



Claim for Reimbursement of Hospital Excess

Member Name:

Address:

Email: Phone:

FNL Member Firm:

HCF Membership Number:

HCF Claim Number: *If no hospital receipt*

Hospital to which excess was paid:

Amount of excess paid:

Amount of excess claimed:

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. Forward to FN National Office at PO Box 546 Richmond VIC 3121.

I confirm the above details to be true and correct and request that First National Ltd. Excess Refund Account 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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Member or Employee Signature Dated

Account Details for Payment:

| | | | |
|-----------------------------|--|-----------------|--|
| Account Name: | | | |
| Financial Institution Name: | | | |
| Branch Address: | | | |
| BSB Number: | | Account Number: | |