

Please read the information below before completing your claim. When completed post to PO Box 10075, Wellington 6143.
If you have any questions please call toll free on 0800 ACCURO (0800 222 876).

Please use BLOCK LETTERS

Applicant - Member details - i.e. contributor

Membership number

Title Mr Mrs Miss Ms Other

Surname

First name

Member's address

Number and street

Suburb and town

Tick box if address changed since previous claim

If different from residential address, please provide your mailing address

Email address

Refund options (Tick one option only) If neither option is indicated, we will refund by cheque.

Option 1 By cheque

Option 2 Direct credit to bank account

For direct credit refunds, please ensure that the correct bank account details are listed and that you have ticked Option 2.

Bank account number

Bank/Branch Number

Account Number

Suffix

Name of person(s) for whom benefit is claimed

First Name

First Name

First Name

First Name

Are you entitled to any payment in respect of this claim from a Friendly Society, ACC, other Health Insurer, etc. Yes No If 'Yes' please give details:

Declaration - this must be completed in all cases

I certify that all particulars shown on this form are true and correct, that this claim is made in accordance with the conditions of my membership, that Accuro Health Insurance is hereby authorised to obtain copies of any medical records which they may require and agree to submit to any medical examination by a Registered Medical Practitioner appointed by Accuro Health Insurance if required.

Main Member's name in full

Signature of Main Member Date

Your relationship to patient(s)
i.e. self, partner, dependant(s)

