APPLICATION FOR HEALTH INSURANCE AND CHANGE OF DETAILS

Complete and mail to:
HCF
GPO Box 4242
Sydney NSW 2001

(Select which option by marking `X' in one of the boxes below)

- 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 1, 2 and 8) ☐
- Change my level of cover (complete sections 1, 3 and 8) ☐

OFFICE USE ONLY
4052250 Apr 19
Corp Source code
Deal code W E B
Rate code
Sales Source code H 2 0 0 2 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 | Gender (Please mark 'X') M ☐ F ☐

Home address

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 (go to Section 2) ☐ Retain my existing products

2 OTHER PERSONS TO BE COVERED (USE ANOTHER FORM IF SPACE IS INSUFFICIENT)

Provide details of all people covered by the policy (do not include yourself). If you are unsure of who can be covered on your membership, please see FAQs at **hcf.com.au**

First name | Surname | Date of birth (DD MM YYYY) | Gender (Please mark 'X') M ☐ F ☐ | Relationship

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First name | Surname | Date of birth (DD MM YYYY) | Gender (Please mark 'X') M ☐ F ☐ | Relationship

3 PRODUCT CHOICES (PLEASE MARK 'X')

Hospital cover options	Hospital excess options
☐ HCF Hospital Bronze Plus	$250 ☐ $500 ☐ $750 ☐
☐ HCF Hospital Silver	$250 ☐ $500 ☐ $750 ☐
☐ HCF Hospital Silver Plus	$250 ☐ $500 ☐ $750 ☐
☐ HCF Hospital Gold	Nil ☐ $250 ☐ $500 ☐ $750 ☐

Ambulance

☐ HCF Ambulance Only

(Available to resident of ACT, NSW, NT, SA, Vic and WA. Residents of Qld & Tas are ineligible to purchase HCF Ambulance Only cover due to state schemes)

Cash Assist

☐ Cash Back Cover

☐ Kids' Accident Cover†

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

(Use another form if space is insufficient)

Package options	Hospital excess options
☐ HCF My Future 250 Basic Plus	$250 ☐
☐ HCF My Future 500 Basic Plus	$500 ☐
☐ HCF My Future 750 Basic Plus	$750 ☐
☐ HCF My Family Silver Plus	$250 ☐ $500 ☐ $750 ☐
☐ HCF My Family Advanced Silver Plus	$250 ☐ $500 ☐ $750 ☐

Extras cover options

☐ HCF Starter Extras ☐ HCF Starter Extras (with Optical)

☐ HCF Vital Extras ☐ HCF Mid Extras

☐ HCF Top Extras

4 APPLICATION TO RECEIVE THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE AS A REDUCED PREMIUM

All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium. If you are unsure whether you are eligible for Medicare, go to **humanservices.gov.au/customer/services/medicare/medicare-card** for more information.

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card? (Please mark 'X') Yes ☐ No ☐

Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling **132 011**. **Note:** Call charges apply – calls from mobile phones may be charged at a higher rate. For more information about the Australian Government Rebate on Private Health Insurance, go to **privatehealth.gov.au**

Are you covered by the policy? (Please mark 'X') Yes ☐ No ☐

(If no) applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Please complete the relevant details below:

Your Medicare card number

Medicare card valid to (DD MM YYYY)

Gender (Please mark 'X') M ☐ F ☐

Date of birth (DD MM YYYY)

Your full name as it appears on your Medicare card

First name

Surname

Nominate your rebate tier below. If at any stage you wish to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible. **Note:** you may incur additional tax payments if you nominate the incorrect rebate tier.

