

StudentCare Claim Form

**Post or fax to: InterGlobal Limited, PO Box 8672, Symonds Street, Auckland, New Zealand
Facsimile 64-9-309 4119. Telephone 64-9-309 2119**

IMPORTANT NOTE: Please return this form as soon as possible. For prompt payment you must attach the following: 1. Police or Local Authority/Airline/Carrier reports. 2. Original doctor's certificates and/or receipts. 3. Original purchase receipts for old and new items and replacement quotes. 4. For Loss of Deposits claims – a copy of your original itinerary from your travel agent. 5. If none of these are available please state why:

Sections of this policy are subject to an excess and these will be deducted from the amount of the claim.

Member No:	Period of Cover from: <small>DD / MM / YY</small> to: <small>DD / MM / YY</small>
First Name:	Surname:
Postal Address:	
Date arrived in New Zealand: <small>DD / MM / YY</small>	Nationality:
Attending School:	Date of birth: <small>DD / MM / YY</small> Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home phone: ()	Mobile: () Home fax: () E-mail:

Important: Were any special conditions, terms or endorsements applied to this policy? Yes No If 'Yes' please state:

Please complete this section if your claim relates to any of the following: Doctor or Specialist Fees – Public Hospital Services – Private Hospital Services – Pharmaceutical – Ambulance Services – Physiotherapy – Rehabilitation – Emergency Dental Treatment – Emergency Maternity Services – Medical Evacuation – Repatriation – Funeral Expenses – Family Assistance/Travel Expenses – Medical/Dental Emergency

Name of the person treated:		Date of birth: <small>DD / MM / YY</small>
Date: <small>DD / MM / YY</small>	Time: <input type="checkbox"/> morning <input type="checkbox"/> afternoon <input type="checkbox"/> night	Country:

Please advise the reason you visited the doctor. What was wrong with you?

What treatment did you receive and what was the final diagnosis: (this question must be answered before the claim can be processed)

Were you suffering or receiving treatment for this illness before purchasing this Insurance? Yes No If YES, when and which type of treatment had you received?

Did you contact First Assistance for this claim? Yes No

Name and address of your usual doctor:	Doctors phone: ()
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Are these expenses recoverable from any other Medical Plan or Insurance Policy? Yes No

If YES, declare the name and address of the Medical Plan or Insurer:

REIMBURSEMENT: How do you wish payment of your claim to be made? Cheque (please state currency)

or <input type="checkbox"/> Bank account - Bank:	Branch name and country:
Account number:	Account holder's name:

or <input type="checkbox"/> Credit card - Card number: <input style="width: 150px; height: 20px;" type="text"/>	Expiry: <input style="width: 50px; height: 20px;" type="text"/>	Card Type:
Cardholders name:		

Type of treatment — complete the appropriate sections being claimed and circle relevant treatment	Have you paid this account	Date(s)	Amount claimed
Doctor or Specialist Fees	Yes / No		
Public/Private Hospital Services	Yes / No		
Pharmaceutical/Ambulance	Yes / No		
Physiotherapy/Rehabilitation	Yes / No		
Emergency Dental Treatment/Emergency Maternity Services	Yes / No		
Medical Evacuation/Repatriation	Yes / No		
Funeral Expenses/Family Assistance/Travel Expenses	Yes / No		
Medical/Dental Emergency	Yes / No		

Important: You must provide invoices and receipts to support your claim AND you must sign this declaration before sending to InterGlobal Limited. InterGlobal Limited is not liable for any bank charges incurred in settling your claim.

Declaration: Please read and sign. 1. I declare that all the above information is true. 2. I agree that if I have made any false statement, or fraudulent claim or suppress or conceal any information that this policy will be invalid and all rights of recovery will be forfeited. 3. I declare that I do or I do not (please tick applicable) have any claim with any other insurance company covering this loss. 4. I declare that I have not had any previous claim declined. 5. I authorise InterGlobal Limited to obtain any medical or other information from any other source, doctor or specialist that will assist in the process of this claim. 6. I agree to provide the Insurer or its' Representative any relevant information regarding current or past claims and to the Insurer or its' Representative releasing claims information to any other party.

Signed:	Dated: <small>DD / MM / YY</small>
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Name of Person who has completed this form:

