



PMMI MEDICAL CLAIM FORM

MEDICAL

Your Surname _____ Christian Name _____ Date of Birth _____

Your Employer/Scheme _____ Policy No: _____

Telephone Number (675) _____ Fax Number (675) _____ Date you Joined Scheme _____

1. Are you covered for these expenses under any other Medical Insurance Plan, Personal Accident Insurance or any other insurance policy or plan? Yes No

If Yes, Please provide details _____

2. Do any of the expenses you are claiming arise from a sickness/injury that occurred as a result of your employment? Yes No

If Yes, Please provide details _____

3. Has the Insured person who is making this claim ever suffered from the same sickness/injury? Yes No

If Yes, Please provide details _____

PLEASE SUPPLY THE FOLLOWING ORIGINAL DOCUMENTS:

1. Medical Certificates Yes No Prescriptions Yes No

2. Receipts, Invoices or Accounts, Discharge Summary or Medical Reports for Medical Consultations, Prescriptions Medications, Treatment and if Hospitalised. Yes No

3. Details of any refund from any other claim you may have made in respect of this sickness/injury E.g. Workers Compensation, MVIL, Personal Accident/Sickness Claim, etc.

MEDICAL AUTHORITY

I hereby authorise all hospitals, doctors, or any other person who has provided me and/or my spouse and/or my dependents with medical treatment to supply to **Pacific MMI Insurance Limited** or it's representative with any information that the company may require in relation to any injury/sickness or medical history in connection with any claim for medical expenses.

I agree that a photocopy or facsimile of this authority will be as effective and valid as this original.

Signed: _____ (To be signed by Claimant or Legal Guardian) _____ / _____ / _____
Day Month Year

