

La Trobe Health Care Plan
Excess Refund Pool
Claim for Reimbursement of Excess Paid

Claim Details:

Members Name:

Address:

Employee No:	Work Telephone No:
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Employer:

HCF Health Fund Member Number:

HCF Claim Number:

HCF Membership Commencement date:

Hospital to Which Excess was Paid:

Amount of Excess Paid:

\$	
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Amount of Excess Claimed:

\$	
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To avoid any delay in payment please ensure that the original receipt issued by the hospital for the payment of the excess together with a copy of your HCF Membership Card is attached to this form.

I confirm the above details to be true and correct and request that La Trobe University's Excess Refund Pool reimburse my claim for the insurance excess paid by me and I undertake to furnish a copy of the Claims Statement upon issue from the HCF Health Fund.

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Employee Signature

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Dated

Account Details for Payment

Account Name:

Financial Institution Name:

Branch Address:

Bank/State/Branch (BSB) Number:

Account Number: