BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Accident & Health

INPATRIATE INSURANCE CLAIM FORM

NOTIFICATION OF A CLAIM OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM

YOUR INFORMATION

Policy Number:

Policyholder Name: _____

Your Full Name: _____

Full Address: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Telephone Mobile: _____ Telephone Work: _____

Email Address: _____

Home Country: _____

Policyholder Address: _____ Policyholder Telephone Number: _____

AUTHORITY TO GIVE INFORMATION

I/we hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

Signature: _____ Date: _____

	Date Expense Incurred	Description of Injury/Illness	Name & Relationship	Country	Treatment Received	Service Provided By	Amount Claimed	Currency	Has an expense relating to this injury or illness been paid previously?
e.g.	*01/04/2016*	*Broken Toe*	*Macy/Daughter*	*England*	*Outpatient Doctor*	*Dr. Julie Frost*	*$220*	*NZD*	*No*
1									
2									
3									
4									
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IMPORTANT NOTES ON CLAIMING - IN ORDER TO RECEIVE PAYMENT, YOU MUST:

1. Complete all sections of this claim form (including signing and dating the form).
2. Provide original itemised receipts written in English or with an English translation provided (credit card slips are not sufficient).
3. Itemised receipts must show all services separately, e.g. medical and pharmacy amounts shown separately.
4. All family members are to be included on the one form.

OTHER INSURANCE:

Are you entitled to claim Medical Benefits:

Under the Accident Compensation Act (2001)? ☐ Yes ☐ No

Under any Reciprocal Health Agreements? ☐ Yes ☐ No

Under any Private Health Insurance? ☐ Yes ☐ No

If you have answered Yes to any of the above please provide details:

PAYEE'S ELECTRONIC FUNDS TRANSFER (EFT) DETAILS AND TAX STATUS:

Following approval of your claim, we will pay your claim directly into your bank account. To enable us to do so, please provide the following details:

Name of Financial Institution: _____

Account Name: _____

Bank Code: _____ Account Number: _____

Bank Swift Code (International Payments): _____

Bank Account Currency (International Payments): _____

Bank Address (International Payments): _____

Please note that we are not liable for any bank processing fees incurred by you.

Is the Payee tax resident in New Zealand? ☐ Yes ☐ No

If not, is the Payee registered for GST? ☐ Yes ☐ No

DECLARATION

I declare that the above statements are true and correct and that I understand that:

- this claim form may collect personal information;
- Berkshire Hathaway Specialty Insurance Company requires this information pursuant to my/our insurance policy ("the policy") and to evaluate this claim;
- the Privacy Act 2020 entitles me/us to have access to, and request correction of, any information retained;
- Berkshire Hathaway Specialty Insurance Company is authorised to collect information relevant to the policy and the claim from third parties; and
- Berkshire Hathaway Specialty Insurance Company may make our personal information available to third parties to administer this claim or when required by law to do so.

Signature: _____ Date: _____

Email: ahclaimsnewzealand@bhspecialty.com
Phone: 0800 446 006

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