

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"/>
<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"/>

* 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)

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