

Online Application for health cover



I wish to: (Please mark X) Join HCF. Transfer from another fund (Complete Interfund Transfer section).
 Change people covered, membership details or present cover.

Source	Deal code	Rate code
R20771	LAT	20

LAT Gi11670 Mar 2009-v.1

Your personal details.

Please use capital letters

Title Given names

Surname Current HCF Membership or Covernote No. Sex M F

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

Postcode Phone work Mobile Phone home

Postal address (Please complete your street number, name and suburb)

Postcode Date of birth (Day/Month/Year) / /

Please tick if you would not like to receive either of our free monthly email newsletters

Date you wish your membership to commence / / Email

Please mark X Retain my existing products Single Couple/Family Single Parent Family Extended Family Cover

Other persons to be covered.

Use another form if space is insufficient

<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>	<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>
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Federal Government Rebate

Complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply. Are all people on your membership eligible for full Medicare Benefits?

Yes - Please complete the remainder of this section No - You cannot apply for the rebate.

Your Medicare card number Date of birth (Day/Month/Year) / /

Your name exactly as it appears on your Medicare card

Rebating of claims

If you would like your claims benefit paid directly into your account, please complete the following details:

Account name

BSB number

Account number

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Declaration All applicants please read and sign

By supplying my address, telephone and email details, I agree that HCF can use these to keep me informed of future products and services, until such time as I tell HCF otherwise. I agree to be bound by the rules of the Hospitals Contribution Fund of Australia Limited. For any HCF Life More Protection Options I have chosen, I have read and understood the Product Disclosure Statement and Financial Services Guide. Where payment method requested is Ezipay or Credit Card Deductions, I authorise HCF to debit the account nominated.

I understand and acknowledge the following conditions - please mark X in boxes below

- Hospital excess Pregnancy & birth related services Waiting periods Pre-existing ailments or conditions Minimum Benefits

Please check you have crossed the boxes above before signing this declaration. I confirm that I have read and understood this declaration and the information in the brochure. I agree that HCF may deal with my personal and health information in accordance with its privacy policy (available on the HCF website and at HCF branches)

I declare the information provided to be true and correct.

Signature Date / /

Office use only

IDENTIFICATION - One of Photo licence Passport Govt Employers ID

Number Other photo number
Batch number Other number (attach details)
User ID

Interfund transfer Use another form if space is insufficient

Complete this section if you have been with an Australian Registered health fund at any time since 1/7/2000.

If you have a direct debit arrangement with your existing health fund please remember to personally advise your bank or your pay office (if you pay by payroll deduction) to cancel your deductions. Remember also to sign the Declaration section.

Title Given names Name of existing health fund
Surname Membership number
Home address (Please complete your street number, name and suburb)
 Postcode I hereby authorise HCF to terminate my membership with your organisation and obtain details about my membership.
Date of Birth (Day/Month/Year) / / Signature Date / /

Please note due to privacy reasons, your existing health fund may send you the clearance certificate, which you will need to forward to HCF.



Please complete Application & Payroll Deduction Authority and return to your Payroll Office for processing:

Payroll Department
La Trobe University, Bundoora Campus,
BUNDOORA VIC 3083

Tel: (03) 9479 2048 Fax: (03) 9471 0369