Health Claim

Your health is all that matters. hbf

- Complete the claim form and attach the ORIGINALS of your accounts and receipts. Photocopies and facsimiles are not acceptable.
- Please note, we are unable to pay a benefit for medical services provided out of hospital (out-patient medical services).

1 MEMBER DETAILS

Member Number | Surname | Given Names

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

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

2 DIRECT CREDIT OF BENEFITS

Complete this section only if the details are different to those previously provided.

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

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

Account in the name of | Account Holder's Signature

3 OVERSEAS VISITORS COVER

Are you covered by an Overseas Visitor policy? ☐ Yes ☐ No

4 ST JOHN AMBULANCE CLAIM

Only complete this section if you are claiming for St John Ambulance transport

Do you receive a Centrelink Aged Pension or a Department of Veteran Affairs Age Service Pension (and hold a valid Pensioner Concession Card)? ☐ Yes ☐ No

If yes, you don't need to complete this form.
Please return the account to St John Ambulance as your benefit is covered in full by your concession.

Are you over 65? ☐ Yes ☐ No

5 IS THIS CLAIM RESULTING FROM AN ACCIDENT?

☐ Yes ☐ No Date of accident D D M M Y Y

If Yes, tick type of accident: ☐ Motor vehicle ☐ Home, school or sporting ☐ Whilst at work ☐ Other Please state below

6 GAPSAVER

☐ Tick here if you have GapSaver and would like to use your benefits towards your gap payment.

7 IMPORTANT DECLARATION

I certify that the service to which this claim relates has been received, that the information contained within the account is true and correct and authorise the provider of the service to provide to HBF all requested information, including clinical records relating to the service.

Signature (Policy holder/partner/permanent authority) | Date D D M M Y Y | Please print name

PLEASE TURN OVER FOR PRIVACY STATEMENT

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8 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)

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 overleaf), 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. We may also disclose to service providers contracted by us to offer you services in chronic disease management or health management.

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 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 overleaf, 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 or on request by calling a Member Service Advisor on 133 423.

HOW TO MAKE A CLAIM

In person:

- Visit an HBF branch to claim on the spot.
- There is no need to complete this form if claiming in person.
- Go to hbf.com.au or call 133 423 to find your nearest branch.

By mail:

- Complete this claim form and attach originals of your accounts and receipts. Photocopies and facsimiles are not acceptable.
- Post your claim to HBF, GPO Box S1440, Perth WA 6809.

ADDITIONAL CLAIM INFORMATION

- A benefit may not be paid unless the claim is lodged within two years of the date of service.
- All accounts are retained by HBF and can not be returned. Please keep a copy of accounts and receipts for your records.
- Please ensure your membership is paid until at least the date of treatment.
- If someone other than the Policy Holder or Partner is making a claim, please complete Section 8. The authorised person will be required to produce identification
- If you would like an authorised person to make claims on a regular basis, a 'Power of Attorney/Appointment of Agent' form must be completed and forwarded to HBF.