

# QBE LIFEstyle Solutions™

ACCIDENT AND HEALTH INSURANCE

## Medical Expenses Claim

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**A. NOTES**

1. It is most important that all questions are answered. If not applicable, write "n/a".
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
4. Any amounts further marked as \* are in the currency of the country in which the policy has been issued.
5. Markets  
Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

Market	Business Name	Please tick
Fiji	QBE Insurance (Fiji) Limited	
Papua New Guinea	QBE Insurance (PNG) Limited	
Solomon Islands	QBE Insurance (International) Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

Note: For any other markets please contact the local QBE office.

6. The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:
  - a) the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless
  - b) the policy/ies refer to the laws of a different country applying, in which case, the laws of that country,
 and in relation to those matters, the parties submit to the jurisdiction of the courts of that country.

For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English Law as applicable within Vanuatu immediately before 30 July 1980 and shall be justiciable before the Supreme Court of Vanuatu.

**COMPULSORY COMPLETION FOR ALL CLAIMS**

**B. INSURED DETAILS**

1. Name of insured: .....
2. Address: .....  
..... Postcode: .....
3. Private tel no: ..... Business tel no: .....  
Mobile tel no: ..... Fax no: .....  
Email: .....
4. Occupation: .....
5. Date joined/rejoined scheme: \_\_\_/\_\_\_/\_\_\_

**ONLY COMPLETE RELEVANT SECTIONS PERTAINING TO YOUR CLAIM**

**C. MEDICAL AND HOSPITAL EXPENSES CLAIM**

1. Give name of insured person who suffered injury or sickness:  
.....
2. State type of injury or sickness suffered:  
.....
3. Were any of the medical expenses incurred due to injury or sickness arising out of the insured person's employment? YES  NO   
*If "YES", please state the insured person's entitlement under worker's compensation insurance*  
.....
4. Are you entitled to receive reimbursement of medical expenses under any other medical insurance, fund or plan, personal accident/sickness policy, common law entitlement or travel policy? YES  NO   
*If "YES", please state type of cover and the amount of your entitlement under such cover*  
.....
5. Has the insured person suffering injury or sickness ever suffered the same or similar condition in the past? YES  NO   
*If "YES", please give dates of medical consultation(s) or treatment(s).*  
.....
6. Give name and address of insured person's usual doctor:  
.....
7. Please attach the following ORIGINAL documents (where applicable) to support your claim. Please tick (✓) when attached
  - Medical certificates and prescriptions
  - Receipts, accounts and invoices for medical consultations, treatments and prescription medicines
  - Refund advices from worker's compensation claim, personal accident/sickness claim or medical fund claim

**D. MEDICAL REPATRIATION AND EMERGENCY EVACUATION CLAIM**

1. Give name of insured person who suffered injury or sickness:  
.....
2. State type of injury or sickness suffered:  
.....
3. Attach medical certificate from the attending doctor detailing:
  - a) information requested in 1 and 2 above;
  - b) date he/she attended the insured person;
  - c) that the injury or sickness is of a critical nature and the insured person requires surgery, specialised medical treatment or post-operative attention to enhance recover;

- d) description of required surgery, specialised treatment or post-operative attention; and
  - e) whether the insured person requires a medical escort.
4. Attach medical certificate from local specialist hospital confirming:
- a) the type of specialised treatment, surgery or post-operative attention required for such injury or sickness;
  - b) that such specialised treatment, surgery or post-operative attention is unobtainable in the country.
5. Attach medical certificate from attending doctor overseas detailing:
- a) date he/she attended the insured person;
  - b) type of treatment or surgery performed on insured person;
  - c) the period of confinement or convalescence.
6. Please attach the following ORIGINAL documents (where applicable) to support your claim. Please tick (✓) when attached
- Medical certificate requested in 3, 4 and 5 above
  - Airline ticket
  - Account or invoice for air ambulance or air charter
  - Hospital accounts or receipts for services and confinement
  - Accommodation receipts or accounts
  - Ambulance account or receipt

## E. DENTAL AND OPTICAL EXPENSES CLAIM

1. Give name(s) of insured person(s) who have incurred optical and/or dental expenses  
.....
2. Give date(s) when the above insured person(s) last received a dental and/or vision examination  
.....
3. Please attach the following ORIGINAL documents (where applicable) to support your claim. Please tick (✓) when attached
- Dentist certificates and receipts verifying the type of dental work performed
  - Optometrists certificates and receipts verifying vision examinations and purchase of prescribed spectacles or contact lenses

## F. FUNERAL CLAIM

1. Give name(s) of deceased insured person  
.....
2. Please attach the following ORIGINAL documents (where applicable) to support your claim. Please tick (✓) when attached
- Death certificate of insured person
  - Post mortem certificate and / or coroner's report
  - Invoice or receipt from funeral directors itemising costs
  - Invoice or receipt for transportation of mortal remains
  - Warrant to bury
  - Burial or cremation invoices or receipts



**COMPULSORY COMPLETION FOR ALL CLAIMS**

**I. DECLARATION**

I/We declare that:

1. The information and answers given above are correct to the best of my/our knowledge and belief.
2. I/We understand the claim may be refused or reduced if information is withheld.
3. I/We authorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/We authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured: .....

Date: \_\_/\_\_/\_\_

### Asia Pacific Head Office

Level 7, 345 George Street  
Sydney N.S.W. 2000  
Australia

Tel: +612 9375 4444  
Fax: +612 9375 4070  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

### Licensed insurers for the Pacific Islands region:

#### Fiji

QBE Insurance (Fiji) Limited  
QBE Centre  
Victoria Parade  
GPO Box 101  
Suva, Fiji

Tel: + (679) 331 5455  
Fax: + (679) 330 0285  
Info: [info.fiji@qbe.com](mailto:info.fiji@qbe.com)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

#### PNG

QBE Insurance (PNG) Limited  
QBE Building  
Musgrave Street  
P O Box 814, Port Moresby  
Papua New Guinea

Tel: + (675) 3212 144  
Fax: + (675) 3214 756  
Info: [info.png@qbe.com](mailto:info.png@qbe.com)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

#### Solomon Islands

QBE Insurance (International) Limited  
Panatina Plaza  
Prince Philip Highway  
P.O. Box 764  
Honiara  
Solomon Islands

Tel: + (677) 38884  
Fax: + (677) 38887  
Info: [info.sol@qbe.com](mailto:info.sol@qbe.com)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

#### Vanuatu

QBE Insurance (Vanuatu) Limited  
La Casa, D'Andrea Building  
Port Vila  
P.O. Box 186  
Vanuatu

Tel: + (678) 22299  
Fax: + (678) 23298  
Info: [info.van@qbe.com](mailto:info.van@qbe.com)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

#### French Polynesia

QBE Insurance (International) Limited  
Immeuble Gallieni  
Front de Mer  
P.O. Box 283  
Papeete, Tahiti – French Polynesia

Tel: + (689) 50 66 00  
Fax: + (689) 50 66 01  
Info: [info.fp@qbe.com](mailto:info.fp@qbe.com)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

#### New Caledonia

QBE Insurance (International) Limited  
5 Rue Anatole-France  
BP 449  
98845 Noumea-Cedex  
New Caledonia

Tel: + (687) 246300  
Fax: + (687) 287717  
Info: [qbe@qbe.nc](mailto:qbe@qbe.nc)  
[www.qbe.com/asiapacific](http://www.qbe.com/asiapacific)

For literature in use in the French Territories above,  
please contact the local QBE office in each of these countries.



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