Age	Base Tier	Tier 1	Tier 2	Tier 3
Under 65 years	25.059% ☐	16.706% ☐	8.352% ☐	0.000% ☐
65-69	29.236% ☐	20.883% ☐	12.529% ☐	0.000% ☐
70 years+	33.413% ☐	25.059% ☐	16.706% ☐	0.000% ☐

Date premium reduction to commence (DD MM YYYY)

Privacy notice

Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the department will manage your personal information, including their privacy policy, at **www.humanservices.gov.au/privacy**

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')

There are 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) ☐ Group payroll deduction (please complete Section 6c) ☐

Credit card authority (please complete Section 6b) ☐

A. EZIPAY DIRECT DEBIT REQUEST

I authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from the account set out below through the Bulk Electronic Clearing System (BECS). I agree to be bound by the terms described in the HCF Direct Debit Customer Service Agreement and this authorisation is to remain in force in accordance with these terms.

Debit frequency (Please mark 'X')

Weekly ☐ Fortnightly ☐ Monthly* ☐ Quarterly* ☐ Half yearly* ☐ Yearly* ☐

Please debit on the ____ day* of the month. First debit* to occur on (DD MM YYYY) ____

(*Please nominate a day and note that the 28,29,30 and 31 dates 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)

B. CREDIT CARD AUTHORITY

I authorise The Hospitals Contribution Fund of Australia Limited to debit my credit card set out below. I agree to be bound by the terms described in the HCF Direct Debit Customer Service Agreement and this authorisation is to remain in force in accordance with these terms.

Cardholder name (exactly as it appears on your card)

Type of card (Please mark 'X')

Visa ☐ Mastercard ☐ American Express ☐

Debit frequency (Please mark 'X')

Fortnightly ☐ Monthly* ☐ Quarterly* ☐ Half yearly* ☐ Yearly* ☐

Credit card No.

Expiry date (MMYY)

Please debit on the ____ day* of the month. First debit* to occur on (DD MM YYYY) ____

(*Please nominate a day and note that the 28,29,30 and 31 dates are only available for weekly and fortnightly debits.)

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 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)

Other contribution details

If you wish to pay for other HCF memberships please give their details below:

Membership No.

Surname

Membership No.

Surname

Total contribution deductions (if known)

Health $ ____.__

Cash Assist $ ____.__

Total $ ____.__

7 INTERFUND TRANSFER

(Complete this section if you have held health insurance with an Australian registered health fund at any time since 1 July 2000).

This section must be completed by the owner of the previous fund policy. It permits us to take care of the transfer for you.

☐ (Please mark 'X') I authorise HCF to terminate my membership with my existing health fund and I consent (and confirm I have the authority to do so on behalf of everyone else on that policy) to the disclosure to HCF of the cover details of everyone on that policy including the issue of a transfer certificate to HCF.

If you have a direct debit arrangement with your previous 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

Surname

Date of birth (DD MM YYYY)

Name of previous health fund

Membership No.

Home address

Suburb

State

Postcode

Cancellation effective from (DD MM YYYY)

Signature of previous fund policyholder

X

Date (DD MM YYYY)

8 DECLARATION

(Please read and sign. Before you apply, ask staff for a copy of the HCF Health Insurance Brochure, or download at hcf.com.au)

I acknowledge and agree that:

- I have the authority to act and give consent on behalf of other persons to be covered under the policy, to provide their information (including sensitive information) and to receive from HCF their information for the purposes of the policy;
- I am the policyholder who is 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 Fund Rules of The Hospitals Contribution Fund of Australia Limited (available on the HCF website and from HCF branches); and
- HCF deals with personal information of all members in accordance with the HCF Privacy Policy (available on the HCF website and from HCF branches) and I have informed them of this.

I confirm that I have read and understand:

- this declaration and the information relating to my product choice in the HCF Health Insurance Brochure (including any applicable exclusions and waiting periods) and members' privacy (including the HCF Privacy Policy and the Privacy Statement); and
- the Product Disclosure Statement and Financial Services Guide in the HCF Health Insurance Brochure for any Cash Assist options I have chosen.

I authorise payment by the method indicated on the form and have the authority to do so.
I agree that my insurance will commence once my application is accepted.
I declare that the information I have provided in this form is complete and correct. I understand that giving false or misleading information is a serious offence.

Signature

X

Date (DD MM YYYY)