RESUME MY MEMBERSHIP

HCF Membership No.

Complete and mail to:
HCF
GPO Box 4242
Sydney NSW 2001
or email:
membermaintenance@hcf.com.au

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

COMPLETE IF YOUR DETAILS HAVE CHANGED

Title | First name | Middle initial

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

Home address

Suburb | State | Postcode

Phone - home | Phone - work | Mobile

Postal address (if different from your home address)

Suburb | State | Postcode

Email address

2 COMPLETE SECTION A OR B (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

A. RESUMPTION - OVERSEAS TRAVEL

I have returned to Australia on:
(DD MM YYYY)

Please resume my membership from this date

Evidence of departure and return dates is attached (i.e. copies of passport page(s), airline tickets, travel itinerary, boarding passes, etc.) ☐

B. RESUMPTION - UNEMPLOYMENT/SICKNESS BENEFITS

I ceased claiming unemployment/sickness benefits on:
(DD MM YYYY)

Please resume my membership from this date

Evidence of date of benefits ceasing is attached (i.e. evidence of period of Centrelink entitlement or letter from employer noting date of employment). ☐

3 COMPLETE SECTION C AND DECLARATION (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

C. PAYMENT METHOD (PLEASE MARK X)

I agree that HCF can recommence my payment method previously authorised ☐ or;
Or alternatively, payment can be made by one of the following methods:

- completing the enclosed Payment Authority Form
- automate your payments by calling **13 13 34**
- visiting an HCF branch
- pay online by logging into the members section at **hcf.com.au**

DECLARATION

I agree to have my membership resumed and declare all information stated on this form to be true and complete.
I declare that I and all persons covered by the policy are aware that they are bound by the Health Fund Rules of The Hospitals Contribution Fund of Australia Limited and the HCF Privacy Policy (available on the HCF website at **hcf.com.au**, in HCF branches or by calling **13 13 34**), in accordance with which all members' personal information is dealt, including requests for access to, correction of and complaints about their personal information.
I also understand that if my cover or premium rate has changed, the new premium rate is to be paid to HCF.
The signature must be of the Policyholder or Partner listed on the policy.

Signature | Date (DD MM YYYY)

The Hospitals Contribution Fund of Australia Limited.
ABN 68 000 026 746 AFSL 241 414.
HCF Life Insurance Company Pty Limited.
ABN 37 001 831 250 AFSL 236 806

HCF House 403 George Street, Sydney, NSW 2000
Postal Address: GPO Box 4242, Sydney NSW 2001
hcf.com.au

HCF Resume my membership 0217