

HCF Overseas Visitors Application for health insurance

(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)

Office Use Only

July 11

Corp Source code

Deal code

Rate code

Sales Source code

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
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Sex (Please mark 'X')	
<input type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	
Home address:		
Unit No.	Street No.	Street name
<input type="text"/>	<input type="text"/>	<input type="text"/>
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone - home	Phone - work	Mobile
<input type="text"/>	<input type="text"/>	<input type="text"/>
Postal address (if different from your home address)		
<input type="text"/>		
Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Email		
<input type="text"/> @ <input type="text"/> . <input type="text"/> . <input type="text"/>		
Date of birth (DD MM YYYY)	Date you wish your membership to commence (DD MM YYYY)	
<input type="text"/>	<input type="text"/>	

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

Retain my existing products Single Couple/Family

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 33 in the HCF Brochure (available in branch or online at hcf.com.au)

<p>First name</p> <input type="text"/> <p>Surname</p> <input type="text"/> <p>Date of birth (DD MM YYYY)</p> <input type="text"/> <p>Sex (Please mark 'X')</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship</p> <input type="text"/>	<p>First name</p> <input type="text"/> <p>Surname</p> <input type="text"/> <p>Date of birth (DD MM YYYY)</p> <input type="text"/> <p>Sex (Please mark 'X')</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship</p> <input type="text"/>
<p>First name</p> <input type="text"/> <p>Surname</p> <input type="text"/> <p>Date of birth (DD MM YYYY)</p> <input type="text"/> <p>Sex (Please mark 'X')</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship</p> <input type="text"/>	<p>First name</p> <input type="text"/> <p>Surname</p> <input type="text"/> <p>Date of birth (DD MM YYYY)</p> <input type="text"/> <p>Sex (Please mark 'X')</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship</p> <input type="text"/>

3 HCF product choices (Please mark 'X')

Hospital excess options

<input type="checkbox"/> Overseas Visitors Health Cover	<input type="checkbox"/> \$0	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000
<input type="checkbox"/> Overseas Visitors Health Cover & Multicover	<input type="checkbox"/> \$0	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000
<input type="checkbox"/> Overseas Visitors Health Cover & General Extras Plus	<input type="checkbox"/> \$0	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000

4 Reciprocal health care agreement

If you are a permanent resident in a country that has a Reciprocal Health Care Agreement, please tick the box of the country of residence.

<input type="checkbox"/> Sweden	<input type="checkbox"/> Finland	<input type="checkbox"/> Italy	<input type="checkbox"/> Netherlands	<input type="checkbox"/> New Zealand
<input type="checkbox"/> Malta	<input type="checkbox"/> Republic of Ireland	<input type="checkbox"/> United Kingdom	<input type="checkbox"/> Belgium	<input type="checkbox"/> Norway

These applicants may have a Medicare Card marked with 'RCHA' or 'VISITOR'

Medicare Card No. (if applicable)

5 HCF Overseas Visitors health cover – eligibility checklist

To be eligible for Overseas Visitors Health Cover, you must be

- on a visa 457 (Long stay business visas), 456 (Short stay business visas), 417 (Working holiday), 419 (Visiting academic), 422 (Medical practitioner) or any other visa that gives you the right to work in Australia, OR
- a visitor here for business purposes OR
- a Consulate member here for diplomatic purposes

It is not available for people under student visas, tourist visas or retiree visas.

Membership is available to persons who have previously had their Medicare entitlements revoked providing they meet the above criteria. You may be required to provide a photocopy of your visa before your application is processed.

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)	<input type="checkbox"/>
Credit Card Authority (please complete Section 6b)	<input type="checkbox"/>
Group Payroll Deduction (please complete Section 6c)	<input type="checkbox"/>

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)

Health \$

More Protection \$

Total \$

+

Other contribution details

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

Full name

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.
- 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

X

Date (DD MM YYYY)