Expatriate and Inpatriate Insurance

Claim Form

Important: Please read before you complete this form

1. Please ensure Section 5 – Declaration is signed and dated.
2. Provide original itemised receipts written in English or with an English translation provided.
3. Itemised receipts must show all services separately.
4. All family members are to be included on the one claim form
5. Please scan and email the claim documentation to Arch Insurance at a&hclaims@archinsurance.com.au
6. The issue of this form is not an admission of liability.

Arch Underwriting at Lloyd's (Australia) Pty Ltd

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E: a&hclaims@archinsurance.com.au

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Pursuing Better Together®

Section 1: Personal Information

Policy Number | Policy Holder Name:

Title | Gender

Given Name(s)

Family Name | Date of Birth

Residential Address

Suburb | State | Postcode

Email Address

Daytime Contact Number | Alternative Number

Section 2: Electronic Funds Transfer (EFT) authorisation and GST information

Please provide bank and account details for payment. For security purposes, Arch will contact you to verify the EFT details provided.

BSB Number (6-Digits)	Account Number	Account Holders Name	Bank	Bank Swift Code (International Payments)	Bank Account Currency (International Payments)	Bank Address (International Payments)

Section 3: Declaration for any treatment/expenses incurred in Australia

Are you entitled to claim Medicare benefits:

As an Australian Citizen? Y N

As a result of being granted or applying for permanent residency? Y N

Under a reciprocal health agreement? Y N

Medicare Number | Expiry Date

Do you have Private Health Insurance? Y N

Schedule of Claimed Expenses

Date of Expense	Description of Injury/Illness	Name and Relationship	Country	Treatment Received	Service Provided By	Amount Claimed and Currency

Section 4: Emergency Assistance

Has Arch Assist been notified of this claim? Y N

If yes, please provide case number:

Section 5: Privacy Statement, Declaration and Medical Authority

Privacy Statement

I/We agree that, by signing this form, the personal information I/we provide to Arch may be collected, held, used and disclosed in the manner set out in the Arch Privacy Statement found at www.archinsurance.com.au, including for the processing of this claim.

Medical Authority

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

I agree to Arch using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to Arch's Privacy Policy and this document.

I/We hereby authorise any hospital, medical practitioner, and any other person or entity who has attended to or examined me, to provide Arch with copies of medical records (including but not limited to consultations, prescriptions, treatment, hospital records, reports, medical correspondence) as requested.

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I will use my best endeavours and render all reasonable assistance and cooperation to Arch in the assessment of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, Arch may not be able to process or assess my claim.

Name of Claimant:	Signature of Claimant:
Date: (DD/MM/YYYY)	
Name of Witness:	Signature of Witness (any adult person):
Date: (DD/MM/YYYY)	

