# Release of Claims History Request

Membership Number # Name of Policy Holder:

Please provide a print out of all benefits paid by ACA Health Benefits Fund for all members listed below for the period commencing: / / to / /

| Name | Date of Birth | Signature of those over 13 years |
|---|---|---|
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## Declaration

All family members over the age of 13 years have granted permission for this history to be released and delivered to me (via the below email or postal address) by signing above as required.

Name: Contact Phone:

Email:

OR

Address:

Signed: Date:

Please return to ACA Health Benefits Fund

Locked Bag 2014 Wahroonga NSW 2076 | Email: info@acahealth.com.au