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1. Please complete all the relevant sections of this form using **BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE.**
2. Claims must be submitted within 2 years from the date of service.
3. Read the declaration and sign all the relevant signature panels.

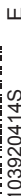
SECTION A: Your details

Membership number												Home Phone (including area code)											
Surname												Work Phone (including area code)											
First name												Mobile											
Initial Title				Date of birth				Sex (M/F)				Email											
Residential address																							
Postcode																							

SECTION B: Ambulance service details

[illegible]

SECTION C: Transportation details

[illegible]

Please complete the following sections where applicable.

1. Are you entitled to compensation from any other source? ☐ Yes ☐ No	7. Are you self-employed? ☐ Yes ☐ No																																								
2. Did the need for Ambulance Transportation occur at work? ☐ Yes ☐ No	8. Did the transport accident occur whilst travelling to or from work? ☐ Yes ☐ No																																								
3. Did the need for Ambulance Transportation occur going to or from work? ☐ Yes ☐ No	9. Do you intend to lodge a claim with the Transport Accident Commission or a Third Party Insurer? ☐ Yes ☐ No																																								
4. Has a claim been lodged with your employer? ☐ Yes ☐ No	10. Was the accident/injury the result of negligence or violence by another person? ☐ Yes ☐ No																																								
5. If no, do you intend to lodge a claim with your employer? ☐ Yes ☐ No	11. Do you intend to lodge a claim against the Crimes Compensation Tribunal? ☐ Yes ☐ No																																								
6. What is your occupation? <table border="1" style="width: 100%; height: 40px; border-collapse: collapse;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																																									12. Do you intend to pursue a common law/personal injuries claim? ☐ Yes ☐ No

Has this account been paid by you?

☐ Yes. If yes, please complete this section ☐ No

Please ensure you have attached all invoices needed to process this claim. Are all the invoices attached to this form?

☐ Yes ☐ No

Name(s) of account holder(s)

Name of financial institution

BSB number Bank account number

If account details are not provided or authority is not present, benefit will be paid to the policyholder. Please enclose original account/receipt. All accounts/receipts and any documents supporting your claim will be retained by Bupa.

I authorise Bupa to contact any necessary persons if information is required to establish my entitlement to benefits. I declare that information provided on this form is true, correct and complete and will notify Bupa of any changes. I declare that: my typed name stands as my signature for the purposes of this form.	Signature of Policyholder	Date D D M M Y Y Y Y
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Check that you have signed all the signature boxes relevant to your application, including the declaration above. PLEASE DO NOT STAPLE. Please mail your claim form to: Bupa Health Insurance GPO Box 4338 Melbourne VIC 3001 Alternatively, you can drop by a Bupa Health Insurance store. If you would like any assistance, please call us on 134 135. Bupa HI Pty Ltd ABN 81 000 057 590	OFFICE USE ONLY Document name Consultant Session ID
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