

DUAL Expatriate Medical Expenses Claim Form

The issue of this form is not an admission of liability

Please Ensure:

- You have fully completed every question on this form. Failure to do so will result in delay in handling your claim.
- If any question is not applicable please state 'N/A'
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- All Medical Accounts are submitted with this form

CLAIMANT DETAILS

Full Name of Insured:	
Policy Number:	
Country of Posting:	Commencement Date of Posting:
Full Name of Claimant:	Claimant Date of Birth:
Occupation/Trade or Profession:	Duties Undertaken:
Nationality:	
Full Address of Claimant:	
Employers Name:	
Contact Details	
Business:	Home:
Mobile:	Mobile:

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 and that I have not withheld any information that could effect this claim.

I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty Ltd 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 reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Your Signature: _____ **Date:** / /

Please Print Your Name

PRIVACY STATEMENT

DUAL Australia are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters. For more information about our Privacy Policy, please refer to: www.dualaustralia.com.au

CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

(Please keep a copy of all document sent to Proclaim)

Online Lodgement (preferred): <ol style="list-style-type: none">1. http://figapp.csc.com.au/proclaim/2. Login: dualah3. Password: claims <p>(Please attach the completed claim form during the online lodgment and record the claim number)</p>	Or by Postal Address: <p>Proclaim Pty Ltd Locked Bag 32012 Collins Street East Victoria 8003</p>
Email Address: ahclaims@proclaim.com.au	Fax No: 1300 858 329
Phone Number: claim specific inquiries - once the claim form has been completed, sent and received by Proclaim claim inquiries can be made to Proclaim on +61 (2) 92871322	
Policy and Coverage queries should first be directed to your Insurance Broker.	

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Currency for reimbursement: _____

Bank: _____

SWIFT CODE (FOR NON AUSTRALIAN BANK): _____

Account Name(s): _____

BSB Number: _____

Account Number: _____

DUAL

Patients Name:	Date of Birth:
Please give full details of injury/illness	
Date of Injury or manifestation of Illness:	
Is there any entitlement to compensation under workers compensation, government law or other insurance? Y / N If yes, please provide details below	
Has the patient ever suffered with this or any similar condition before the present episode? YES/NO If YES, please give details including dates of treatment and consultation:	

Date of Service	
Treatment Received	
Currency	Amount

Date of Service	
Treatment Received	
Currency	Amount

Date of Service	
Treatment Received	
Currency	Amount

Date of Service	
Treatment Received	
Currency	Amount

Date of Service	
Treatment Received	
Currency	Amount

PLEASE ENSURE THAT ALL RECEIPTS OR INVOICES ARE INCLUDED WITH YOUR CLAIM

DUAL