



ace asia pacific

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Policy Number []

Expatriate/Inpatriate Medical Expenses Claim Form

Please ensure this form is completed in all parts applicable to your claim. The information authority and warranty on the back must be completed for all claims.

The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights. Each individual is to complete a separate claim form relating to their expenses.

Insured:

Employee's Name:

Employee's Address:

Patient's Name:

Relationship with Employee:

Have you received any medical advice or treatment for this Condition in the last 3 years?

Description of Illness/Accident:

GST INFORMATION

(a) What is your Australian Business Number (ABN)?

(b) Are you registered for GST Purposes? Yes No

(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) on your Business Activity Statement to the Australian Taxation Office in respect to the GST paid on the insurance policy under which this claim is being made? Yes No

(d) IF YES, what percentage of the GST did you claim or are you entitled to claim? % (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

DETAILS OF AMOUNTS CLAIMED:

Table with 3 columns: Date, Fully describe Procedure, Medical Services, Supplies furnished, Charges (\$A or other currency)

(Attach all relevant documentation and receipts)

Table with 4 columns for attaching documentation: Physicians or Providers Name and Address, and three empty columns.

If claim involves travel to another destination for treatment attach all relevant documentation including medical practitioners statement that the injury or illness made it necessary to obtain treatment in another country.

I hereby authorise the release of any information regarding treatment to the Insurer for the purpose of validating and determining benefits payable in connection with this claim.

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS

I declare that:

- The information on this form and any documents attached to it is correct and complete;
- I have not withheld any information that could affect this claim;
- I am the policy holder or a nominated beneficiary of the Insured Person covered by this policy.

I authorise:

- Any hospital, physician or other person who has attended me to furnish ACE Insurance Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective as the original.

PATIENT'S SIGNATURE:
(Parent if claimant is a minor)

EMPLOYEE'S SIGNATURE:

DATE:

AUTHORISATION: