REIMBURSEMENT CLAIM FORM

- Please ensure all sections are completed in full, failure to do so will result in delays to reimburse your claim.
- Claims & Invoices for reimbursement claims MUST be submitted within thirty (30) days of the claim event/treatment.
- All invoices MUST show the name of the person being treated including the treatment/investigation. Please ensure EFTPOS receipts are not obscuring these details.
- Please ensure full prescription invoices are submitted showing the drug name prescribed.
- Accident-related claims (ACC) including surcharges and any associated costs are not covered by the policy

1.0 MEMBER DETAILS

FULL NAME _____

ADDRESS _____

CONTACT PHONE_____ EMAIL_____

2.0 CLAIMANT DETAILS – (if different from above) **Each person submitting a claim will need to complete their own claim form**

CLAIMANT NAME: _____ DATE OF BIRTH _____

CONTACT PHONE_____ EMAIL_____

3.0 CLAIM DETAILS – Please complete all sections in full or this could result in delays in payment as we may request further information from you.

DATE	CONDITION for example chest pain, flu, high blood pressure etc..	TREATMENT for example GP visit, prescription, x-ray etc...	COST
4.0 PAYMENT DETAILS		**TOTAL**	

ACCOUNT NAME _____

ACCOUNT NUMBER

Bank	Branch	Account Number	Suffix

5.0 CLAIM SUBMISSION

Email: nz.healthcare99@gbtpa.co.nz **Online**: www.healthcare99.org.nz **Phone:** 0800 653 473 Option 2
Post: Healthcare 99, P O Box 74301, Greenlane, Auckland 1546
*We highly recommend claims to be emailed or completed online due to delays in receiving mail, and periods of working from home due to the pandemic and other unforeseen circumstances.

6.0 DECLARATION & CONSENT – Please read and sign this declaration

I declare that all medical information pertaining to me or the claimant and relevant to my insurance claim has been provided and disclosed to the NZ Firefighters Welfare Society. I understand that making any false or fraudulent claim may result in the cancellation of my policy and I may have to repay any claims.
I further understand that the medical information provided is the basis on which the Firefighters Welfare Society will assess and manage my claim. I have fully disclosed all relevant information in good faith. I understand that failure to provide this information may result in my claim being declined or unable to be assessed. I declare all answer on this form to be true and correct

CLAIMANT NAME _____CLAIMANT SIGNATURE _____

DATE _____