## **BERT Ambulance Claim Form**



## Please return this completed form to:

Email: claims@bert.com.au | SMS: 0428 483 324 | Post: BERT, P0 Box 805, SPRING HILL QLD 4004

Office: Level 1, 35 Astor Terrace, SPRING HILL QLD 4000

The BERT Ambulance Scheme provides cover to worker's, and their dependants, who work in Queensland, Northern Territory or New South Wales for the cost of ambulance travel that occurs outside working hours.

**DEPENDANT MEANS:** The Worker's spouse (or partner with whom the Worker has cohabited for no less than 3 consecutive months) and includes the unmarried financially dependant children of the worker up to 16 years of age or up to 25 years of age if a FULL TIME STUDENT.

 INSTRUCTIONS
 The worker needs to complete ALL sections of the form.

 Incomplete and vague information will delay the assessment of the claim.
 The worker will need to provide proof of their employment in Queensland, Northern Territory or New South Wales.

MEMBER DETAILS	
Surname	Mr Mrs Miss Ms
Given names	Date of birth D D M M Y Y Y Y
Street address	
Suburb	State Postcode
Postal address (Write 'AS ABOVE' if same as Street address)	
Suburb	State Postcode
Telephone Home	Mobile
Email address	
BERT Member No. (if known) Union CFMEU CEPU	Union No. (if known)
PAYMENT DETAILS	
Electronic Funds Transfer (EFT) is the quickest and most effective way to re	eceive your benefit.
1. Please indicate your preferred method of payment for your claim:	
	ent to your above address) (Please proceed to question 2)
To receive payment via EFT, we require a copy of your bank statemen	
Name of Bank	BSB Number –
Account Name Accou	ccount Number
CLAIMANT DETAILS	
Surname	Mr Mrs Miss Ms
Given names	Date of birth D D M M Y Y Y Y
Relationship to Member Member Spouse Defacto	Child Dependant Child
EMPLOYMENT DETAILS	
Employer Name	
Street Address	
Suburb State	Postcode
Contact Name	
Telephone Home Home	Mobile
Email address	

AMBULANCE TRAVEL DETAILS	
Give the exact date and time of the ambulance journey D D M M Y Y Y Y	Time : am pm
State in full detail exactly when and why the ambulance was required, advising the ci	ircumstances surrounding the incident.
Was the travel by Road by Air	
Where did the incident requiring the ambulance occur? Home Work Other (gi	ive details)
Address where the incident occurred?	
Suburb	State Postcode
Did the accident occur while training or playing sport? Yes No If yes, name of	club?
PRIVATE HEALTH INSURANCE DETAILS	
Do you have Private Health Insurance? Yes No If yes, name of your Health Ins	surer
Does you Private Health Insurer Include Ambulance Cover? Yes No	
AUTHORISATION OF CLAIMANT (IF YOU ARE UNDER THE AGE OF 18, A GUARDIAN IS TO SIGN	N AUTHORITY)
I hereby authorise any ambulance provider, employer or any other person relevant, to sup	
and prior history relevant to this claim. I agree that a photocopy of this authorisation form original. I also declare that the information provided on this form is to the best of my know	wledge and believe to be true in every aspect. I
understand that supplying false or misleading information will result in my right to compe	ensation beign forfeited.
Signature of Claimant 🔀	Date D D M M Y Y Y Y
AUTHORISATION OF MEMBER (IF YOU ARE UNDER THE AGE OF 18, A GUARDIAN IS TO SIGN A	, ,
I hereby authorise my union to supply BERT with details of my union payments to assist v	with eligibility to claim.
Signature of Member ×	Date D D M M Y Y Y
PLEASE PROVIDE A COPY OF INVOICE / RECIEPT FO	R AMBULANCE USAGE
The BERT Ambulance Scheme provides coverage for the cost of Ambulance for all financia a) Construction Forestry Mining & Energy Union (Queensland / Northern Territory Construction	
b) Plumbers Union Qld / Northern Territory	
Cover ceases immediately once a member is not a finanical member of the above Union(s	s) at the time of the Ambulance travel.
This benefit is only available to union members as specified and working within Que	
Any claim received will only be considered for payment if the claim is submitted to BERT v travel.	within six (6) months from the date of the ambulan
No claims for Ambulance usage will be accepted which are a result of (not a comple	ete list):
• An illegal act	
Health care card holders, where free ambulance cover is available	
<ul> <li>An injury or sickness for which statutory insurance provides compensation</li> <li>Payments made in respect of an event occuring outside Australia or where a member do</li> </ul>	and not remain within the territory of Australia
<ul> <li>Transport between two public hospitals</li> </ul>	oes not remain within the territory of Australia
Transport from a public hospital to an external diagnostic facility	
Transport to and from a public hospital appointment	
If you require assistance please call BERT on <b>1300 261 114</b> .	r email us at <b>enquiries@bert.com.au</b>
fice use only B	
tered By (Initial) Date D D M M Y Y Y Y B	🛃 CFMEU
ember Number	

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