

# + HCF Exercise & Gym benefits authorisation

Complete and send to:  
**HCF**  
GPO Box 4242,  
Sydney, NSW 2001

Under HCF's Health Management Program, Multicover and Super Multicover members can claim towards the costs of an exercise program or gym membership.

This benefit is available if the exercise program is designed to address or improve a specific health or medical condition.

Please submit this completed form along with receipts for your gym fees or exercise regime.

## Section 1 Claimant's details

HCF Membership No.

Date of birth

 /  / 

First Name

Surname

Is this claim the result of an accident or trauma:  Yes  No

If 'yes', please give the date of the event

 /  / 

Is the claimant entitled to any form of compensation, damages or payment as a result of the accident or event?  Yes  No

If 'yes', please provide brief details \_\_\_\_\_

Your GP's name

Postcode

## Section 2 To be completed by your General Practitioner or Specialist

Medical Practitioner's Name

Medicare provider number

Telephone number including area code

Postcode

Please indicate the patient's **medical condition** that this exercise regime is addressing:

Please indicate the **exercise regime** you are recommending to improve the patient's medical condition:

Please indicate the length of time recommended for this course of treatment:  months

**Declaration (to be completed by the doctor)** I declare that the information I have provided is true and accurate.

General Practitioner / Specialist signature and practice stamp

Date

 /  / 

**Declaration and Authority (to be completed by the member)**

I declare all information stated in this claim form and any supporting documentation to be true and correct. All goods and/or services were received by the patient and administered by the provider shown. No ancillary benefits are being claimed from HCF that have been, or will be, claimed from Medicare. The patient was not aware of any symptom related to the condition for which benefits are claimed before joining HCF or transferring to current level of cover. I acknowledge that HCF may need to disclose details of this claim to third parties to establish the correct benefit entitlement and I authorise HCF to contact the provider and to access any information needed to verify and process this claim. I acknowledge that HCF otherwise deals with personal information of patients in accordance with the terms of its privacy policy, which is available on the HCF website, or by request from HCF branches. I confirm I was a financial member of HCF when these goods and/or services were provided and I am authorised to sign the claim form as the contributor or contributor's nominated partner on the policy.

Signature of Member

Date

 /  / 

**PRIVACY** How HCF collects, uses, keeps and secures personal information is described in the HCF Privacy Policy.

For a copy of this policy, visit a branch, call 13 13 34 or log onto [www.hcf.com.au](http://www.hcf.com.au)

Call HCF Member Information 13 13 34

**HCF**

+ We're different.™

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