HEALTH INSURANCE
MEMBER CLAIM REIMBURSEMENT FORM

This form should be used when submitting claims under your Health Insurance Plan for eligible expenses which are covered (or not covered in full) by your health insurance policy.

PLEASE COMPLETE THIS FORM IN CAPITAL LETTERS

Please provide the below information. To avoid any delays in the processing of your claim, please ensure that:

1. All claim documents submitted are clear to read.
2. All necessary claim documents are to be submitted within 30 days of the incurred date. Subject to your policy terms and conditions, claims submitted more than 90 days after the incurred date may be denied.
3. All the required information is provided (marked with *). Without all the required info we will be unable to approve your claim.

Section 1 — Plan Member/Employee Information

Please print clearly

Employer Name:*			
Employee Full Name:*			
Phone:	(675)	D.O.B (dd/mm/yyyy):*	
Email:			

Do you have any other Group Insurance coverage that may include these services as benefits? ☐ Yes ☐ No

If the answer above is *yes*, please provide policy holder (employer) and Insurer name below.

Section 2 — Patient Details

Member from Section 1? If yes please proceed to Section 3 and 4 ☐ Yes ☐ No

Patients Full Name:*	
D.O.B:*	

Relationship to Member:* ☐ Self/Employee ☐ Spouse (Legal) ☐ Dependent Child

Section 3 — Payment Details and Authorisation

By completing this section I request that all amounts payable from this claim are paid to the account details below:

Bank:*		Account Name:*	
BSB:*		Account Number:*	

Authorization Statement

I hereby certify that all answers and all original documents submitted with the claim form are complete and true. I hereby authorize any doctor, hospital, or medical provider, any insurance company or any other company, institution or any other person who has any record or information about me and/or any of my family members to provide Parnell Assurance PNG Ltd with the complete information's, including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

Disclaimer

I verify that the documentation submitted electronically is true and unaltered and I have all the original documents that can be presented upon request of the Insurance Company. I also accept and recognize that at the sole discretion of Parnell Assurance PNG Ltd, these documents may be requested at any time during a period of one year counted from the submission of the claim, which I will provide within a period not exceeding 30 days from the request. Failing to comply could imply the claim to be declined. If the case is confirmed to be declined, I will reimburse any amount paid by Parnell Assurance PNG Ltd to me or to any party as related to this claim.

I hereby provide Parnell Assurance PNG Ltd unambiguous consent, to process, share, and transfer my personal data to any recipient whether inside or outside the country, including but not limited to the Company, affiliates, Reinsurers, business partners, professional advisers, Insurance Brokers and/or service providers where the transfer or share, of such personal data is necessary for: (i) the performance of this Policy; (ii) assisting the Company in the development of its business and products; (iii) improving the Company's customers experience; (iv) for the compliance with the applicable laws and regulations; or (v) for the compliance with other law enforcement agencies for international sanctions and other regulations applicable to the Company. *Personal Data means all information relating to me (whether marked "personal" or not) disclosed to Parnell Assurance PNG Ltd by whatever means either directly or indirectly which concerns, including but not limited to, my medical conditions, treatments, prescriptions, business, operations, contact details, account balances/activities or any transactions undertaken with Parnell Assurance PNG Ltd.

Member/Employee's Signature:* _____ **Date (dd/mm/yyyy):*** _____

HEALTH INSURANCE
MEMBER CLAIM REIMBURSEMENT FORM

PARNELL Assurance PNG

Section 4	Claim and Coverage Details

- Please attach all original paid receipts, prescription and authorized forms.
- Please retain copies for your files as original receipts will not be returned.
- The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud

Health Care Expenses

Date of Service	Invoice/Receipt Number	Condition/Diagnosis	Gross Claim Amount