HCF

AMBULANCE AND CASH BACK COVER APPLICATION

OFFICE USE ONLY

Apr 18

Corp Source code

Deal code

Rate code

Sales Source code

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

- Join HCF health fund (Available to NSW/ACT residents only)
- Change people covered on my membership (complete sections 1, 2 and 6)
- Change my level of cover (complete sections 1, 3 and 6)

HCF Membership No.

1 A. YOUR PERSONAL DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

To be completed by the Policyholder – see section 6 for definition.

Title

First name

Middle initial

Surname

Sex (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')

Retain my existing products Single Single parent family 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, refer to the HCF Ambulance and Cash Back Cover 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

HCF

3 PRODUCT CHOICES (PLEASE MARK 'X')

☐ Ambulance and Cash Back Cover ☐ Ambulance Cover only

4 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.

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

You may be entitled to a Medicare card if you are:

- a person who lives in Australia, and
- an Australian citizen, or
- a holder of a permanent resident visa, or
- a New Zealand citizen, or
- an applicant for a permanent resident visa.

If you're unsure whether you're eligible for Medicare, go to **humanservices.gov.au/customer/services/medicare/medicare-card** for more information 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 **humanservices.gov.au/privatehealth**

Are you covered by this 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 (MM YYYY)

Sex (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	25.415% ☐	16.943% ☐	8.471% ☐	0.000% ☐
65-69	29.651% ☐	21.180% ☐	12.707% ☐	0.000% ☐
70+	33.887% ☐	25.415% ☐	16.943% ☐	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 of Human Services or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law. You can get more information about the way in which the Department of Human Services will manage your personal information, including their privacy policy at **humanservices.gov.au/privacy** or by requesting a copy from the Department of Human Services.

5 PAYMENT METHOD (PLEASE MARK 'X')

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

Ezipay direct debit (please complete Section 5a) ☐ Credit card authority (please complete Section 5b) ☐

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')

Monthly ☐ Yearly ☐ Monthly not available for Ambulance Cover only

First debit to occur on (DD MM YYYY)

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)

HCF

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')
Monthly ☐ Yearly ☐ Monthly not available for Ambulance Cover only

Credit card No.

Expiry date (MMYY)

First debit to occur on (DD MM YYYY)

6 DECLARATION

(Please read and sign. Before you apply, ask staff for a copy of the HCF Ambulance and Cash Back Cover 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 Ambulance and Cash Back Cover 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 Ambulance and Cash Back Cover 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 the information provided to be true and complete and I understand that giving false or misleading information is a serious offence.

Signature must be of the Policyholder or Partner listed on Policy

X

Date (DD MM YYYY)