QBE Medical Expenses Claim

QBE Pacific Islands

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) Pty Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

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

6. Jurisdiction

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 exclusive 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 exclusively justiciable before the Supreme Court of Vanuatu.

Compulsory completion for all claims.

B. Insured details

Name of insured

Address

Private tel. no **Business tel. no** **Mobile tel. no**

Fax no **email**

Occupation

Date joined/rejoined scheme **Policy no**

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?

If "Yes", please state the insured person's entitlement under worker's compensation insurance. ☐ Yes ☐ No

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?

If "Yes", please state type of cover and the amount of your entitlement under such cover. ☐ Yes ☐ No

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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. **Ask the attending doctor to complete Section J - Medical repatriation certificate - at the end of this claim form.**

4. **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.

5. **Please attach the following original documents (where applicable) to support your claim. Please tick when attached.**

- ☐ **Medical certificate requested in 3 and 4 above**
- ☐ **Economy airline ticket and boarding passes**
- ☐ **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 (not applicable in Fiji)

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**

G. Medical authorisation

I hereby authorise any hospital, physician or other person who has attended me and/or my spouse and/or my dependents to furnish QBE or its representatives with any information regarding any injury or sickness or medical history which the company may request in connection with any claim for medical expenses. I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original.

Signature of claimant

Date

H. Schedule

Name of insured person	Name of hospital, clinic, dentist, doctor, hotel, etc.	Have accounts been paid Yes/No	Type of injury/ sickness or treatment	Date of treatment or period of confinement	Amount incurred *
			Less expenses not covered (office use only)		
			Less amount of deductible		
			Reimbursement		

Complusory completion for all claims

I. Signature and 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 hauthorise 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 ______________________

Fiji

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Papua New Guinea

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Solomon Islands

QBE Insurance (International) Pty Limited

Panatina Plaza, Prince Philip Highway, Honiara
Tel: + 677 388 84
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Vanuatu

QBE Insurance (Vanuatu) Limited

Level 2, Office 2a - 2c / 2g
Tana Russet Complex, Port Vila
Tel: + 678 353 00
Fax: + 678 355 10
Email: info.van@qbe.com
qbepacific.com

J. Medical repatriation certificate

If you have completed section D of this claim you need to obtain this medical repatriation certificate from your attending doctor.

QBE requires this form to be completed and signed by the attending Physician before considering any Medical Repatriation expenses claim.

1. Patient's name

Patient's date of birth:

2. Name of clinic

Date of attendance

3. Please provide details of the patient's complaint:

Is the patient's complaint an:

a. injury — Yes / No

b. sickness — Yes / No

c. other (describe condition) — Yes / No

4. Estimate period of incapacity, if any:

5. Is the patient's complaint of a critical nature? If "Yes", please provide details. — Yes / No

6. Is it necessary for the patient to obtain or receive specialised treatment, surgery or post-operative attention which is not available in the country[1]. If so, state the nature of same. — Yes / No

7. Is it necessary for the patient to be confined in a hospital for the specialised treatment, surgery or post-operative attention described in 6. above? — Yes / No

8. What is the expected confinement and convalescence period?

9. Within what period must the patient obtain or receive such specialised treatment or surgery?

a. immediately — Yes / No

b. within ____ weeks

c. within ____ months

10. Is it medically necessary for the patient to be escorted to the hospital overseas? — Yes / No

If "Yes", please provide details and reason:

11. Is it medically necessary for the patient to be escorted on the return journey to the country? — Yes / No

If "Yes", please provide details and reason

Physician's name (print): **Qualifications**

Signed

Date

Note

[1]Country means the country where this claim is made.

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