AMBULANCE COVER CLAIM FORM

Complete the form below and return with your ambulance invoice and any other supporting documents to info@twunsw.org.au. Alternatively, hand it to your Delegate/Official or post to TWU Member Services, PO Box 54, Mt 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

Employer _____

Occupation _____

CLAIM DETAILS

Person Affected _____

Relationship to Member ☐ Member ☐ Spouse/Defacto ☐ Child (under 18yrs)

Date of Emergency _____

Reason for Ambulance _____

_____

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

Was the response related to a medical episode, injury or accident that occurred in the workplace? ☐ Yes ☐ No

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

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

OFFICE USE ONLY

Authorised by: _____ Date: _____

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