

## Make a claim on your hospital, medical or extras cover

Please print in black ink, using capital letters and mark check boxes with an X.

GU Health Membership No.

Please complete the information requested below and send your completed form by:

- Scan and email to corporate@guhealth.com.au; **or**
- FreePost to GU Health, Reply Paid 2988, Melbourne Vic 8060 (no stamp required)

For assistance or more information call your GU Health Member Relations Team on 1800 249 966 between 8.30am and 5pm (EST) Monday to Friday **or** email corporate@guhealth.com.au

### Section 1: Policyholder's details (the person in whose name membership is held)

Title	Surname	
<input type="text"/>	<input type="text"/>	
Given name	Date of birth	
<input type="text"/>	<input type="text"/>	
Telephone number (the best number to contact you in relation to this claim)		Check box if address has changed and update details over page <input type="checkbox"/>
<input type="text"/>		

### Section 2: Claim details

#### Patient details

Claim No.	Patient's name	Date of birth
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>

#### Practitioner's details

	Practitioner's name	Date of service
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>

Please supply receipts, letters or top portion of Medicare receipt/s for all claims

### Section 3: Hospital details (complete if treatment was received as a private patient in hospital)

Claim No.	Name of hospital	Date of admission
<input type="text"/>	<input type="text"/>	<input type="text"/>

### Section 4: Declaration (must be signed)

I declare and acknowledge that all the information I have provided in this form is correct. I understand that there are penalties for giving false or misleading information.

I authorise all relevant hospital and medical practitioners to provide any information to GU Health to assess this claim. I have the consent and authorisation of all people under this membership to make declarations on their behalf.

I understand and agree that GU Health reserves the right to recover any benefits paid to the member if the cost of treatment is compensated or reimbursed by a third party, such as workers' compensation, third party, repatriation, or any other insurance or award for damages.

Member's signature

Date signed

Continued over page

## Only complete these sections if applicable

### Section 5: Complete to update your contact details

Apply these changes	Permanently <input type="checkbox"/>	For this claim only <input type="checkbox"/>
Home address	<input type="text"/>	
	State <input type="text"/>	Postcode <input type="text"/>
Postal address (if different from home address)	<input type="text"/>	
	State <input type="text"/>	Postcode <input type="text"/>
Work telephone number	Home telephone number	Mobile number
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email address	<input type="text"/>	

### Section 6: Add / change direct credit details (FastBack) – this will update your GU Health records permanently.

**Would you like to save time and effort when you claim?**

Take advantage of the GU Health FastBack direct credit, and get your money back even faster! FastBack means we can directly deposit any claim reimbursement into your nominated Australian financial institution account. Just complete the 'authority' section below and we'll set it up for you.

**Authority for FastBack payments**

I request that GU Health until further notice, credit the following Australian account with any amount which may be payable to me as a result of a claim made under my membership.

**Bank details**

Name of Australian financial institution at which your account is held

Branch address

State  Postcode

Name on the account to be credited

BSB number  Account number

Policyholder's signature

Date signed

### Checklist

Please check you have actioned the following

- All claims are less than two years old
- Declaration section has been completed
- All accounts/receipts and letters (where required) are attached
- Updated address provided (if applicable).

**Next time,  
why not claim online  
using Flex-eClaim?**

Our innovative claiming system  
is efficient and easy to use.

To get started, simply log into  
Online Member Services at  
[guhealth.com.au](http://guhealth.com.au)



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