



Your Guide to Cover

Effective from August 2011



healthcare
insurance

we care for our own



Your guide to Health Membership

Health Care Insurance (HCI) extends a warm welcome and wishes to thank you for choosing to explore the many benefits of becoming a member.

Since 1938, HCI has provided great value for money health cover nationwide for the many people who are or have been associated with the forestry, timber, paper and downstream processing industries.

As a not-for-profit, industry based private health insurer, we are proud of the high level of personal service provided to members and the comprehensive range of health insurance cover options offered at very competitive rates.

HCI cover provides access to the very best in hospital care and other health care services including dental, optical, physiotherapy, chiropractic and many more.

The Fund is controlled by a Board of Directors elected by the members.

The information in this Guide is a summary of the Rules and policies of HCI and has been designed to clearly explain many of the entitlements and benefits available to you as a member. You should read carefully all documentation provided about your membership and retain for future reference. HCI reserves the right to change the Rules at any time. We will advise you of any changes as soon as possible.

For more information or assistance in choosing the right cover for you, please call **Freecall 1800 804 950** or visit our web site at **www.hcilt.com.au**

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Why have private health cover?

Peace of mind

Protecting and ensuring the health of you and your family is most important. Private health insurance gives you financial peace of mind in knowing that you have guarded against large and unexpected hospital, medical and other health care bills. For those who are on high incomes, private health insurance also helps you avoid paying an additional Medicare Levy Surcharge.

Hospital treatment

Medicare covers you for hospital and medical costs in a public hospital as a public patient. You have no choice of doctor and will usually be treated in a shared ward. In many cases, especially for elective surgery, there may be a substantial waiting time for the type of treatment you need.

By taking out private health insurance, you can make sure that if you or your family require hospital treatment you will have greater control over who, where and when you are treated. In most cases, your HCl private health cover will greatly reduce the waiting time for elective surgery by providing access to over 500 private hospitals and day hospital facilities and more than 16,000 doctors.

Other health care treatments

Medicare does not cover the cost of treatment for dental, optical, physiotherapy, chiropractic and many other non-medical type services. HCl offers you extras cover options which are designed to help offset the costs of these non-medical health care services.

Who can join HCl?

You are eligible to join HCl if you are or have been:

- a) employed in the forestry, timber or downstream processing industries including the production of timber and paper products; or
- b) a contractor (including employees) providing services to forestry, timber and paper industry businesses; or
- c) an officer or employee (including contractors) of HCl; or
- d) a dependant of a person covered by one of the above categories; or
- e) a sibling, grandchild, niece, nephew or parent of a person covered by one of the above categories a), b) or c).

Once accepted as a member you retain your HCl membership eligibility for life.

Types of membership

Singles

Health Care Insurance understands what's important to you as a single person. Perhaps you'd rather keep it simple. So for the budget conscious, we have hospital cover tailored to suit young people who are less likely to require full cover. And you'll still get great basic extras including physio, dental, and optical.

- ✔ Single membership covers only one person.

Couples

Whether it's just the two of you or whether you're thinking about starting a family soon, we give you the flexibility to select the hospital coverage that best suits your lifestyle. You'll also be impressed by the generous range of extras such as major dental, podiatry, and alternative therapies.

- ✔ Couples membership covers you and your partner.

Families

Whatever stage you're at, it's nice to know you and your family have a reliable friend in Health Care Insurance. We offer affordable hospital packages with no excess charged on child admissions. That's peace of mind. Add to that, extras including orthodontics, audiology, speech therapy and generous pharmacy cover.

- ✔ Family membership covers:
 - you and your partner
 - children, stepchildren and legally adopted children who are not married or living with a partner and who:
 - are 22 years of age or younger; or
 - are 23 or 24 years of age, who are full-time students at any school, college or tertiary educational institution in a course which entitles them to the Student Youth Allowance or any allowance that replaces it.
- ✔ Family Dependant Plus covers:
 - you and your partner
 - children, stepchildren and legally adopted children who are not married or living with a partner and who:
 - are 24 years of age or younger.





Choosing your health cover

Health Care Insurance provides you with a range of options to select from:

Extras cover

Private hospital cover

Public hospital cover

Premier Package

The HCI Premier Package combines our top hospital cover (Premier Hospital) with our top extras cover (Premier Extras).

Essential Package

The HCI Essential Package combines our top hospital cover (Premier Hospital) with our Essential Extras.

Extras cover

HCI has three extras cover options available: They are:

Premier Extras provides comprehensive cover over an extensive range of services.

Essential Extras is only available when combined with private hospital cover.

Select Extras is available for singles and is tailored to give you cover for what you need without breaking the budget.

Services	Premier Extras	Essential Extras	Select Extras
Acupuncture	✓	✓	✓
Ambulance	✓	✓	✗
Audiology (Hearing Tests)	✓	✓	✗
Chiropractic	✓	✓	✓
Dental – General	✓	✓	✓
Dental – Major (excl. Orthodontics)	✓	✓	✗
Diabetes Education	✓	✓	✗
Diabetes Australia Membership	✓	✓	✗
Dietetics	✓	✓	✗
Eye Therapy (Orthoptics)	✓	✓	✗
First Aid Training	✓	✗	✗
Funeral + (eligible members only)	✓	✗	✗
Health Screening Checks	✓	✓	✗
Hearing Aids	✓	✓	✗
Home Nursing	✓	✗	✗
Hydrotherapy	✓	✓	✗
Laser Eye Surgery	✓	✗	✗
Medical Appliances	✓	✓	✗
Natural Therapy (incl. Remedial Massage)	✓	✓	✓
Non-surgical Prosthesis	✓	✗	✗
Occupational Therapy	✓	✓	✗
Optical	✓	✓	✓
Orthodontics	✓	✓	✗
Orthotics	✓	✓	✗
Osteopathy	✓	✓	✓
Pharmacy	✓	✓	✓
Physiotherapy	✓	✓	✓
Podiatry / Chiropody	✓	✓	✗
Psychology	✓	✓	✗
Quit Smoking Programs	✓	✓	✓
Speech Therapy	✓	✓	✗
Surgical Footwear	✓	✗	✗
Travel & Accommodation *	✓	✗	✗
Weight Loss Programs	✓	✓	✓

* When taken with a hospital cover (for full details refer to pages 3-6)

+ Please refer to page 6 for special conditions relating to the funeral benefit

Annual Limits

An Annual Limit is the maximum amount of benefits that can be claimed for an individual or group of services within a calendar year with the exception of orthodontic benefit Annual Limits which are based on the date treatment commenced. The limits are per person on the policy unless stated otherwise.

Services	Extras levels of cover		
	Premier	Essential	Select
Ambulance			
For emergency transport provided by a registered ambulance provider within Australia	Cost	Cost	No cover
Alternative Therapies Group Annual Limit	\$500	\$400	\$110
Chiropractic			
- Annual Limit	\$500	\$250	\$110
- Initial Consultation	\$32	\$20	\$20
- Subsequent Consultations	\$28	\$20	\$20
- X-Rays	\$65	\$50	No cover
Osteopathy			
- Annual Limit	\$500	\$250	\$110
- Initial Consultation	\$32	\$20	\$20
- Subsequent Consultations	\$28	\$20	\$20
Acupuncture			
- Annual Limit	\$300	\$150	\$110
- Initial Consultation	\$30	\$17	\$20
- Subsequent Consultations	\$30	\$17	\$20
Natural Therapy			
- Annual Limit	\$300	\$150	\$110
- Initial Consultation	\$28	\$17	\$20
- Subsequent Consultations	\$28	\$17	\$20
Dental Treatment			
Benefits are paid according to the Australian Dental Association item number used. Benefits are payable at 90% of cost to a set maximum per item.			
General Dental Annual Limit	No Limit	\$500	\$400
Some service limits apply. Examples of set benefit levels are:			
Item 011 - comprehensive oral examination	\$32	\$22	\$27
Item 121 - topical flouride application	\$20	\$11	\$13
Item 311 - simple extraction	\$87	\$50	\$70
Item 511 - metallic filling 1 surface	\$66	\$42	\$53
Major Dental			
Crowns & Bridgework	up to \$1,000	up to \$650	No cover
Periodontics	up to \$700	up to \$400	No cover
Dentures - (benefits are payable every 2 years)	up to \$750	up to \$500	No cover
Orthodontics			
- Lifetime Limit	\$2,700	\$1,200	No cover
- Annual Limit per person	up to \$900	up to \$400	No cover
- Annual Limits are based on rolling years related to the date the treatment commenced.			

Services	Extras levels of cover		
	Premier	Essential	Select
Hearing Tests & Appliances			
Hearing Aids Appliance limit every 3 years with a benefit payable of 90% of cost for: <ul style="list-style-type: none"> - Single hearing aid - Bilateral hearing aid - Repairs (per year) 	up to \$1,200 up to \$2,000 up to \$120	up to \$400 up to \$700 up to \$50	No cover No cover No cover
Audiology (hearing tests) <ul style="list-style-type: none"> - Annual Limit - Initial Consultation - Subsequent Consultations 	\$200 \$50 \$40	\$30 \$30 \$30	No cover No cover No cover
Home Nursing			
For a visit by a home nursing provider approved by the Fund. Visit/treatment must be prescribed by a doctor. <ul style="list-style-type: none"> - Annual Limit - Per Visit 	\$500 \$25	No cover No cover	No cover No cover
Laser Eye Surgery			
For laser eye surgery performed in a recognised day surgery facility registered for operation in a State. Annual maximum benefit entitlements per person increase with each completed year of membership, as follows: <ul style="list-style-type: none"> 1 year 2 years 3 years 4 + years 	Nil up to \$500 up to \$750 up to \$1,000	No cover No cover No cover No cover	No cover No cover No cover No cover
Life Choices Annual Limit	\$350	\$180	\$100
Quit Smoking Programs Programs must be approved by the Fund.	\$150	\$50	\$50
Weight Loss Programs Programs must be approved by the Fund.	\$150	\$50	\$50
Diabetes Education <ul style="list-style-type: none"> - Annual Limit - Consultation 	\$200 \$20	\$100 \$15	No cover No cover
Diabetes Australia Membership	\$36	\$36	No cover
Health Screening Checks For health checks that are not eligible for Medicare benefits. Screening services must be approved by the Fund. <ul style="list-style-type: none"> - Annual Limit - Per Service 	\$250 \$100	\$50 \$25	No cover No cover
First Aid Training <ul style="list-style-type: none"> - Benefit payable upon completion of a Level 2 Senior First Aid course. Benefit per person is claimable once only. - Benefit payable upon completion of an approved refresher course. 	\$75 \$30	No cover No cover	No cover No cover
Medical Appliances (limit for same appliance every 3 years)			
Medical Appliances Prescribed by a doctor, including tens machine, nebuliser, glucose monitor, blood pressure monitor.	90% of cost up to \$500	90% of cost up to \$200	No cover
CPAP machine	90% of cost up to \$700	90% of cost up to \$400	No cover

Services	Extras levels of cover		
	Premier	Essential	Select
Non-surgical Prostheses			
Items prescribed by a prostheses doctor, including breast prosthesis and surgical stockings.	90% of cost up to \$200	No cover	No cover
Optical			
Annual Limit for supply of glasses and contact lens	\$250	\$220	\$170
- Single Vision	\$200	\$170	\$170
- Bifocal	\$220	\$190	\$170
- Multifocal	\$250	\$210	\$170
- Contact lenses - 90% of the cost	up to \$225	up to \$180	up to \$170
Annual Limit for repairs to glasses	\$50	\$40	\$50
Other Therapies Annual Limit	\$1,000	\$500	No cover
Podiatry / Chiropody			
- Annual Limit	\$300	\$140	No cover
- Initial Consultation	\$30	\$18	No cover
- Subsequent Consultations	\$27	\$18	No cover
Orthotics Annual Limit	\$200	\$100	No cover
Orthotic Casting Annual Limit	\$100	\$30	No cover
Eye Therapy (Orthoptics)			
- Annual Limit	\$375	\$200	No cover
- Initial Consultation	\$30	\$15	No cover
- Subsequent Consultations	\$25	\$15	No cover
- Group Session	\$10	No cover	No cover
Speech Therapy			
- Annual Limit	\$375	\$200	No cover
- Initial Consultation	\$50	\$18	No cover
- Subsequent Consultations	\$30	\$18	No cover
- Group Session	\$10	No cover	No cover
Dietetics			
- Annual Limit	\$200	\$120	No cover
- Initial Consultation	\$35	\$18	No cover
- Subsequent Consultations	\$30	\$18	No cover
Occupational Therapy			
- Annual Limit	\$375	\$300	No cover
- Initial Consultation	\$40	\$18	No cover
- Subsequent Consultations	\$30	\$18	No cover
- Group Session	\$10	No cover	No cover
Pharmacy			
- Annual Limit	\$1,000	\$600	\$300
- Per Script	\$100	\$35	\$35
100% less the cost of PBS script amount. Benefits are excluded for items that can be obtained without a prescription, contraceptives, anabolic steroids and drugs not approved for sale in Australia.	An Annual Limit of \$600 applies for prescriptions for the following conditions: weight loss, baldness and male erectile dysfunction	An Annual Limit of \$350 applies for prescriptions for the following conditions: weight loss, baldness and male erectile dysfunction	

Services	Extras levels of cover		
	Premier	Essential	Select
Physiotherapy Group Annual Limit	\$750	\$500	\$200
Physiotherapy			
- Annual Limit	\$700	\$450	\$200
- Initial Consultation	\$32	\$20	\$22
- Subsequent Consultations	\$28	\$20	\$22
- Group Session	\$15	No cover	No cover
Hydrotherapy			
- Annual Limit	\$300	\$300	No cover
- Consultation / Treatment	\$15	\$15	No cover
Psychology			
- Annual Limit	\$250	\$150	No cover
- Initial Consultation	\$60	\$35	No cover
- Subsequent Consultations	\$50	\$35	No cover
- Group Session	\$20	\$15	No cover
Surgical Footwear			
For surgical footwear prescribed by a doctor and individually made by a provider approved by the Fund.	90% of cost up to \$1,000	No cover	No cover
Funeral (eligible members only)*			
This benefit is only payable to members who had entitlement under the Rules in force prior to 1st April 2007. A benefit is payable to eligible members following the death of a member or dependent (refer waiting period).	\$1,150	No cover	No cover
Travel & Accommodation			
Only payable if taken with a hospital cover. Benefits payable when attending a medical specialist or hospital more than 50kms from normal place of residence within home State.			
Accommodation - per night	\$50	No cover	No cover
Travel - per km	15 cents	No cover	No cover
Travel & Accommodation			
- Maximum Per Trip per person	\$125	No cover	No cover
- Annual Limit per person	\$300	No cover	No cover
- Annual Limit per family	\$800	No cover	No cover

***Note:** Federal Government legislation introduced on 1st April 2007 prohibits health funds from offering funeral benefit as an item in a complying health insurance product attracting the Government rebate. Consequently, members who joined the Premier Extras product on or after 1st April 2007 are not eligible to claim this benefit.

Hospital cover

When you purchase HCI hospital cover, you have the confidence to say 'yes' to treatment in a private hospital or treatment as a private patient in a public hospital.

HCI Premier Hospital does not have exclusions or benefit limitations for treatment that is clinically necessary and eligible for Medicare benefits. If you have served the relevant waiting periods and any other standard conditions - you're covered.

Premier hospital cover

Premier hospital cover provides the following benefits:

- Up to 100% of the cost of hospital accommodation and theatre fees in all contracted hospitals and day surgery facilities in Australia.
- Up to 100% of the cost of surgically implanted prostheses (as listed by the Federal Government).
- Private room accommodation (if available).
- Up to 100% of the cost of most hospital prescriptions relating to the admission. (Subject to hospital agreement details).
- Dental theatre costs for surgical tooth extraction by an oral surgeon.

- 100% of the cost of the difference between the Medicare refund and the CMBS fee for medical services provided during a hospital admission.
- Up to 100% of the cost of medical services provided during a hospital admission where the doctor charges above the CMBS fee and chooses to use Access Gap Cover.

Benefits are not payable for:

- Cosmetic surgery.
- Charges for extra services such as physiotherapy not included in the hospital agreement.
- Personal expenses such as phone calls.
- Hospital benefits are not payable where the professional service performed is not eligible for Medicare benefits.

Public hospital cover

Public hospital cover provides the following benefits as a private patient in a public hospital:

- Choice of doctor.
- 100% of the cost of hospital accommodation fees.
- Up to 100% of the cost of surgically implanted prostheses (as listed by the Federal Government).
- 100% of the cost of the difference between the Medicare refund and the CMBS fee for medical services provided during a hospital admission.

- Up to 100% of the cost of medical services provided during a hospital admission where the doctor charges above the CMBS fee and chooses to use Access Gap Cover.

If you have Public Hospital cover you will face significant out-of-pocket expenses if treatment is provided in a private hospital.

This level of cover is considered inadequate for treatment in a private hospital.

When deciding what level of hospital cover is best for you, you should consider the following information about treatment options:

A public patient in a public hospital

As an Australian resident, Medicare entitles you to free treatment in a public hospital by a doctor appointed by the hospital at a date and time suitable to the hospital.

A private patient in a public hospital

If you decide to be treated as a private patient in a public hospital, you have the right to choose the doctor who treats you but there is no guarantee you will be able to avoid the public hospital waiting lists.

A private patient in a private hospital

As a private patient in a private hospital, you will usually gain immediate access to hospital services and be able to choose the doctor who treats you at a time that is convenient to you.

Agreement Hospitals

HCI has entered into agreements with over 500 private hospitals, same day and day hospital facilities around Australia.

For details of contracted hospitals, visit our web site at: www.hcilt.com.au/industrysearch/hospitals.html





What costs will be incurred as a private patient?

By electing to be treated as a private patient you may be charged for:

- ✔ Hospital bed accommodation in public and private hospitals;
- ✔ Treatment in intensive/critical/high dependency care units in a private hospital;
- ✔ Operating theatre costs in a private hospital;
- ✔ Doctor's services whilst a patient in hospital including diagnostic tests such as radiology and pathology;
- ✔ Other health services such as physiotherapy;
- ✔ Surgically implanted prostheses such as hip joints, coronary artery stents, heart pacemakers, etc.; and
- ✔ Consumable items such as drugs and dressings.

The amount you may be out-of-pocket will depend upon the level of hospital cover you choose, whether the hospital where you are treated has an agreement with HCl and whether the doctor(s) who treat you in hospital use our Access Gap Cover scheme.

Surgically implanted prostheses

Surgically implanted prostheses are pieces of equipment that are implanted during a hospital surgical procedure. For example an artificial hip, a heart pacemaker, a cardiac stent, pins and screws.

All procedures in the Medical Benefits Schedule requiring a prosthesis, have at least one approved item that will be supplied without cost to the patient.

The Prostheses Schedule lists prosthetic items, the costs of which will be covered 100% by health funds (no gap) and items that may require you to meet part of the cost (gap).

It is recommended that if you require surgery involving a surgically implanted prosthesis, discuss with your specialist doctor the option of using the prosthesis listed as a no gap item.

Excess Options	Premier Hospital		Premier Package		Essential Package	
	per adult	per policy	per adult	per policy	per adult	per policy
Level 1	\$250	\$500	\$250	\$500	\$250	\$500
Level 2	\$500	\$1,000	\$500	\$1,000	\$500	\$1,000
Level 3*	\$1,000	\$2,000	\$1,000	\$2,000	\$1,000	\$2,000

* Not exempt from Medicare levy surcharge.

Hospital cover excess options

An excess is an amount that you elect to pay towards any overnight hospital treatment.

Through choosing to include an excess in your hospital cover, the amount of contributions you pay will be reduced. The larger the excess, the lower the contribution rate.

The following excess options are available for single, couple or family membership when you choose any of the covers listed on this page.

Please note the following features about HCl's excess options:

- ✔ Excess options are not available if you choose Public Hospital cover.
- ✔ There is no excess on day hospital procedures, medical services incurred whilst in hospital and extras benefits.
- ✔ The excess per adult is only payable once in any calendar year.
- ✔ For Family and Couples cover, the total excess is split in two and divided between the first two adults to claim for hospital treatment in any one calendar year.
- ✔ There is no excess payable for dependant children under the age of 18 years who are admitted to hospital.

Doctors' fees and access gap cover

HCl pays benefits for treatment provided to you by a doctor whilst you are a patient in hospital. As a private patient in a public or private hospital, Medicare pays 75% of the Commonwealth Medical Benefits Schedule fee (CMBS) and HCl pays 25% of the CMBS fee.

If your doctor chooses to charge above the CMBS fee you may have to pay the gap.

However, if your doctor chooses to use HCl's Access Gap Cover, you will have either no out-of-pocket expenses or, before receiving treatment, the doctor will give you an estimate of the costs you will have to meet.

It is in your best financial interests to discuss the issue of fees with your doctor to determine whether they will use Access Gap Cover which will minimise or eliminate your medical out-of-pocket costs.

It is your doctors' choice whether they treat and charge you under Access Gap Cover.

Please note: HCl does not pay benefits for medical treatment provided to you whilst you are not in hospital, such as surgical procedures conducted in a doctors' rooms. To search for doctors who have agreed to participate in the Access Gap Cover scheme, visit our web site at <http://www.hcilt.com.au/industrysearch/doctors.html>

Waiting periods

A “waiting period” is the period of time a person must have hospital health cover before benefits are paid.

HCI applies the following waiting periods:

Extras cover

Services	Waiting Periods (months)
Acupuncture	2
Ambulance	2
Audiology (Hearing Tests)	2
Chiropractic	2
Dental – General	6
Dental – Major (incl. Orthodontics)	12
Diabetes Education	2
Diabetes Australia Membership	2
Dietetics	2
Eye Therapy (Orthoptics)	2
First Aid Training	2
Funeral + (eligible members only)	120
Health Screening Checks	2
Hearing Aids	24
Home Nursing	2
Hydrotherapy	2
Laser Eye Surgery	12
Medical Appliances	12
Natural Therapy	2
Non-surgical Prosthesis	12
Occupational Therapy	2
Optical	6
Orthodontics	12
Orthotics	2
Osteopathy	2
Pharmacy	2
Physiotherapy	2
Podiatry / Chiropody	2
Psychology	2
Quit Smoking Programs	2
Speech Therapy	2
Surgical Footwear	2
Travel & Accommodation *	6
Weight Loss Programs	2

* When taken with a hospital cover (for full details refer to pages 3-6)

+ Please refer to page 6 for special conditions relating to the funeral benefit



Hospital Cover

12 months

- Pre-existing ailments
- Obstetrics
- IVF & assisted reproductive technology
- Sterilisation including reversal

2 months

- All other benefits not listed above

Pre-existing ailments (PEA)

The PEA Rule, agreed by all health funds as an industry standard rule, is designed to protect existing members from people who either join or upgrade their cover and make claims related to an ailment, illness or condition that was in existence at the time of joining or changing cover.

HCI may decline to pay benefits or reduce benefits to the level of the previous cover, if within the first 12 months of any membership cover a claim is made where, in the opinion of an independent medical practitioner appointed by HCI, signs or symptoms of an ailment, illness or condition related to that claim were in existence at any time during the six (6) months preceding the date the membership cover commenced. In forming an opinion the medical practitioner must have regard to any information relating to the ailment, illness or condition that was given to them by the

appropriately qualified person who treated the ailment, illness or condition.

This Rule will apply even though you or your practitioner were not aware what your ailment, illness or condition was. If you knew you weren't well, or had signs of an ailment, illness or condition that would have been detected by a practitioner during the 6 months prior to joining or changing cover, the Rule still applies.

If you have less than 12 months membership on your current level of cover, you should contact us on **Freecall 1800 804 950** before arranging hospital treatment to find out whether the PEA Rule applies to you.

Waiting periods for new born babies

Babies themselves are only covered by family cover.

Any treatment a newborn baby requires is therefore only covered if the mother has family cover at the time of treatment and all relevant waiting periods, with respect to the baby, have been served.

