

# HEALTHCARE REQUEST FORM



Please complete ALL sections of this form. (You may find the check list on the reverse useful.)  
Once completed please post to: Marram Community Trust. PO Box 24006, Manners Street, Wellington 6142.

Name of current employer: ..... Employee No (if known): .....

First Name ..... Last Name: .....

Email (Home): .....

Email (Work): .....

Home Postal Address: .....

Suburb: ..... City: ..... Postcode: .....

Home Phone: [0 ] ..... Work Phone: [0 ] .....

Mobile: [0 ] .....

Do you wish to be contacted by: Home Email  Work Email

Do you want your partner/husband/wife to make enquiries on your behalf? Yes  No

## DETAILS OF THE ACCOUNT TO BE CREDITED

Bank Branch Account Number Suffix

All reimbursements will be paid as direct credits, no cheque or cash payments will be made.  
Marram accepts no responsibility for the bank account details you have provided.

Do you have medical insurance? Yes  No   
For assistance see reverse

Name of Insurer: ..... Policy type: .....

### Type of expenses: *Please tick*

GP  Prescriptions  Specialist/Surgical  Physiotherapy  Alternative Therapists

Medical Equipment  Psychology  Other Please provide details .....

Optical Are you eligible to claim for your optical expenses through your employer?  No

Yes *If so, please claim through your employer first. Marram requires documentation confirming the amount paid.*

### These expenses are for:

Full Name	Date of Birth	Relationship to You
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

NOTE: Dependent children can be reimbursed up to their 18th birthday.

## You MUST tick the boxes below to complete the form

The information stated on this form is a true and accurate declaration of facts.

I am currently employed by a Marram Affiliated Organisation.

I acknowledge that payment is made at the absolute discretion of the Board of Trustees.

Signed: ..... Date: .....

FOR OFFICE USE ONLY	Eligibility date:	Last contribution:	Amount paid: \$
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## CHECK LIST

### **READ THIS BEFORE YOU SUBMIT YOUR FORM**

This is a checklist only, you don't need to send it us

- Receipts must show full payment.
- Receipts must be submitted within 12 months of the treatment being provided.
- Receipts must show clearly who received the treatment.
- Receipts must show what the treatment was and the date the service was received.
- Please supply your own bank account details each time.
- Please sign the form.
- Receipts are not for expenses incurred within the first 3 months of contributions.

Special conditions apply to some benefits and the circumstances under which they are reimbursed.

For the full range of Marram Healthcare benefits, please go to our website: [marram.co.nz](http://marram.co.nz), contact Contact Support 04 801 2920, or email [support@marram.co.nz](mailto:support@marram.co.nz)

### **Remember if you have Medical Insurance**

- Lodge your claim with your insurance company first.
- Include the remittance advice from your Insurer detailing any payments received.