Overseas Student
Health Cover

Allianz
Global Assistance

Medical Certificate

Part A: Patient Information

Policy number:

Family name:

First name:

Date of birth: / /

Nationality:

Passport number:

Phone:

Email address:

Address:

State: | Postcode:

I hereby authorise the release to AWP Australia Pty Ltd trading as Allianz Global Assistance of any relevant information, including health information held by a treating doctor or by a hospital at which I received treatment, for the purpose of Allianz Global Assistance administering any claim in relation to that treatment under my health cover.

I consent to the use and disclosure of my information as specified under the heading 'Privacy Notice' below and in accordance with the Allianz Global Assistance OSHC Policy Document.

Signature of patient:

If you are under 18 years of age please state your legal guardian or next of kin.

Name:

Relationship:

Signature of guardian:

Date: / /

Please email the completed form to oshcclaims@allianz-assistance.com.au or fax to (07) 3305 7009.

Privacy Notice

The personal information that you provide is collected for the purpose of issuing you with OSHC, determining any claims you may make on this policy (including complying with regulatory requirements in relation to OSHC) and for ancillary purposes as set out in our Privacy Policy. By providing your personal information, you agree and consent to our Privacy Policy which is available on request or view it on the web at http://www.allianz-assistance.com.au/privacy-and-security/.

For example, in the course of providing our services, assessing claims, and carrying out our business activities, your personal information (including personal information of others named on your Certificate of Insurance) can be disclosed to education providers, health fund providers, underwriters and insurers including Peoplecare Health Limited, marketing and service provider intermediaries, government departments including the Department of Home Affairs, medical practitioners, hospitals, and other medical service providers, claims assessors, investigators, our related and group companies including Allianz , and other international assistance and service providers with whom we engage. To provide our services, we may transfer your personal information overseas. You also agree to allow us to disclose details of your OSHC and other personal information received from any healthcare provider who provides you with treatment for the purposes set out in this Privacy Notice. We do not disclose your medical information for marketing purposes.

If you would like to gain access to or correct any of your personal information, please contact Allianz Global Assistance at personalinformation@allianz-assistance.com.au If you do not agree with our Privacy Policy, you must inform us as we may not be able to provide our services to you including assessment of your claim.

Part B: Patient's Treating Doctor

Members of Allianz Global Assistance OSHC have agreed, in respect of any claim, to allow Allianz Global Assistance to provide details of their cover or to obtain details from any healthcare provider in order to process their claims (refer Allianz Global Assistance OSHC Policy Document).

Important: The medical attendant is requested to give as much details as possible in order to assist our client and avoid the necessity of additional enquiries.

Medical Practitioner name:

Medical Centre name:

Address:

State: | Postcode:

Phone/Fax:

How long have you been the treating Medical Practitioner for the above patient?

Describe the nature of the presenting symptoms and diagnosis:

Date of onset of condition/illness/injury: / /

What was the date you first investigated or were consulted by the patient for this condition/illness/injury? / /

Has the patient previously been investigated, diagnosed or treated by another doctor in respect of the same, similar or related condition/illness/injury as described above? ☐ Yes ☐ No

If yes, please provide details:

Please provide brief details of the patient's medical history with regards to this or related conditions/illnesses/injuries:

Proposed treatment plan likely to be required:
Short term ☐ (<6 weeks) Medium term ☐ (6 – 12 weeks)
Long term ☐ (12 weeks +)

Details of treatment plan:

I certify that the statements contained in this Medical Certificate are true and correct.

Signature of Medical Practitioner:

Date: / /