ace insurance

ACE Insurance Limited
ABN 23 001 642 020
The ACE Building
28 O'Connell Street
Sydney NSW 2000
Australia

GPO Box 4065
Sydney NSW 2001
Australia
www.aceinsurance.com.au

Send claim to:
International Services Network **(ISN)**
Level 2, 280 George Street
Sydney NSW 2000
Australia

Tel: +61 2 8256 1780
Fax: +61 2 8256 1775
Email: claims@isn.au.com

Expatriate Medical Expenses Claim Form

IMPORTANT INFORMATION

Please ensure that all relevant sections of this claim form are fully completed. We are unable to consider assessment of your claim unless all information has been given. Failure to complete all information may result in a delay in the assessment of your claim.

- The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.
- Each individual is to complete a **separate** claim relating to their expenses.

Policy and Claimant Details

Insured Company		
Policy Number		
Employee's Name		
Email		
Employee's Address		
Patient's Name		Relationship with Employee:

What is the patient's nationality?

Is the patient entitled to Medicare Benefits in Australia? ☐ Yes ☐ No

Does the patient hold Private Health Insurance? ☐ Yes ☐ No

Electronic Funds Transfer Details

Following ACE approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Australian Bank Account Details

Name of Financial Institution:

Account Holder's Name:

BSB Number:

Account Number:

Bank Address

Overseas Bank Account Details

Name of Financial Institution:

Account Holder's Name:

BSB Number / Routing Code /ABA Number / IBAN:

Account Number:

Bank Address

Currency for Refund $

Swift Code:

Overseas Medical and Dental Details of Amounts Claimed

Date of Service	Injury/Illness (e.g. sprained ankle)	Fully Describe Procedure, Medical Services, Supplies Furnished (e.g. x-ray, plaster, doctor consultation, physiotherapy, etc.)	Charges ($A or other currency)

(Attach all relevant documentation and receipts)

Physicians or Providers Name and Address:	

Hospitalisation Only Benefit Claim

Type of Injury or Sickness	Date of Accident or commencement of Sickness

If Injury - Give full details of Accident. If Sickness, give details of onset of condition

Date of First Medical Consultation	Name of Doctor or Hospital
/ /	

Details of other treatment by Doctors/Hospital

Dates in Hospital	Admitted / /	Discharged / /

List the Country and the currency of the Country in which you incurred the medical costs	Country:	Currency:	Total Amount:
	Country:	Currency:	Total Amount:

Have you ever suffered from the same or similar complaint in the past? Yes ☐ No ☐

If **Yes**, give details, dates names and addresses of treating physicians	

ACE Insurance Limited Claim Privacy Consent, Medical Authority and Declaration

Claim Privacy Consent

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including without limitation your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you have a complaint or want more information about how ACE is managing your personal information, please contact the Privacy Officer, ACE Insurance Limited, GPO Box 4907, Sydney NSW 2001, Tel: +61 2 9335 3200 or email Privacy.AU@acegroup.com

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email CustomerService.AUNZ@acegroup.com.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE is its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date

/ /

Name of Claimant

Signature of Witness

Date

/ /

Name of Witness

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Fax: +61 2 8256 1775
Email: claims@isn.au.com

To Be Completed by Representative of the Insured for all Expatriate and Inpatriate Claims and Submitted with First Claim

I, (Company Representative) _____

confirm that (Insured Person) _____

is an employee of _____

and that he/she is a Nominated Expatriate/Inpatriate with effect from _____/_____/_____

Cover (please tick) ☐ Family ☐ Couple ☐ Single

Signature _____

Name _____

Title _____

Contact Number _____

Claim Reference (if known) _____

Policy Number (if known) _____