

APPLICATION FOR HEALTH INSURANCE AND CHANGE OF DETAILS

(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)

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

OFFICE USE ONLY
 4052250 Apr 18
 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

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')

- 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)

If you are unsure of who can be covered on your membership, please see FAQs at hcf.com.au

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

3 PRODUCT CHOICES (PLEASE MARK 'X')

| | | | |
|--|--|---|---|
| Hospital cover options | Hospital excess options | Package options | Hospital excess options |
| <input type="checkbox"/> Basic Hospital | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> | <input type="checkbox"/> Young Starter (singles and couples only) | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> |
| <input type="checkbox"/> Mid Hospital | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> | <input type="checkbox"/> My Family | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> |
| <input type="checkbox"/> Mid Plus Hospital | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> | <input type="checkbox"/> My Family Plus | \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> |
| <input type="checkbox"/> Premium Hospital | Nil <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> | | |

Cash Assist

Cash Back Cover

Kids' Accident Cover*

Extras cover options

Bronze Silver Plus Platinum

Bronze Plus Gold

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

(Use another form if space is insufficient)

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
- a New Zealand citizen, or
- an Australian citizen, or
- an applicant for a permanent resident visa.
- a holder of a permanent resident visa, or

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 | Date premium reduction to commence (DD MM YYYY) |
|----------|----------------------------------|----------------------------------|----------------------------------|---------------------------------|---|
| Under 65 | 25.415% <input type="checkbox"/> | 16.943% <input type="checkbox"/> | 8.471% <input type="checkbox"/> | 0.000% <input type="checkbox"/> | |
| 65-69 | 29.651% <input type="checkbox"/> | 21.180% <input type="checkbox"/> | 12.707% <input type="checkbox"/> | 0.000% <input type="checkbox"/> | |
| 70+ | 33.887% <input type="checkbox"/> | 25.415% <input type="checkbox"/> | 16.943% <input type="checkbox"/> | 0.000% <input type="checkbox"/> | |

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 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*

(DD MM YYYY)

Please debit on the day* of the month. First debit* to occur on

(*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)

(DD MM YYYY)

Please debit on the day* of the month. First debit* to occur on

(*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

Health \$

Total contribution deductions (if known)

Membership No.

Surname

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 |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Surname | Date of birth (DD MM YYYY) | |
| <input type="text"/> | <input type="text"/> | |
| Name of previous health fund | Membership No. | |
| <input type="text"/> | <input type="text"/> | |
| Home address | | |
| <input type="text"/> | | |
| Suburb | State | Postcode |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Cancellation effective from (DD MM YYYY) | | |
| <input type="text"/> | | |
| Signature of previous fund policyholder | Date (DD MM YYYY) | |
| <input type="text" value="X"/> | <input type="text"/> | |

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 the information provided to be true and complete and I understand that giving false or misleading information is a serious offence.

| | |
|--------------------------------|----------------------|
| Signature | Date (DD MM YYYY) |
| <input type="text" value="X"/> | <input type="text"/> |