



Reimbursement of War Disablement Pension Medical Expenses

This is to seek reimbursement of expenses for **medical treatment from a registered health professional for an accepted disability**, the disability you receive a War Disablement Pension for. These are listed on your treatment card.

Please attach the receipts for the visits to the health professional or for the pharmaceuticals you are claiming for **to this form**.

In order to speed up the processing of your claim, can you please get the health professional or pharmacist to verify that the treatment or pharmaceutical is for one of your accepted disabilities. This can be done by getting them to endorse the receipt or by signing this claim form.

We would appreciate it if you sent in your reimbursements every six months or when they total at least \$50, unless you need to be reimbursed earlier.

Please write in BLOCK LETTERS with a blue or black pen. Please do not write in pencil.

Veterans Details

War Pension Number (if known)

Full Name

Residential Address

Postal Address (if different to residential address) All correspondence will be sent to this address.

Contact Telephone Number (home)

(work)

Email

Fax

The completed claim form and any supporting documentation should be sent to Veterans' Affairs New Zealand, PO Box 9448, Hamilton 3240.

I wish to apply for reimbursement for the following treatment costs for my accepted disabilities

Accepted Disability	Treatment	Date	Amount	Verification by Treatment Provider (Signature or Practice Stamp)
<i>Example Osteoarthritis left knee</i>	GP <input type="checkbox"/> other <input type="checkbox"/> prescription	12/03/09	\$3.00	
	GP <input type="checkbox"/> other <input type="checkbox"/> prescription <input type="checkbox"/>			
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Declaration This claim form needs to be signed. If someone has filled the claim form in for you, you need to make sure that you agree with what they have written prior to signing the claim form.

I have completed this claim form, or this claim form has been completed for me. I declare that the information provided in this claim form is, to the best of my knowledge true and complete.

Signature	Date
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