

Claim Form



Step 1 Complete your policy details

Your customer number

Your family name _____ Your first name _____

Your current postal address (this is the address nib will send any correspondence to do with this claim)

_____ Daytime phone number (_____)

Step 2 Complete the details of your claim

I am claiming everyday Extras (e.g. dental, optical, physio)				
Date	Type of service	Name of the provider	Is this related to compensation?	Is the account paid in full?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

I am claiming medical services received in a hospital (e.g. doctors & specialists fees)				
Date of admission	Date of discharge	Name of the hospital	Is this related to compensation?	Is this the result of an accident?
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Step 3 How do you want nib to pay your claim?

- please send me a cheque made out in my name
- please send me a cheque made out in my partner's name (only available if you have authorised nib to do this)
- please credit my SafeClaim account (if you have authorised nib to credit your account using a Direct Credit Authority Form)
- I authorise nib to pay cash to _____

If you have not yet paid the account, nib will send you a cheque to forward to your provider. You will need to pay the rest of your bill.

Step 4 Read the following important information and sign this form

I declare that all the information I have given on this form is true. I allow nib to use the information on this form and to use information I have previously given nib, and to contact if needed:

Yes No My previous fund.

Yes No My treating health professional/s and/or the provider of the services.

I acknowledge that nib may use the information on this claim form to assess and process this claim, or for other purposes related to this claim as outlined in the nib Privacy Policy. I confirm the services submitted on this claim form were performed by the providers, and received by the persons named on this form. I declare the services above where I have indicated 'no' cannot be claimed from worker's compensation, a third party or any other source.

Your signature
(or your authorised partner)

Date / /

My claims checklist

- I have attached all the receipts and/or accounts for each item I am claiming.
- All the receipts/accounts I have attached are original, itemised in full, written in English, and are on the provider's official stationery or have the provider's official stamp.
- I received the services within the last two years.
(nib does not pay claims made two years or more after the services were received)
- I am claiming for optical services and have attached the original prescription.
(Please let us know if you want your prescription returned)
- I am claiming services from an nib recognised provider.
(nib does not pay claims for the services of providers who are not recognised by nib)
- I have claimed with Medicare for medical services I had in hospital and I have attached the top portion of the Medicare Statement of Benefits and my receipts.
- I have indicated where applicable that the claim is related to worker's compensation.

nib Claims Processing
Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

*You can mail your
claims to this address
(no stamp required)*

Or take your claim to an nib Retail Centre.

Need help completing this form?

Call the nib Customer Care Centre on **13 14 63**
or visit **nib.com.au**