onemedifund®

Claim Form

Your details

First name: _____ **Surname:** _____

Contributor Number: _____ **DOB:** / /

Comments

Please leave a note below if there is anything special we should know about this claim. If not, just leave blank.

(For example: if you have changed your address or if you would like this claim paid into a different account. If you would like this claim paid into a different account, please write your BSB, account number and name on your account below. Note: we can't pay into a credit card or your key card number).

I acknowledge that

By lodging this claim:

- I certify this claim has been paid and that all related goods/services have been received.
- I authorise *onemedifund* to use my personal information in accordance with the Privacy Policy.
- The services listed on this claim are not claimable from other sources e.g. Medicare or other third parties.
- I authorise any medical practitioner, health service provider or hospital to provide information about this claim.
- I acknowledge that all information related to this claim is true and correct.

☐ Tick here to agree to these conditions.

*For more info about our Privacy Policy please refer to onemedifund.com.au or call **1800 148 626**.*

Please send this form and your receipts to:

Email: info@onemedifund.com.au | **Mail:** Locked Bag 25, Wollongong NSW 2500 | **Fax:** 1300 673 406

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