Attach Receipts Here

NEW ZEALAND FIREFIGHTERS WELFARE SOCIETY

HEALTHCARE 99 CLAIM FORM
OUT OF HOSPITAL ONLY

Name of Member _____ *

Address _____ *

City _____ Postcode _____ *

Email _____

Date of Birth _____ *

Healthcare 99 Membership Number _____ *

Phone Contact Number _____ *

Is this a Fire Service work related accident? YES/NO (delete one) *

Is this an ACC/Accredited Employer Scheme (AES) related accident? YES/NO (delete one) *

Out of Hospital Benefits Claim **Members must claim within THIRTY (30) days of the date of treatment or event. Healthcare 99 does not cover ACC surcharges.**

Claimant 1 Name _____ * D.O.B. _____ * Sex _____ *

Date of Treatment	Name of Doctor or Specialist	Reason for Treatment (Please be specific)	Amount Claimed	
		Prescriptions		
		SUB-TOTAL		

Claimant 2 Name _____ * D.O.B. _____ * Sex _____ *

Date of Treatment	Name of Doctor or Specialist	Reason for Treatment (Please be specific)	Amount Claimed	
		Prescriptions		
		SUB-TOTAL		

Claimant 3 Name _____ * D.O.B. _____ * Sex _____ *

Date of Treatment	Name of Doctor or Specialist	Reason for Treatment (Please be specific)	Amount Claimed	
		Prescriptions		
		SUB-TOTAL		

TOTAL AMOUNT CLAIMED $ _____

MEMBERS Bank Account Number Bank [ ][ ] Branch [ ][ ][ ][ ] Account Number [ ][ ][ ][ ][ ][ ][ ] Suffix [ ][ ][ ] *

Name of Account Holder _____ * (Please Print) _____ * (Signed)

Post to: **Aon**
P.O. Box 2845
Wellington 6140

*Please fill in all fields marked with a *, or your claim will not be processed*
Healthcare 99 is a mutual fund not an Insurance scheme.

07/08/17