

HCF Online Application for health cover

Office Use Only

July 11

Corp Source code

Deal code

Rate code

Sales Source code

(Please mark 'X')

Join HCF health fund – new to private health insurance (complete sections 1-8, excluding 7)

Transfer to HCF health fund from another fund (complete sections 1-8)

Add people to my membership (complete sections 1a, 2 and 8)

Change my level of cover (complete sections 1a, 3 and 8)

Change my payment details (complete sections 1a, 6 and 8)

HCF Membership No.

1 a) Your personal details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

To be completed by the Policyholder – see section 8 for definition

Title First name Middle initial

Surname Sex (Please mark 'X')
M F

Home address:

Unit No. Street No. Street name

Suburb State Postcode

Phone - home Phone - work Mobile

Postal address (if different from your home address)

Suburb State Postcode

Email @ .

Date of birth (DD MM YYYY) Date you wish your membership to commence (DD MM YYYY)

b) Choose your cover requirement (Please mark 'X')

Single (go to Section 3) Couple/Family (go to Section 2)
 Single Parent Family (go to Section 2) Extended Family Cover (available for options which include Top Plus or Hospital Savings) (go to Section 2)

2 Other persons to be covered (Use another form if space is insufficient)

If you are unsure of who can be covered on your membership, please see page 34 in the HCF Brochure

First name

Surname

Date of birth (DD MM YYYY) Sex (Please mark 'X')
M F

Relationship

First name

Surname

Date of birth (DD MM YYYY) Sex (Please mark 'X')
M F

Relationship

First name

Surname

Date of birth (DD MM YYYY) Sex (Please mark 'X')
M F

Relationship

First name

Surname

Date of birth (DD MM YYYY) Sex (Please mark 'X')
M F

Relationship

3 HCF product choices (Please mark 'X') (See pages 10-30 of the HCF Brochure for further information)

1 Young singles & couples (page 10) Hospital excess options

Option 1 – Young Singles & Couples Cover \$450

Option 2 – Hospital Advanced Savings & General Extras Plus \$250 \$450

Option 3 – Hospital Advanced Savings & Multicover \$250 \$450

2 Planning a family (page 14) Hospital excess options

Option 1 – Hospital Savings & General Extras Plus \$250

Option 2 – Hospital Savings & Multicover \$250

Option 3 – Top Plus & Multicover \$0 \$150 \$250 \$450

3 Families with kids (page 18) Hospital excess options

Option 1 – Hospital Advanced Savings & General Extras Plus \$250 \$450

Option 2 – Hospital Advanced Savings & Multicover \$250 \$450

Option 3 – Top Plus & Multicover \$0 \$150 \$250 \$450

4 Older singles & couples (up to 65) (page 22) Hospital excess options

Option 1 – Fit & Free \$0 \$250

Option 2 – Top Plus & Multicover \$0 \$150 \$250 \$450

Option 3 – Top Plus & Super Multicover \$0 \$150 \$250 \$450

5 Wiser & Older (over 65) (page 26) Hospital excess options

Option 1 – Top Plus & Multicover \$0 \$150 \$250 \$450

Option 2 – Top Plus & Super Multicover \$0 \$150 \$250 \$450

6 HCF Stand Alone Products (page 30) Hospital excess options

Hospital Advanced Savings \$450

Top Plus \$0 \$450

Multicover only

Ambulance

Additional Cover – more protection
(Please see pages 37-44 of the HCF Brochure for further information)

Accident Cash Advantage*

Health and Life Premium Insurance

Cash Back Cover

Permanent Disability Benefit Plus*

Kids' Accident Cover†

*Name of person to be covered for Accident Cash Advantage and/or Permanent Disability Benefit Plus

†Name/s of children to be covered by Kids' Accident Cover

(Use another form if space is insufficient)

+

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4 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. All people listed in Section 1 and 2 must be eligible to claim Medicare Benefits for you to receive the rebate as a reduced premium.

Are all people on your membership eligible for Medicare Benefits? Yes - Please complete the remainder of this section

First name Middle initial Sex (Please mark 'X') M F Date of birth (DD MM YYYY)

Surname Your Medicare card number

5 Reimbursing of claims

To have your claims paid directly into your bank account, please complete the following:

Account name

BSB No.

