suppress or conceal any information that this policy will be invalid and all rights of recovery will be forfeited. 3. I declare by signing this form that I have not submitted a claim with another insurance company covering this loss. 4. I declare that I have not had any previous claim declined. 5. I authorise Inbroke StudentCare Insurance to obtain any medical or other information from any other source, doctor or specialist that will assist in the process of this claim. 6. I agree to provide the Insurer or its' Representative any relevant information regarding current or past claims and to the Insurer or its' Representative releasing claims information to any other party

Signed: ……………………………………………… **Dated** dd/mm/yyyy

Name of person who has completed this form: ………………………………………………

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