Liberty Assurance
Covers You Right Through

CLAIM FORM
HEALTH INSURANCE

ISSUE OF THIS FORM DOES NOT CONSTITUTE AN ADMISSION OF THE COMPANY'S LIABILITY

CLIENT DETAILS	COVER TYPE
INSURED'S NAME:	☐ SINGLE
ADDRESS:	☐ COUPLE
PHONE:	☐ FAMILY
INSURED MEMBER'S DETAILS	**MEMBERSHIP TYPE**
MEMBER'S NAME: DATE OF BIRTH:	
OCCUPATION:	☐ CLASSIC
PHONE/MOBILE:	☐ CLASSIC PLUS
EMAIL:	☐ SILVER
CLAIM TYPE	☐ GOLD
☐ Illness/Sickness ☐ Accident/Injury ☐ Pregnancy ☐ Dental ☐ Optical	☐ PLATINUM
☐ Other (please specify)	

CLAIM DETAILS

1. Do you have any other policy covering claims for this illness/injury? If yes, please provide details

2. Are any of the medical costs you are claiming, due to illness/injury that occurred as a result of employment? If yes, please provide details

3. Has the claimant ever suffered from the same sickness/injury within the past 12 months? If yes, please provide details

CLAIM REQUIREMENTS MUST BE ATTACHED

☐ Copy of customer's health 'smart card'	☐ Admission slip
☐ Medical receipts & invoices	☐ Discharge Summary
☐ Prescriptions (must state diagnosis)	☐ Diagnostic Report
☐ Doctor's Report	☐ Copy of Medical Certificate
☐ Copy of ID (Not applicable if provided in first claim)	☐ Copy of birth certificate for claimants without any ID

PAYMENT DETAILS

Bank Account Holder's Name:	
Bank Account Number:	Bank:
BSB Number:	Branch Location:

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Total Claim Cost:		
Excess Applicable:		
Claim Settlement Amount:		
Checked by Liberty Officer:	Signature:	Date:

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INPATIENT DETAILS

Date of first consultation: Date of Admission: Date of Discharge: No. of Hospital Visits:

Type of Room: ☐ Single ☐ Shared ☐ Private ☐ Deluxe ☐ Suite ☐ Other (please specify)

Diagnosis:

Treatment/Procedure/Surgery Type:

Name of Doctor, Hospital & Department:

SCHEDULE OF CLAIM

Receipt Date	Claimant's Name	Relation to Insured	Diagnosis or condition or Illness been treated (ICD CODE)	Medication Prescribed or Treatment/Surgery Taken (CPT CODE)	Name of Hospital or Medical Service Provider	Medical Cost

DECLARATION

I/We declare that the particulars on this claim form are true and correct in every aspect, and that the completion and signing of it, is a claim against my/our insurer. I/We further acknowledge that any non-disclosure and/or misrepresentation by or on behalf of me/us in any declaration or statement in support of the claim made herein makes the policy under which this claim is made void and the premium forfeitable.

Insured's Name: Signature: Date: