

Clearance Request

You need only complete this section if you or somebody covered by your Health Care Insurance membership is transferring from another health fund. When we receive your form, Health Care Insurance will cancel your existing health fund membership for you and request a Clearance Certificate. If you have a direct debit or payroll deduction arrangement with your existing fund, please remember to personally cease the arrangement. Remember also to sign the authorisation below. We need the Clearance Certificate from your current fund in order to ensure that waiting periods, benefit entitlements and Lifetime Health Cover loading and days of absence (if any) are correctly identified.

Title	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Surname	<input type="text"/>					
Given names	<input type="text"/>					
Address	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Other persons to be transferred:

Name	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name of existing health fund	<input type="text"/>		
Member number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date paid to	<input type="text"/> / <input type="text"/> / <input type="text"/>

I hereby authorise Health Care Insurance to terminate my membership from / / and obtain details about my membership.

I request a refund for any premiums paid in advance of my termination date / /

Signature

Date / /

Signature

Date / /

I further request you to forward a Clearance Certificate directly to **Health Care Insurance Limited** PO Box 931, Burnie, Tas, 7320.