Patient Name:_____

Admission Date: ____/_____/____

DECLARATION CONCERNING CLAIM OF HOSPITALISATION

At the time of joining your health fund or upgrading your cover, did you have any symptoms of this condition? .....

When were you first aware of the symptoms of your illness? .....

Did your hospital treatment result from an accident? .....

If **YES** please specify type of accident-
e.g. Road, Work, Sport, Home, Other. .....

Is there any right to claim Worker's Compensation,
Third Party Insurance or damages from any other source? .....

(If **YES** please specify) .....

ACKNOWLEDGEMENT OF INFORMED FINANCIAL CONSENT

In accordance with the National Health Act 1953, you have the right to be informed of your out-of-pocket expenses associated with your hospital stay including:

- charges for medical services provided by your doctor and associates.
- hospital excess, gap and co-payments.
- gap amount for prostheses or medical devices required to be used in surgery.

❑ YES - I have been informed of my expected out-of-pocket expenses
❑ NO - I have not been informed of my out-of-pocket expenses

- I declare that all relevant information furnished in connection with this claim is true and correct and authorise the Fund to obtain any information from any Doctor for Assessment purposes relating to this claim.
- I authorise payment of benefit due under this claim to be made direct to St Andrew's Hospital Inc.

Signature of Contributor..... Date ..... / ..... / .....