LIFE INSURANCE CORPORATION (PNG) LIMITED

A Group Company of *National Teachers Insurance Limited*
P.O. Box 5684, Boroko, National Capital District, Papua New Guinea

REGISTERED OFFICE: **"Insurance Rumana", Sec 35, Lot 48, Frangipani Street, Hohola, NCD**
P.O.Box 5684, Boroko, National Capital District, Papua New Guinea

TELEPHONE: 323 2900 **FACSIMILE: 323 1307** **EMAIL: enquiries@ntilic.com.pg**

MEDICAL CLAIM FORM

NAME OF INDIVIDUAL
INSURED MEMBER (YOUR NAME): _____ EMPLOYMENT NO : _____

NAME OF GROUP/ EMPLOYER: _____
(if known)

POLICY NO / TYPE: _____ POLICY EXPIRY DATE: _____/_____/_____
(dd / mm / yy)

ADDRESS: _____ TEL: _____

_____ MOBILE: _____

_____ EMAIL: _____

CLAIM QUERIES

Are any of the Medical or Professional Services Claimed, resulting out of the following categories (Please Tick).

* WORK RELATED WHICH ENTITLES YOU TO WORKERS COMPENSATION CLAIM?	YES	NO
* RELATED TO MOTOR VEHICLE ACCIDENT?	YES	NO
* TREATMENT RELATED TO DRUG ADDICTION, ALCOHOLISM, MENTAL ILLNESS?	YES	NO
* TREATMENT OR CONDITION THAT HAD BEEN PRE-EXISTING PRIOR TO JOINING SCHEME?	YES	NO

If the response is YES to any of the above please give details:

_____

_____

_____

_____

_____

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_____

_____

NOTE:

TURN OVERLEAF TO PROVIDE PROFESSIONAL MEDICAL TREATMENT & SERVICE DETAILS

Form Ammended: 31/05/2024

IMPORTANT NOTICE

1. ORIGINAL MEDICAL INVOICES AND RECEIPTS WITH VALID STAMP MUST BE ATTACHED.
2. ENSURE TO PROVIDE ITEMIZED BILLING FOR TREATMENT OR SERVICES OR MEDICINES ELSE AN EXCESS OF 30% MAY BE APPLIED TO THOSE EXPENSES.
3. PERSONS DECLARED IN ORIGINAL PROPOSAL/APPLICATION FORM CAN BE ELIGABLE FOR A CLAIM.
4. ENSURE THAT ALL COLUMNS OF CLAIM FORM ARE FILLED INCLUDING THE DECLARATION SECTION.

PROFESSIONAL MEDICAL TREATMENT AND SERVICE DETAILS

Patient's Name	Relation to Member	Date of Birth	Doctor or Hospital	Details of Illness	Date Treated	Receipt No.	Amount (K)

NOTE: *PLEASE ITEMISE/SPECIFY DOCTOR'S MEDICINES, OTHERWISE AN EXCESS OF 30% WILL BE APPLIED TO THESE COSTS.*	**TOTAL (K)**	

DECLARATION

I, hereby claim medical benefits for the professional services to which the claim relates and I declare that I have incurred and paid the expenses for the services.

I do solemnly and sincerely declare that answers in the declaration section are full and true and that I have not withheld any relevant information. Futher I accept the responsibility that if any information is false, the company reserves the right to repudiate the claim

I hereby authorize any physician or any organization that has any records of my health to furnish Life Insurance Corporation (PNG) Limited (LICL) with information concerning my medical history and physical condition.

PAYMENT DETAILS

Member's Bank Account Detail (s);

Bank Name: _____

Bank Branch and/or Bank BSB No: _____

Bank Account No: _____

Bank Account Name (Payee): _____

NOTE: *For Corporate Members HR Department payment instructions, if any, take precedence.*

SIGNATURE: _____ **DATE:** _____/____/_____

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