Capital INSURANCE LTD
THE PACIFIC'S INSURER

Medical Claim Form

IMPORTANT NOTES:
1. This form is to be scanned and emailed with all receipts, invoices and any other supporting information.
2. Only persons declared on the proposal or application form can be considered for a claim.
3. Incomplete or missing information will result in delays. Please check carefully before submitting your claim.

Name of Employer: .....

EMPLOYEE DETAILS

Surname: ..... Given Name(s): ..... D.O.B. ..... (dd/mm/yyyy)

Policy Number: ..... Postal Address: .....

Email: ..... Mobile/Phone: .....

Date first insured with capital: ..... (dd/mm/yyyy) Policy/Plan Type: single ☐ couple ☐ family ☐

The Following section must be fully completed and signed by the member/ employees.

Do any of the Medical or professional Services claimed relate to the categories listed below?	yes	no	If yes please comment
1. Work related incidents which entitles you to workers compensation claim?			
2. Motor Vehicle accident?			
3. Drug addiction, Alcoholism, Mental Illness or HIV/AIDS?			
4. Condition(s) that existed prior to joining the medical scheme?			

BANK ACCOUNT DETAILS

I ..... hereby authorize Capital Life Insurance Limited, to pay any payments directly into my accounts as listed below.

Bank: ..... Accounts Name/Title: .....

Account Number: .....

BSB Number: ..... Branch Location: .....

DECLARATION

I do solemnly and sincerely declare that the answers given are true and accurate and that I have not with-held any relevant Information. Further that I accept the consequences of not providing accurate information and acknowledge that the Capital Life Insurance Limited (hereinafter called the "Company") reserves the right to repudiate my claim.

I further authorise the company to obtain from the Physician or organization that maintains records of my health, medical history or conditions for which treatments had previously been sought. A copy of this authorization shall be as effective and valid as the original.

Signature of the Claimant ..... Date .....

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Invoice/Receipt (Date of service)	Invoice No.	PAYEE TYPE (Mandatory) Type of entity to be paid. (Provider/ Broker/Member/Employer).	Employer Name	Employer-Cig Medical Policy Number	Patient/Insured Full Name	Gender	Date of Birth	Link to Member (Spouse, Child or Natural Parent)

Benefit being claimed	Cause condition Group	Hospital Admission Date	Hospital Discharge Date	Gross Claim Amount	Comments

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