

# HCF Medical Trauma Insurance Application Form – HCF Members

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HCF Membership No:

Benefit Amount:

\$20,000  \$40,000

Level of cover:

Single  Family\*

**Details of person covered.** Please use capital letters

Title

Given names

Surname

\*Under Family cover the persons who are covered by your Medical Trauma Insurance policy are those recorded on your HCF membership.

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## Declaration

I wish to add Medical Trauma Insurance to my HCF membership and understand the premium will be added to my existing HCF contribution payments. If my contributions are paid by payroll deduction HCF will notify my pay office. My decision to apply for this product is based on material received and read and my understanding of the information, including the Product Disclosure Statement.

Signature

Date

## Office use only

Source

User ID

Date

Product Codes: FMT, SMT

Please complete the application, detach and return to any HCF Branch or post to:  
(no stamp required if posted in Australia)

HCF Life  
Reply Paid 4445  
Sydney NSW 2001

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# HCF Medical Trauma Insurance Application Form – Non Members of HCF

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## Details of person covered. Please use capital letters

Title

Given names

Surname

Date of birth (day/month/year)

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Benefit Amount:

Sex:  Male  Female \$20,000  \$40,000

Home Address (Please complete your street number, name and suburb)

Postcode

Phone work

Phone home

Phone Mobile

Email

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## Payment method. Please mark X

 Ezipay (complete Ezipay Direct Debit Request section) Credit Card Authority (complete Credit Card Authority)

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## Credit Card Authority Cardholder name (exactly as it appears on your card)

**Type of card** (please mark X)  Visa  Mastercard  American Express**Debit frequency** (please mark X)  Monthly  Quarterly  Half Yearly  Yearlyon the  day\* of the month (Please note: debit dates of 28, 29, 30 and 31 are not available)

\* Please nominate day. I acknowledge that the credit card I am using to pay for this insurance has been issued and used prior to paying for this insurance.

Credit card number

Expiry date

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Continued over...

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### Ezipay Direct Debit Request

I/we authorise the Hospital Contributions Fund of Australia Limited under user ID Number 245164 to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System (BECS).

Please mark X  Weekly  Fortnightly  Monthly  Quarterly  Half Yearly  Yearly

on the   day\* of the month (please note: debit dates of 28, 29, 30 and 31 are only available for weekly and fortnightly debits) \*Please nominate your first debit day.

The authorisation is to remain in force in accordance with the terms described in the HCF Direct Debit Customer Service Agreement.

#### Details of the account to be debited (All details must be supplied)

Name of financial institution

Branch

Account holder name (first initial and surname)

BSB number

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Account number

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**Declaration** (Applicants please read and sign) Date  /  /   
My decision to apply for this product is based on material received and read and my understanding of the information, including the Product Disclosure Statement and I authorise HCF to debit the account nominated.

Signature

#### Office use only

Source

User ID

Date  /  /  Product Codes: FMT, SMT

Please complete the application, detach and return to any HCF Branch or post to:  
(no stamp required if posted in Australia) HCF Life. Reply Paid 4445, Sydney NSW 2001

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