



Form - PH 02

Attach Receipts Here

NEW ZEALAND FIREFIGHTERS WELFARE SOCIETY

HEALTHCARE 99 IN HOSPITAL PRE-APPROVAL CLAIM FORM

Pre-approval Number

Name of Member _____ *	Date of Birth _____ *
Address _____ *	Healthcare 99 _____ *
City _____ Postcode _____ *	Membership Number _____ *
Email _____	Phone Contact Number _____ *
Name of Patient _____ *	Date of Event _____ *
Type of Procedure _____ *	

In-Hospital Benefits Claim – Is this an ACC/AES Claim? YES/NO* – GST included? YES/NO*

Surgeons Fees (Invoice/Receipt attached)	Amount Claimed \$ _____
Anaesthetist Fees (Invoice/Receipt attached)	Amount Claimed \$ _____
Hospital Charges (Invoice/Receipt attached)	Amount Claimed \$ _____
Post Surgical Costs (Invoice/Receipt attached)	Amount Claimed \$ _____
Oral Surgery (Invoice/Receipt attached)	Amount Claimed \$ _____

Total In Hospital Claims \$, .

I authorise my medical consultants to release any information relating to this claim to the administrators of Healthcare 99.

_____ *
signed

Please fill in all fields marked with an *, or your claim will not be processed.

NOTES - Healthcare 99 is your Mutual Fund
Healthcare 99 is a mutual fund not an insurance scheme

- 1 Please be specific with your claims.
- 2 Claims outside the 30 day rule requirement are not automatically covered.
- 3 All claims are subject to the conditions of Healthcare 99 and the schedule of benefits in force at the time.

MEMBERS Bank Account Number	Bank	Branch	Account Number	Suffix	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	*

Name of Account Holder _____ * _____ *

Please Print *Signed*

Queries: Phone 0800 50 51 52
Mail claim forms to:

Aon
P.O. Box 2845
Wellington 6140

Refer to Rules and Rates Brochure for your entitlements.
Go to www.firefighters.org.nz/membership
The site has helpful information and also has FAQ (Frequently Asked Questions).