The period prior to the birth of a baby, during which the mother is covered by either a couples or family cover, will be counted towards all waiting periods for the baby.



A person with single membership is eligible for obstetric benefits provided she has been a member of a hospital table for 12 months or more.

We strongly recommend single members upgrade to family membership as soon as pregnancy is confirmed so that waiting periods for the baby can be commenced prior to birth.

If you haven't been covered by family hospital cover for 12 months prior to becoming pregnant, we suggest you give us a call on **Freecall 1800 804 950** to check you and your baby's benefit entitlements.

First-time health cover

If you are taking out private health insurance for the first time, you will be required to serve full waiting periods before benefits can be paid.

Transferring from another health fund (portability)

If you already have health cover with another health fund, you can transfer to HCl at any time.

If you join within 2 months of the expiration of your cover with your previous fund and pay contributions effective from the date cover ceased with your previous fund, you will not have to serve any new waiting periods for the same or lower level of cover with HCl. HCl's normal waiting periods will be applied, including the pre-existing ailments rule, to benefits not covered by your previous fund cover.

Under the Federal Government's Lifetime Health Cover initiative, your "certified age at entry" with your previous fund will be recognised by HCl if you join immediately after the expiration of your cover with your previous fund.

Changing your HCl cover

You can vary your level of cover to meet your changing needs at any time. If you increase your level of cover by adding a new benefit type, or by increasing your benefit level, or moving from an excess product to a lower or excess free product, waiting periods will apply to the higher benefits of your new cover. You will, however, be entitled to the benefit levels of your previous cover.

How do I make a claim?

Electronic claiming

HCl members have access to a simple and convenient way to claim benefits. Electronic claiming systems such as HICAPS lets you claim your extras benefit right there, on the spot, after the consultation with your health service provider such as dentists, optometrists, chiropractors, physiotherapists, podiatrists and a number of other therapies.

With one swipe of your HCl membership card through an EFTPOS style terminal your health service provider can have the cost of your consultation assessed electronically. Based on your level of cover, entitlements will be authorised on the spot. You will need to pay the difference (if any) between your extras benefit, which HCl pays directly to the practitioner, and the fee charged.

To find a practitioner who uses HCl's electronic claiming system, you can search using HICAPS link on our website at www.hcilt.com.au

Extras claims

If your claims are not processed at the point of treatment through an electronic swipe card system such as HICAPS, you can forward your claims to us by:

- ✎ **Mail** to PO Box 931 Burnie, TAS 7320
- ✎ **Fax** to 1800 643 969
- ✎ **In person** at our Burnie office
- ✎ **Email** to enquiries@hcilt.com.au

Extras claims are processed on the day they are received, assuming they include all the necessary information.

Hospital claims

In most cases, when you are discharged from hospital, the hospital staff will forward the account for your hospital treatment direct to HCl. Ask the hospital before you leave.

Medical claims for treatment received whilst in hospital

If you receive bills from your doctor for medical treatment you received whilst in hospital, you can lodge your medical claims at either a Medicare office or at the HCl office.

Benefit payments

You can receive your benefits by:

- ✎ **Direct Credit**
If you have paid the account, your benefit can be paid electronically into your nominated bank account. You will receive separate notification as to the payment details.
- ✎ **Cheque**
If you have paid the account, a cheque will be made payable to you, or if you have not paid the account, a cheque will be made payable to the practitioner who provided the treatment.

Lodging a claim

- ✎ All accounts and receipts must include the appropriate item number and/ or a full description of the services / products being claimed and must be accompanied with a completed claim form.
- ✎ All services / products must be provided by practitioners who are operating in private practice and who are approved by HCl.
- ✎ Claims must be lodged within 2 years of the date of service.
- ✎ Benefit payments are calculated on the date services / products are provided.

Recognised / approved providers of treatment

To help ensure the propriety of services offered to members by health care providers, benefits will only be paid for services rendered to members by providers who are recognised and approved by HCI.

Recognition of providers by HCI is subject to change without notice. If you are not sure about a providers approved status with HCI, please call us on **Freecall 1800 804 950** to check before arranging treatment.

On-line member services

Members can access their information by visiting our website 24 hours a day. You can join HCI on-line. You can also tell us about changes to your membership details through our website.

In the secure On-line Member Services section of the website, you can:

- ✔ View your membership, contact, cover and contribution details,
- ✔ View extensive details of the current level of cover held,
- ✔ Change your membership, contact, and contribution details,
- ✔ Change your on-line member services password,

- ✔ Make contribution payments via a credit card, and
- ✔ View your claiming history and the amount of unused benefit limits.

The information submitted through this service will be confirmed by HCI staff and your membership on-line details will be updated within 2 working days.

All information passed through the secure site along with access to your membership details is protected by the use of your own chosen passwords.

This service enables you to check your membership details at your convenience and advise us of changes when it suits you.

Members can register by visiting our website and selecting the member services link.

Key information about health insurance

Ceasing or suspending membership

Payment default

Should your contributions fall more than two months in arrears, your membership may be ceased. Acceptance of arrears payments after two months is not automatic, so please talk to us if you need time to pay. It should be noted that benefits are not payable for treatment if

your contributions are in arrears and do not cover the date(s) you received the treatment.

Ceasing membership

If you choose to cease your hospital cover, your future hospital health cover contributions will be subject to the Lifetime Health Cover provisions dealing with periods of absence (refer to page 12).

Suspending your cover

Members may apply for suspension of their membership, if at the time of application, they have held private health insurance cover for at least 12 months and paid all contributions due by them at the date of application.

Application for suspension of membership can only be made on one of the following grounds:

- ✔ the member's absence from Australia due to employment overseas for a period not less than 1 month and not more than the duration of the overseas employment or 2 years, which ever is the shorter period; or
- ✔ the member's absence from Australia for travel reasons for a period not less than 1 month and not more than 1 year (2 years for special cases) ; or
- ✔ the member's financial hardship for a period not less than 1 month and not more than 6 months.

Periods of suspension of hospital cover do not count towards the 1,094 days cumulative absence allowed by Lifetime Health Cover legislation.

If a member reinstates membership within 30 days of the period of suspension ending and pays contributions from the end of the suspension period, there will be no new waiting periods to be served.

