Claim Form

Claiming Options:
Visit: Members Online Email to: claims@westfund.com.au Post to: Westfund, Po Box 235, Lithgow Nsw 2790 or claim using our App

Please attach all unaltered accounts/receipts. In the case of photocopies and emailed accounts/receipts, original documents must be retained by you, the member, for a minimum of 24 months from the date the claim is made. Westfund may request to sight the original document during this time. Claim must be made within two years of date of service to be eligible for a benefit. Benefits are payable at the date a service is provided. If all claim information is not supplied this may result in the claim/s not being paid.

Your Details

Member No:	Address:
First Name:	
Surname:	City:
Email:	Postcode: / State:
Mobile: / Home:	

Patient and Claim Details

DOB:	First Name:	Date of Service:	Practitioner:	Account Paid?	
				Y	N
				Y	N
				Y	N
				Y	N

Electronic Transfer Details

Do you wish to nominate a bank account other than the current bank account on your membership? If yes, please specify below:

a) Would you like to make this change permanently on your membership? Y N

OR:

b) Do you wish to record these bank details against your name, for future claims on this membership? Y N

Name of Financial Institution:

Acount Name:

BSB: Account Number:

Declaration and Statement

I understand that Extras benefits cannot be claimed from Westfund that have been, or will be, claimed from Medicare (unless permitted by law).

Is any part of this claim the result of an accident, illness, injury, condition or other incident for which there exists in the opinion of Westfund, a right to claim compensation from a third party, or for which a payment or consideration in settlement of a claim for compensation or damages has been received ? If yes, provide the date of event _____/_____/_____.

If any part of this claim was for services received while in a hospital as an inpatient, complete the following details:
Name of hospital:_____ Admitted: ___/___/____ Discharge date: ___/___/___.

I declare that this claim is for treatment or services received by myself and/or dependants covered by this policy. All details and answers in this form and all attached documents are true and correct. I authorise my medical practitioner, or other health service provider, to provide Westfund with any details of treatment, hospitalisation, injury, disease, ailment or diagnosis about me or my dependants necessary to access my entitlements.

I consent to the collection, use and disclosure of my personal information provided with this claim in accordance with Westfund's Privacy Policy. I authorise Westfund to contact the relevant hospitals or health service providers to access such personal information as may be necessary to assess this claim.
If I am lodging this claim for another person on the same membership, I have made that person aware of the privacy statement below and have their consent to lodge this claim and give this consent and authorisation on their behalf.

MEMBER'S SIGNATURE: DATE:

Our Privacy Policy contains information about use and disclosure of personal information, how you may access and seek correction of your personal information, how you may make a complaint about privacy, and how we will respond to your complaint. Westfund's Privacy Policy is available on our website www.westfund.com.au and at any of our Care Centres.