MEDICAL EXPENSES INSURANCE CLAIM FORM

Company Insured:		**Client Code:**	
Person Insured:		**Date Joined Scheme:**	
Role Title:		**Telephone:**	
Date of Loss:			
Name of Patient(s):			

1. **Are you covered for these expenses under any other Medical Insurance Plan, Personal Accident Insurance or any other insurance policy or plan?**
   ☐ **YES**, please provide details:____ ☐ **NO**
2. **Are any of the expenses you are claiming, a sickness/injury that occurred as a result of your employment?**
   ☐ **YES**, please provide details:____ ☐ **NO**
3. **Has the Insured person, who is making this claim, ever suffered from the same sickness/injury?**
   ☐ **YES**, please provide details:____ ☐ **NO**
4. **The Insured person's usual Doctor is:**
   Doctor: ____
   Hospital: ____
   Address: ____
   ____

DENTAL & OPTICAL EXPENSES

1. Name of Insured person who has incurred Optical or Dental expenses: ____________________
2. Date of last Dental or Optical examination: ____________________

Please ensure to attach the following original documents with this form, when completed:

		Attached	
i.	Dental/Optical Certificates verifying the type of work performed	☐ **YES**	☐ **NO**
ii.	All Receipts, Invoices or Accounts relating to the Dental work performed	☐ **YES**	☐ **NO**
iii.	Optometrist's receipts and Certificates verifying the Optical Examination or supply of prescribed spectacles or contact lenses	☐ **YES**	☐ **NO**

GENERAL MEDICAL

Please ensure to attach the following original documents with this form, when completed:

		Attached	
1.	Medical Certificates	☐ **YES**	☐ **NO**
2.	All Prescriptions for Medicines & Treatments	☐ **YES**	☐ **NO**
3.	All Receipts & Invoices for Consultations, Prescription Medicines & Treatments	☐ **YES**	☐ **NO**
4.	Details of any refund from any other claim you may have made in respect of this sickness/injury, e.g. Workers Compensation, MVIT, Personal Accident/Sickness Claim.	☐ **YES**	☐ **NO**

P O Box 808, Port Moresby, N C D, Papua New Guinea
Level 9, Monian Tower, Douglas Street, Port Moresby, N C D, Papua New Guinea
Telephone (675) 308 3400; Facsimile (675) 308 3444; email : info@scal.com.pg

ENTER THE DETAILS OF YOUR CLAIM BELOW

PATIENT'S NAME	SERVICE PROVIDER (Name of Dr., Clinic/Hospital)	ACCOUNT PAID (CIRCLE)		DIAGNOSIS/NATURE OF ILLNESS	DATE OF TREATMENT	AMOUNT CLAIMED
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
		Yes	No			
					TOTAL	

DECLARATION & AUTHORITY TO PROVIDE INFORMATION

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 listed.

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 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.

I also authorize all hospitals, doctors or any other person who has provided medical services to me and/or my dependents, to provide Southern Cross Assurance Limited or its representative any information the company may require in relation to any sickness, injury 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.

Signed: ______________________________ Date:

Name:

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