Please note that high income earners will be subject to the Medicare Levy Surcharge (MLS) during a period of suspended hospital cover (refer to page 13 for details of the MLS).

For details of what information you will need to provide in your application for suspension of membership, please call us on **Freecall 1800 804 950**.





Services provided by family members

Unless a member has received prior approval from the General Manager, HCI will not pay benefits for services or goods provided to a person covered by a membership where those services or goods are supplied by a family member.

Compensation and damages

HCI does not pay benefits for services or treatment where you are entitled to receive compensation or damages from another source.

Where an accident or illness is caused by the actions of another party, HCI expects that you will pursue a claim for compensation or damages from the party concerned.

HCI may, however, make provisional payments where compensation or damages are claimable by you, provided you agree to repay such payments from your final settlement.

If you become involved in circumstances where compensation or damages may be claimable by you, please call us on **Freecall 1800 804 950** to seek clarification of your benefit entitlements.

30 day money back guarantee

A cooling off period of 30 days applies to all new applicants for HCI membership. Any member who has not made a claim within 30 days from the commencement date of their health cover is entitled to cancel the policy and receive a full refund of any contributions paid.

Private health insurance rebate

The Federal Government introduced the Private Health Insurance Rebate to make private health insurance more affordable for Australians who chose to take out private health cover.

Who is eligible for the rebate?

The Rebate is available to anyone who is eligible for Medicare benefits and who holds any level of private health insurance cover, no matter the level or type of cover. The Rebate eligibility is not subject to a means test.

What rebate am I entitled to receive?

From 1 April 2005:

- ✔ if you and all persons covered by your policy are under the age of 65 years, you are entitled to receive a 30% rebate on your premiums.
- ✔ if either you or a person covered by your policy are aged 65 to 69 years, you are entitled to receive a 35% rebate on your premiums.
- ✔ if either you or a person covered by your policy are aged 70 years and over, you are entitled to receive a 40% rebate on your premiums.

How can I claim the rebate?

You can claim your rebate in one of three ways:

- ✔ as a reduction in your contributions; or
- ✔ as an income tax offset on your income tax return; or
- ✔ as a cash claim from a Medicare office.

For convenience and certainty that you receive your full rebate entitlement, we recommend you register to have your rebate taken off the contributions you pay to HCI. Just fill out and return the enclosed rebate application form.

Lifetime health cover

The aim of the Federal Government's Lifetime Health Cover (LHC) initiative is to encourage people to take out private health insurance hospital cover early in life. If you join earlier in life and continue private hospital cover, you will be rewarded with lower contributions than those who join later in life.

HCI is required by the Federal Government to set hospital contribution rates based on the age a person first takes out hospital cover.

Certified age at entry

Each adult is assigned a "certified age at entry" for contribution rate setting purposes. People who do not have hospital cover on the 1st of July following their 31st birthday must pay a 2% loading on top of the "base rate" contribution for the hospital cover they wish to purchase. The "base rate" is the lowest contribution rate for the hospital cover chosen.

For example, John turns 31 on 1st April 2011. If he purchases hospital cover by 1st July 2011, he will pay the base contribution rate. If he purchases hospital cover on 2nd July 2011, he will pay a 2% loading. If he further delays purchasing hospital cover, he will pay an extra 2% for each year he delays.

The contributions for couples and families with two adult partners will be a combined rate which reflects the certified age at entry of each of the partners.

The maximum loading is 70%.

The loading applies only to hospital cover and not to extras.

People born before 1st July 1934 are exempt from the provisions of LHC and can take out hospital cover at any time and only pay the "base rate" contribution level.

Note: Where a member is paying a loading, the loading will cease after the member has held hospital cover for a period of 10 consecutive years.

Permitted days without hospital cover

You are able to stop your hospital cover for a cumulative period of 1094 days in your lifetime without affecting your certified age at entry. However, after the 1094 days aggregated absence, your certified age at entry will be increased by one year.

Periods of suspension

You may suspend your hospital cover in accordance with HCI's Rules. Periods of suspension do not count towards the 1094 days period of absence that is allowed before your certified age at entry is affected.

Call our friendly staff for a personal quote - **Freecall 1800 804 950.**

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a levy on taxable income of 1% in addition to the standard Medicare Levy of 1.5%. The MLS applies if you do not have an appropriate level of hospital cover and your annual taxable income exceeds the limit set by the Federal Government for single, couple and family memberships.

For details of these income levels, call us on **Freecall 1800 804 950.**

Standard information statements

Federal Government legislation requires health insurers to provide a document called a Standard Information Statement (SIS) which provides a brief summary of a member's level of cover.

Health Insurers are required to send a Standard Information Statement to every member once a year. The Standard Information Statement is aimed at assisting members to better understand the many and varied private health insurance product options offered by all registered health funds.

For further information about Standard Information Statements you can phone on **Freecall 1800 804 950** or visit our website at **www.hcilt.com.au**

You can view each health fund's Standard Information Statements by visiting the web site **www.privatehealth.gov.au**



Privacy statement

HCI respects your privacy and is committed to keeping your personal information safe through compliance with the *Commonwealth Privacy Act 1988* and the National Privacy Principles which form part of the Act.

The following is a summary of HCI's privacy statement.

Why is my information needed?

HCI collects information that is necessary to assist the fund to meet your health insurance needs. This includes:

- ✔ Establishing your membership.
- ✔ Receiving contributions.
- ✔ Paying benefits.

Your personal information is not collected unless we first ask you for it.

How is my information protected?

HCI exercises great care to protect the personal information that is held.

This protection includes:

- ✔ Document storage security policies.
- ✔ Document access controlled and limited to only those that require it to administer your policy.
- ✔ Internal electronic security access systems.
- ✔ Secure disposal of waste.

What information is disclosed?

HCI will only disclose your information to third parties in the following circumstances:

- ✔ To administer your insurance policy, this includes to:
 - Practitioners and professionals who are providing your health care treatment; and
 - Hospitals in relation to membership eligibility checking.
- ✔ To a third party who performs core business activities on our behalf and with whom we have a confidentiality agreement.
- ✔ If required by law.

