AMBULANCE COVER CLAIM FORM

Fill out the form below completely. All supporting documents should be attached and emailed to info@twunsw.org.au - alternatively you can hand the documentation to your TWU Official or Delegate or post it to: TWU Member Services - PO Box 54 Mount Druitt, NSW 2770.

MEMBER DETAILS

TWU Member Number _____

First Name _____

Surname _____

Date of Birth _____

Address _____

Suburb/State/Postcode _____

Mobile _____

Email _____

Payment Method ☐ Direct Debit ☐ Statement ☐ Payroll Deduction

Employer _____

Occupation _____

CLAIM DETAILS

Person Affected _____

Relationship to Member _____

Date of Emergency _____

Time of Emergency _____

Reason for Ambulance _____

_____

Was the response related to a motor vehicle accident? ☐ Yes ☐ No

Was the response related to a workplace accident ☐ Yes ☐ No

Is the claimant a holder of a Health Care Card, Pensioner Concession Card or Commonwealth Seniors Health Care Card? ☐ Yes ☐ No

Does the claimant hold Ambulance Cover through Private Health Insurance? ☐ Yes ☐ No

Please check that you have correctly completed all sections and attached relevant evidence prior to submitting the claim form

OFFICE USE ONLY

Authorised by: _____ Date: _____

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