

# 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? For assistance see reverse Yes  No

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

#### Type of expenses: Please tick

- GP     Prescriptions     Specialist/Surgical     Physiotherapy     Alternative Therapists  
 Medical Equipment     Disability Support     Other Please provide details .....  
 Optical Are you eligible to claim for your optical expenses through your employer? Yes  No

*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.

Please Enter Your Name: ..... Date: .....

Click **Submit** to email direct



## CHECK LIST

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

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

- Receipts must be originals or certified copies (not photocopies).
- Receipts must show full payment.
- All staples have been removed from the receipts.
- 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.
- 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: [www.marram.co.nz](http://www.marram.co.nz), contact **Support** on **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.
- Request that your insurance company returns originals or certified copies of your invoices and receipts.
- Include the remittance advice from your Insurer detailing any payments received.