Can I see my information?

You may access your personal details by requesting to do so in writing.

Your dependants and their privacy

To protect the privacy of all persons covered under your membership, you are required to inform any dependants aged 16 years and over of HCI's privacy policy, and obtain their consent before providing HCI with their personal information. As such, any reference in your health policy to 'you' should be taken to be a reference to both you and your dependants.



Need more information?

If you wish to obtain more information about HCl's Privacy Policy, please contact our Privacy Officer on **Freecall 1800 804 950** or refer to our web site at **www.hcilt.com.au**

How do I complain if my privacy is breached?

HCl will do everything possible to ensure that your privacy is not breached.

However, if you believe we have breached your privacy, you may write to:

HCl Privacy Officer
PO Box 931
BURNIE TAS 7320

We will endeavour to resolve the matter amicably with you.

However, if you consider we have not resolved the matter to your satisfaction, you may contact the Privacy Commissioner's Office at:

The Director of Compliance
Office of the Privacy Commissioner
GPO Box 5218
SYDNEY NSW 2001

Private health insurance ombudsman

Complaints

We welcome and value your comments on our products and service. If you require further explanation or have problems on matters affecting any aspect of your health insurance cover, please call us to discuss your concerns. We will endeavour to resolve all issues of concern to your satisfaction as quickly as possible. However,

if you believe we have not addressed your issues satisfactorily, you can obtain independent free advice from the Private Health Insurance Ombudsman (PHIO).

A copy of our complaints and dispute policy is available on our website **www.hcilt.com.au**

Private health insurance industry code of conduct

HCl is a signatory to the Private Health Insurance Industry Code of Conduct. The code was developed by the industry and is designed to set benchmarks of standards of service to members to be achieved by all Private Health Insurers.

The aims of the code are to ensure:

- ✔ you receive the correct information on private health insurance from appropriately trained HCl staff;
- ✔ you are aware of the dispute resolution procedures available in the event that you have a dispute with HCl;
- ✔ policy documentation contains all the information you require to make a fully informed decision about your health insurance purchase and that all communications between you and HCl are conducted in plain easy to understand language;
- ✔ all information between you and HCl is protected in accordance with national and state privacy principles.

A copy of the code is available at **privatehealth.com.au/codeofconduct**

Membership Application Form

Office Use Only

Member number

Level of cover

Standard contribution

1st deduction & period covered

Apply for new membership

Change current details

/ / **Effective date**

Previous Health Fund details

Fund name

Member number

Date paid to

 / /

Cover code

Eligibility

Ex Member/Dependant Member number

Ex/Current worker in the forestry, timber, paper industries Employer

Ex/Current contractor to the forestry, timber, paper industries Employer

Sibling, grandchild, niece, nephew or parent of an eligible person Contracted to Company

Dependant of the above (If you tick this box you must provide details in one of the other eligibility criteria) Industry Association

Choice of cover

Combined Packages Family* Family Dependant Plus Couple Single

Premier Package Excess Essential Package Excess

Hospital Cover Premier Excess Public

Ancillary / Extras Cover Premier extras Select extras (Singles Only)

Title **Date of birth** / / **Sex** Male Female

Surname

Given names

Postal address

Home address

Home phone **Work / Day phone**

Mobile **Fax**

Email

Persons to be covered (do not include yourself)

Surname	Given names	Sex M/F	D.O.B	Relationship to member	Existing conditions
<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"/>	<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"/>	<input type="text"/>	<input type="text"/>
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<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"/>	<input type="text"/>

* If a dependant is aged between 23 and 25, a student dependant declaration is required.

Are you aware of any treatment or hospitalisation needs in respect of any person to be covered by this membership?

Yes No

Please detail any conditions or ailments the signs of which existed at any time in the past 6 months. (Attach a separate sheet if required)

Five empty text input boxes for detailing conditions or ailments.

Declaration

I hereby declare the above statements to be true and complete and agree to abide by health benefit fund rules of Health Care Insurance Ltd as amended from time to time. I acknowledge that this application form and brochure does not contain all the Rules of Health Care Insurance Ltd, but I am free to inspect the full copy of the Rules at the office of Health Care Insurance Ltd. I also acknowledge my membership is subject to the pre-existing Rule, waiting periods and eligibility criteria as explained in this brochure. I acknowledge that Health Care Insurance Ltd has a Privacy Policy which I may view upon request, and I will inform any dependants referred to on this application of the existence of the Health Care Insurance Ltd Privacy Policy. I consent to the collection, use and disclosure of my personal and sensitive information in the provision by Health Care Insurance Ltd of a health insurance service and I have authority to provide and consent to the release of personal and sensitive information on behalf of the dependants referred to in this application. I authorise the release of personal and sensitive information from my previous health fund, and from any hospital, medical practitioner or other health service provider that Health Care Insurance Ltd deems necessary to administer my policy. If the information supplied on this application is inaccurate or fraudulent, I acknowledge Health Care Insurance Ltd may refuse to pay a claim, cancel the policy or require payment of any additional premium loading payable in accordance with the Lifetime Health Cover legislation.

Signature Date

Payment Options – Direct Debit/Credit Request



Member number

I/we authorise Health Care Insurance Limited (Debit user ID 16895) to arrange for funds to be debited from my/our nominated account at the Financial Institution shown below according to the instructions specified. Please complete **one** of the options below.

Frequency of deduction

Fortnightly Monthly Quarterly 6 monthly Annually

Bank Account deduction Please read the Direct Debit Request – Service Agreement conditions and complete the Direct Debit Request form.

Name of Financial Institution Branch
Name of account holder

BSB number Account number

Yes - Please use this account for credit of benefit payments.
 No - Please use alternative account details for credit of benefit payments (as detailed below)

Name of Financial Institution Branch
Name of account holder

BSB number Account number

Credit Card deduction Please read the Direct Debit Request – Service Agreement conditions and complete the Direct Debit Request form.

Type of credit card Mastercard VISA

Card number Expiry date

Name on credit card

I/we acknowledge that this Direct Debit arrangement is governed by the terms of the Direct Debit Request – Service Agreement received from you.

Signature Date

Signature Date

Payment Options – Invoice/Payroll Deduction

Title **Date of birth** / / **Sex** Male Female

Surname

Given names

Postal address Street / PO Box City / Suburb State Post Code

Member number

Invoice

Frequency Monthly Quarterly 6 monthly Annually

I understand that it is a condition of membership that contributions are paid in advance.

Payroll deduction

I authorise the pay officer of to deduct from my pay \$

Frequency Weekly Fortnightly Monthly

This authorisation extends to any changes to my contributions that the Fund may make from time to time.

This authority is to continue until such time as it is withdrawn by me in writing.

Signature **Date** / /

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 **Date of birth** / / **Sex** Male Female

Surname

Given names

Address

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"/> <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.

Direct Debit Request – SERVICE AGREEMENT

Direct Debit Request – Service Agreement

The following is your Direct Debit Service Agreement with **Health Care Insurance Ltd**. The agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit Provider.

We recommend you keep this agreement in a safe place for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR form.

Definitions

- **account** means the account held at your *financial institution* from which we are authorised to arrange for funds to be debited.
- **agreement** means this Direct Debit Request Service Agreement between you and us.
- **banking day** means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.
- **debit day** means the day that payment by you to us is due.
- **debit payment** means a particular transaction where a debit is made.
- **direct debit request** means the Direct Debit Request between us and you.
- **us or we** means **Health Care Insurance Ltd**, (the Debit User) you have authorised by signing a *direct debit request*.
- **you** means the customer who signed the *Direct Debit Request*.
- **your financial institution** means the financial institution nominated by you on the DDR at which the *account* is maintained.

1. Debiting your account

By signing a *Direct Debit Request*, you have authorised us to arrange for funds to be debited from your *account*. You should refer to the *Direct Debit Request* and this *agreement* for the terms of the arrangement between us and you.

We will only arrange for funds to be debited from your *account* as authorised in the *Direct Debit Request*.

If the *debit day* falls on a day that is not a *banking day*, we may direct your *financial institution* to debit your *account* on the following *banking day*. If you are unsure about which day your *account* has or will be debited you should ask your *financial institution*.

2. Amendments by us

We may vary any details of this *agreement* or a *Direct Debit Request* at any time by giving you at least fourteen (14) days' written notice.

3. Amendments by you

You may change, stop or defer a debit payment, or terminate this agreement by providing us with at least fourteen (14 days) notification by writing to: Health Care Insurance, Attn:Membership Department, PO Box 931, Burnie TAS 7320 or enquiries@hcilt.com.au or by telephoning us on 1800 804 950 during business hours or arranging it through your own financial institution.

4. Your obligations

Is your responsibility to ensure that there are sufficient clear funds available in your *account* to allow a *debit payment* to be made in accordance with the *Direct Debit Request*.

If there are insufficient clear funds in your *account* to meet a *debit payment*:

- (a) you may be charged a fee and/or interest by your *financial institution*;
- (b) you may also incur fees or charges imposed or incurred by us; and

- (c) you must arrange for the *debit payment* to be made by another method or arrange for sufficient clear funds to be in your *account* by an agreed time so that we can process the *debit payment*.

You should check your *account* statement to verify that the amounts debited from your *account* are correct

If **Health Care Insurance Ltd** is liable to pay goods and services tax ("GST") on a supply made in connection with this *agreement*, then you agree to pay **Health Care Insurance Ltd** on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5. Dispute

If you believe that there has been an error in debiting your *account*, you should notify us directly on 1800 804 950 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up with your financial institution direct.

If we conclude as a result of our investigations that your *account* has been incorrectly debited we will respond to your query by arranging for your *financial institution* to adjust your *account* (including interest and charges) accordingly. We will also notify you in writing of the amount by which your *account* has been adjusted.

If we conclude as a result of our investigations that your *account* has not been incorrectly debited we will respond to your query by providing you with reasons and any evidence for this finding in writing.

6. Accounts

You should check:

- (a) with your *financial institution* whether direct debiting is available from your *account* as direct debiting is not available on all accounts offered by financial institutions.
- (b) your *account* details which you have provided to us are correct by checking them against a recent *account* statement; and
- (c) with your *financial institution* before completing the *Direct Debit Request* if you have any queries about how to complete the *Direct Debit Request*.

7. Confidentiality

We will keep any information (including your *account* details) in your *Direct Debit Request* confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about you:

- (a) to the extent specifically required by law; or
- (b) for the purposes of this *agreement* (including disclosing information in connection with any query or claim).

8. Notice

If you wish to notify us in writing about anything relating to this *agreement*, you should write Health Care Insurance, Attn: Membership Department, PO Box 931, Burnie TAS 7320 or enquiries@hcilt.com.au.

We will notify you by sending a notice in the ordinary post to the address you have given us in the *Direct Debit Request*.

Any notice will be deemed to have been received on the third *banking day* after posting.

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

Yes No

You are entitled to a Medicare card if:

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

Any enquiries about Medicare eligibility can be made at any Medicare office or by phoning 132 011 for the cost of a local call.

Declaration

I declare that the information I have provided is correct. I understand that there are penalties for giving false or misleading information.

Signature

Date

The information provided on this form will be used for the purposes of registering you for the Federal Government 30% rebate. Its collection is authorised by law, and information collected may be disclosed to the Department of Health and Ageing, the Private Health Insurance Ombudsman and the Australian Taxation Office.

Please send this registration form to

Health Care Insurance

Postal Address: PO Box 931, Burnie, Tasmania 7320

Street Address: 50 Marine Terrace, Burnie, Tasmania 7320

Need more information about the Federal Government 30% rebate?

If you need to know more about reduced premiums through your health fund, contact the Department of Health and Ageing.

Internet Home Page at <http://www.health.gov.au>

Freecall **1800 676 296** business hours



healthcare
insurance

healthcare insurance

A Registered Private Health Insurer ABN 43 009 579 088

Freecall 1800 804 950 **Freefax** 1800 643 969

Email enquiries@hcilt.com.au **Website** www.hcilt.com.au

Postal Address PO Box 931, Burnie, Tasmania 7320

Street Address 50 Marine Terrace, Burnie, Tasmania 7320



we care for our own