Account No.

6 Payment method (Please mark 'X')

HCF offers you a number of easy ways to pay your premiums. Please fill out one of the options below to pay your premiums automatically.

- Ezipay Direct Debit (please complete Section 6a)
- Credit Card Authority (please complete Section 6b)
- Group Payroll Deduction (please complete Section 6c)

a) Ezipay Direct Debit Request

I/We authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from my/our account and as prescribed below through the Bulk Electronic Clearing System (BECS).

(Please mark 'X')

Weekly Fortnightly Monthly* Quarterly* Half yearly* Yearly*

(DD MM YYYY)

Please debit on the day* of the month. First debit* to occur on
(*Please nominate day: **Debit dates of 28, 29, 30, 31 are only available for weekly and fortnightly debits**)

Details of account to be debited (all details must be supplied)

Name of financial institution

BSB No.

Account No.

Branch

Account holder name (first initial and surname)

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

b) 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* Yearly*

Credit card No.

Expiry date (MM YY)

Please debit my account on the day* of the month

(*Please nominate day: **Debit dates of 28, 29, 30 and 31 are not available**)

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

c) Group Payroll Deduction Authority

Payroll deductions are available only when your employer has an arrangement with HCF.

Employer's name

Payroll or employee ID

+

I hereby authorise my employer to deduct from my wages or salary. (Please mark 'X')

Weekly Fortnightly Monthly Quarterly Half yearly Yearly

Employee's personal details

Title

First name

Middle initial

Membership No.
(if already a member)

Surname

Date marking the end of the first
deduction pay period (DD MM YYYY)

Total contribution
deductions (if known)

Other contribution details

If you are currently paying for other HCF memberships please give their details below:

Full name

Health \$

More
Protection \$

Total \$

Membership No.

7 Interfund transfer (Complete this section if you have been registered with an Australian Registered health fund at any time since 1 July 2000)

Complete the following details and we'll take care of the transfer for you.

I authorise HCF to terminate my membership with my existing health fund and obtain details concerning (Please mark 'X'):

Myself All persons covered

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.

Title First name Middle initial Date of birth (DD MM YYYY)

Surname

Name of existing health fund Membership No. +

Home address:
 Unit No. Street No. Street name

Suburb State Postcode Cancellation effective from (DD MM YYYY)

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

8 Declaration (Please read and sign)

I acknowledge and agree that:

- The Policyholder is the person responsible for payment of the contribution rates, the ongoing maintenance of the policy, and the receipt of all policy correspondence;
- I am bound by the Health Fund rules of The Hospitals Contribution Fund of Australia Limited (available in HCF branches);
- by supplying my address, telephone and email details, the HCF Group can use these to keep me informed of products and services, until such time as I tell HCF otherwise;
- HCF deals with personal information of all members in accordance with the HCF Group Privacy Policy (available on the HCF website and in HCF branches). To request information we have collected about you see Privacy & Security at www.hcf.com.au or call 13 13 34. HCF reserves the right to

charge a reasonable cost for processing your request;

- where payment method requested is Ezipay or Credit Card Deductions, I authorise HCF to debit the account nominated. Where payment method is Group Payroll Deduction, payments will be paid to HCF. If my cover or rate is changed the new rate is to be paid to HCF. This replaces any existing authority for payments and is to continue until withdrawn in writing;
- in the case of an Interfund Transfer, HCF may terminate my membership with another health fund and obtain details about my membership.

I confirm that I have read and understand:

- this declaration and the information relating to my product choice in the HCF Brochure;
- the Product Disclosure Statement and Financial Services Guide provided to me with this application, for any More Protection options I have chosen. My decision to apply for these products is based on material received and read and my understanding of the information including the Product Disclosure Statement.

I agree that my insurance will commence once my application is accepted.

I declare the information provided to be true and correct.

I have understood the following conditions – please mark 'X' in all boxes once you have understood these:

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

Signature

Date (DD MM YYYY)

