Reimbursement of Health Overcharges
application

To avoid delays with your reimbursement, please read this form carefully.
If you need any help completing the form, call us on 0800 999 999.
Post your completed application to PO Box 5054, Lambton Quay, Wellington 6145

Tell us about yourself

If you’ve received a benefit or extra financial help from us before, write your client number here if you know it. This number can be found on your Community Services Card if you have one.

Client number

Tell us your details

1. What is your full name?
   First and middle names
   Surname or family name

2. What date were you born?
   Day   Month   Year

3. What is your Inland Revenue tax number?

Tell us how we can contact you

4. Where do you live?
   Flat/House number   Street name
   Suburb
   Town/City

5. Is your mailing address different from where you live?
   No   Yes
   Tell us your mailing address
   Mailing address can include a PO Box, rural delivery details, or C/O address.
How else can we contact you?

<table>
<thead>
<tr>
<th>Contact Type</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home phone</td>
<td>( )</td>
</tr>
<tr>
<td>Mobile phone</td>
<td>( )</td>
</tr>
<tr>
<td>Other phone</td>
<td>( )</td>
</tr>
</tbody>
</table>

Tick the best way for us to first contact you.

Do you agree to get emails from us?

- [ ] No
- [x] Yes  
  Tell us your email address
- [ ] I don't have an email address

Who are you applying for?

- [ ] Myself
- [ ] My dependent children  
  Please provide details below

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child 1's full name</td>
<td>Day Month Year</td>
</tr>
<tr>
<td>Child 2's full name</td>
<td>Day Month Year</td>
</tr>
<tr>
<td>Child 3's full name</td>
<td>Day Month Year</td>
</tr>
</tbody>
</table>

Are any of these overcharges covered by ACC?

- [ ] No
- [x] Yes

Do you have a High Use Health Card?

- [ ] No
- [x] Yes  
  Please give details below

<table>
<thead>
<tr>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Use Health Card number:</td>
</tr>
<tr>
<td>Start date:</td>
</tr>
<tr>
<td>Expiry date:</td>
</tr>
<tr>
<td>Day Month Year</td>
</tr>
</tbody>
</table>

Do you have a Pharmaceutical Subsidy Card?

- [ ] No
- [x] Yes  
  Please give details below

<table>
<thead>
<tr>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmaceutical Subsidy Card number:</td>
</tr>
<tr>
<td>Start date:</td>
</tr>
<tr>
<td>Expiry date:</td>
</tr>
<tr>
<td>Day Month Year</td>
</tr>
</tbody>
</table>
Bank details

Do you get income support payments from Work and Income?

[ ] No  [ ] Yes  [Go to question 13]

The reimbursement will be paid to the same account as your other payments.

ATTACHMENT FOR Q13:
You need to provide proof of your bank account details, such as a bank statement or deposit slip.

What bank account would you want your payments to be paid into?

The account is in the name of:

[ ]

The account number is:

[ ]

Bank  Branch  Account number  Suffix

Declaration and signature

The information I have given you is true and complete.

Applicant’s name (print)  Applicant’s signature  Date

[ ]

Day  Month  Year

Checklist

Are all the original receipts attached? (EFTPOS receipts are not acceptable.)  [ ] No  [ ] Yes

How many receipts are you attaching?  [ ]

Do you want the receipts returned to you?  [ ] No  [ ] Yes