

## Making a claim by mail

- › Complete the claim form and attach the ORIGINALS of your accounts and receipts. Photocopies and facsimiles are not acceptable.
- › All accounts are retained by HBF and can not be returned. Please keep a copy of accounts and receipts for your records.
- › If you have claimed from Medicare for in-hospital medical services please include the Medicare Statement of Benefit.
- › Ensure your membership is paid until at least the date of treatment.
- › A benefit may not be paid unless the claim is lodged within the two years of the date of service.

## 1 Member details

Member Number (if known)

Surname

Given Names

Are you on Overseas Visitors Cover? Yes  No

Have the attached accounts been paid? All  Some  None

Please attach accounts and/or receipts.

### Direct credit of benefits

Please complete this section if you would like your benefit credited directly to your financial institution. **Complete this section only if the details are new/different to those previously provided by you.** This authority will remain in force until it is changed or cancelled by the policy holder or partner. Account details must be those of policy holder or partner only.

Name of Financial Institution  BSB/Financial Institution Number  Account Number (credit card not accepted)

Account in the name of

Account Holder's Signatures

2 Have your contact details changed? Yes  No  If no please go to section 3.

Postal Address  Postcode

Update this Address for all members current on the policy? Yes  No

Daytime Phone Numbers (Enables HBF to minimise processing delays should any queries arise) Home  Business  Mobile

Email Address

Preferred Method of Contact: Phone  Email  Mail

## 3 Is this claim resulting from an accident?

Yes  No  /  /  Date of accident

If yes, tick type of accident:  Motor vehicle  Home, school or sporting  Whilst at work

Other Please state

## 4 If the treatment was in hospital please complete this section

Medicare Number	Card Ref.	Expiry Date	Patient's First Name	Patient's Surname	Hospital	Date Admitted	Discharged Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5 Tick this box if you wish to use any GapSaver accruals you may have to help cover the out-of-pocket expenses on the accounts.

**Please note: GapSaver accruals may be used towards the cost of hospital and medical inpatient services and out-of-pocket costs for Essentials and Wellness services.**

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## Signature and Declaration

I declare and agree –

- › The recipient of the treatment or service of this claim:
  - › was the member named above or a registered dependant of the member.
  - › authorises the provider of that treatment or service to provide to HBF all information including clinical records or details HBF may request in respect to the claim or any additional information or assistance requested by HBF concerning the claim.
- › All details and answers in this form and all attached documents are true and correct.

Signature (Policy holder/partner/permanent authority)

Date

Please print name

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While you have a relationship with HBF, we'd like to give you promotional information for some of the other products we offer like general insurance and financial services. This could include phone calls and emails. Is this okay with you? Yes  No

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## HBF Privacy Statement

HBF will use the information you supply on this form, and the information we collect from third parties in connection with your claim (see the declaration in section six above), to assess and process your claim. When you make the claim you consent to HBF collecting related sensitive information directly from those third parties or, if you are not the recipient of the treatment or service the subject of the claim, you give consent on behalf of that recipient.

The Policyholder is responsible for maintaining the policy and paying premiums. So we will disclose information to them about benefit limits and treatment for all persons covered by the policy. The personal information we collect may be disclosed to our related companies. By making this claim you give your consent to us sharing the personal information we collect (including sensitive information) with its related companies of HBF (the HBF Group) for the purpose of preventing and detecting fraudulent or invalid claims or misrepresentation which would cause loss to the HBF Group.

We may also disclose certain personal information to your bank or financial institution if you choose to have your benefit paid by direct credit, and to any person you authorise to collect your benefit on your behalf.

HBF is also obliged by the Private Health Insurance Act 2007 to maintain certain transaction records and make those records available to the Department of Health and Ageing, the Private Health Insurance Ombudsman and Medicare Australia. We will disclose this and any other information as required by law.

If you do not provide personal information which is required, or give the authority in the declaration in section six above, HBF may not be able to process your claim.

In most circumstances you have a right to access any personal information which we collect and hold about you. Please contact us if you wish to access your personal information. We may deny your request in some circumstances and if we do this, we will tell you why.

More information about the way we handle personal information is detailed in our Privacy Policy, which is available at [hbf.com.au](http://hbf.com.au) or on request by calling a Member Service Advisor on 133 423.

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## Authority to collect benefit

**Please complete if someone is collecting on your behalf.**

I authorise the person whose signature I have witnessed here to collect cash/cheque due to me in respect of this claim.

Authorised Person's Signature

Authorised Person's Name (Please Print)

Member's Signature (Must be Policy Holder or Partner)

## How to Make a Claim

### Making a claim in a Service Centre

- › There is no need to complete a claim form if you are visiting one of HBF's Service Centres.
- › If someone other than the Policy Holder or Partner is making a claim, then please complete Section 9 and ensure that the authorised person produces identification.
- › If you would like an authorised person to make claims on a regular basis, a 'Permanent Authority' form must be completed and forwarded to HBF.