CORPORATE SERVICES NETWORK

EMAIL: CLAIMS@CSNET.COM.AU
PHONE: +61 2 8256 1770
FAX: +61 2 8256 1775
GPO BOX 4276
SYDNEY NSW 2001

EXPATRIATE / INPATRIATE MEDICAL EXPENSE CLAIM FORM

Employer / Company:

Name (Last, First, M.I.):

Nationality:

Address:

Country:

Policy Number:

☐ Male ☐ Female Date of Birth: ☐☐/☐☐/☐☐

Medicare Eligibility: ☐ Eligible ☐ Not Eligible

Mobile Phone:

Work Phone:

Do you consent to us communicating with you by email? Yes ☐ No ☐

Email Address:

CLAIM DETAILS

Treatment Date	Description of Injury/ Illness	Treatment	Name/Relationship	DOB	Currency	Claimed Amount
e.g. 31/1/2019	Broken Leg	Consultation	Julie / Daughter	29/1/2015	USD	$100
					Total	

Are these costs incurred in your home country? Yes ☐ No ☐

If so please provide us with the travel dates of each family member to and from your home country.

Bank Details

Bank Name:

BSB (Branch):

Account Holder's Name:

IBAN Number:

Bank Address:

Account Number:

Swift Code:

Currency:

IMPORTANT: Itemise each expense and attach/scan your relevant invoices, receipts and prescriptions before submitting your claim.

Please ensure copies are kept of all documentation

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PRIVACY STATEMENT, MEDICAL AUTHORITY AND DECLARATION

Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN's Privacy Policy and this document.

In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant: _____ Date: ☐☐/☐☐/☐☐

Name of Claimant: _____