StudentCare Insurance
Medical Claim Form

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 and in ENGLISH. Please send completed claim form to StudentCare Claims, PO Box 4513, Auckland, New Zealand.

Email claims@studentcareinsurance.com Tel +64 (0) 9 309 2119 Fax +64 (0) 9 309 4119

Policyholder Details

Membership number	*Policy dates* dd / mm / yyyy to dd / mm / yyyy
First name	*Last name*
Date of birth dd / mm / yyyy	*Postal address*
Gender Male / Female	
Date you arrived in your country of study dd / mm / yyyy	*Email*
Nationality	*Home fax*
Home phone	*Mobile phone*
Important – how would you like us to contact you?	Email Fax Post

Claim Details

Name of patient	*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?	*Were you suffering from or receiving treatment for this medical condition before purchasing this insurance policy?* Yes / No *If **Yes**, please state the date(s) and the type of treatment you received:*
Are these expenses recoverable from any other policy? Yes / No *If **Yes**, please provide the name and address of your medical plan or insurer:*	*Please provide the name and address of your usual doctor (include overseas doctor if applicable):*

Name of doctor/dentist, pharmacy, hospital or provider	Date of treatment or consultation	Amount charged (include currency)	Paid?
			Yes / No
			Yes / No

Payment Details

Bank name	*Bank address*
Account name	
Account number	*IBAN / SWIFT code*

DECLARATION – PLEASE READ AND SIGN: 1. I declare that all of the above information is true. 2. I agree that if I have made any false statement or fraudulent claim or have suppressed or concealed any information 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 authorize StudentCare to obtain any medical or other information from any other source, doctor or specialist that will assist in the processing 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.

Name of person who has completed this form:	*Relationship to policyholder:*