Pacific Assurance Group

PAG HEALTH INSURANCE PLAN
MEDICAL CLAIM FORM

MEDICAL

Your Surname ____________________ Christian Name ____________________

Your Occupation __________________ Date of Birth ____________________

Telephone No. __________________ Date you Joined Scheme _____________

1. Are you covered for these expenses under any other Medical Insurance Plan, Personal Accident Insurance or any other insurance policy or plan Yes ☐ No ☐

   If yes, Please provide details ____

2. Do any of the expenses you are claiming arise from a sickness/injury that occurred as a result of your employment? Yes ☐ No ☐

   If yes, Please provide details____

3. Has the Insured person who is making this claim ever suffered from the same sickness/injury? Yes ☐ No ☐

   If yes, Please provide details____

4. Who is the Insured Persons usual doctor? Name: ___________________________
   Address: ___________________________

PLEASE SUPPLY THE FOLLOWING ORIGINAL DOCUMENTS:

Medical Certificates Yes ☐ No ☐ **Prescriptions Yes ☐ No ☐**

Receipts, Invoices or Accounts for Medical Consultations,
Prescription Medicines & Treatments Yes ☐ No ☐

Details of any refund from any other claim you may have made in respect of this sickness/injury Eg. Workers Compensation, MVIT, Personal Accident/Sickness Claim.

DENTAL & OPTICAL EXPENSES

Name of Insured Person who had Optical or Dental Expenses ______________________
Please advise the last date this person had a Dental or Optical examination / /
Day Month Year

PLEASE SUPPLY THE FOLLOWING ORIGINAL DOCUMENTS:
(i) Dental Certificates verifying the type of work performed
(ii) Receipts, Invoices or Accounts relating to the Dental work performed.
(iii) Optometrists receipts and Certificates verifying the Optical Examination or supply of Prescribed Spectacles or Contact Lenses

MEDICAL AUTHORITY

I hereby authorise all hospitals, doctors, or any other person who has provided me and/or my spouse and/or my dependents with medical treatment to supply to **Pacific Assurance Group Limited** or it's representative with any information that the company may require in relation to any injury/sickness or medical history in connection with any claim for medical expenses.

I agree that a photocopy or facsimile of this authority will be as effective and valid as this original.

Date / /

Signed: ______________________________ Day Month Year

PLEASE COMPLETE THE FOLLOWING

Name of Insured Person	Name of Hospital. Clinic. Doctor Etc	Have Account Been Paid? Yes/No	Nature of Sickness or Injury	Date of Treatment	Amount of Claim

I hereby submit this claim for Medical expenses for the professional service to which this claim relates and do solemnly and sincerely declare that:

1. I have incurred the expenses.
2. The services I am claiming are not claimable under any other insurance including Workers Compensation, Personal Accident/Sickness and MVIT.
3. All the information contained in this claim form is true and correct to the best of my knowledge. Further, I have not made any fraudulent or false statements or concealed any information relative to this claim.

Date / /

Signed: ______________________________ Day Month Year

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