Southern Cross Health Society

Public hospital cash allowance claim

This form must be completed for public hospital cash allowance claims only. Please read the instructions carefully before filling in the form.

Membership number

- To be eligible for this benefit a member must be hospitalised in a public facility.
- Please have the hospital inpatient certificate completed or enclose an account or discharge summary from the hospital showing admission and discharge dates.
- Please ensure you have entered your membership number and signed the declaration.
- If you have any questions please call toll free on **0800 800 181**. Calls to this number may be recorded.
- **After completing this form, please sign and return to: Southern Cross Health Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240, Freepost Authority 158217**.

MEMBER DETAILS Policyholder name and mailing address

Title _____ First name _____ Surname _____ Date of birth _____

Postal address _____

Home phone _____ Work phone _____

Mobile phone _____ E-mail _____

REFUND OPTIONS If we don't have your bank account we will refund by cheque

BANK/BRANCH NUMBER | ACCOUNT NUMBER | SUFFIX

If your bank account details above are incorrect please update them below

PRIVACY ACT/DECLARATION

This claim form collects personal information about each member named on this form for the purpose of evaluating your claim and for contacting you from time to time (using any of the above contact details) with information about Southern Cross products and services. The intended recipient of this information is Southern Cross Medical Care Society. The information is being collected and held by Southern Cross Medical Care Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240, Southern Cross Medical Care Society, Private Bag 3216, Waikato Mail Centre, Hamilton 3240, Freepost Authority 158217. If you fail to provide the information requested your claim may be declined. Each member named on this claim form has the right to access and request correction of this information in accordance with the Privacy Act 1993.

This declaration must be signed in order for your claim to be paid

I declare that:

- All of the information supplied on this claim form is complete, true and accurate.
- I am authorised by each member named on this claim form to complete and sign on their behalf.
- This claim is made in accordance with my policy document and the Rules of Southern Cross Medical Care Society.
- I authorise Southern Cross Medical Care Society to obtain from any person or organisation any further information required to evaluate this claim, and I authorise that person or organisation to disclose such information to Southern Cross Medical Care Society.
- I authorise any change of bank account details noted on this claim form.

Policyholder signature _____ **Date signed** ____/____/____

PATIENT DETAILS

Name of patient _____

Date of birth _____

Male/female
(Please circle)

Name of hospital _____

Date admitted ____/____/____ Date discharged ____/____/____

Date of accident ____/____/____
(If applicable)

HOSPITAL INPATIENT CERTIFICATE

I certify that the above patient was admitted to

_____

hospital on _____

and discharged on _____

and that the hospital admission details specified on this form are correct.

Signature of official _____

Position held by signatory _____

_____

Date ____/____/____

Please endorse with official stamp of hospital.