

La Trobe Health Plan
Claim for reimbursement of hospital excess
Excess Refund Pool

Section 1 - Claim Details

Members Name:

Address:

Employee Number: Work Telephone Number:

Employer: **La Trobe University** HCF Claim Number:

HCF Health Fund Member Number:

HCF Membership Commencement date:

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 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.

Employee Signature: Dated:

Section 2 - Account Details for Payment

Account Name:

Financial Institution Name:

Branch Address:

Bank/State/Branch BSB Number: Account Number: