healthcare insurance

Membership Application Form

I would like to

☐ Join HCI. Effective Date / /

☐ Transfer to HCI from another fund. If you are transferring from another fund please complete the Clearance Certificate Request on page 26 in the Guide to Cover.

Your details

Title		Date of birth / /	Sex ☐ Male ☐ Female
Surname		Given Names	
Postal address		Home address	
Suburb		Suburb	
State	Postcode	State	Postcode
Mobile		Daytime Phone	
Email			

Persons to be covered (do not include yourself)

If you need to add more than 8 people, please attach a separate page with their details.

Surname	Given names	Sex M/F	D.O.B	Relationship to member
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

** If a dependant is aged between 23 and 25, please refer to page 4 in the Guide to Cover for more information.*

Membership authority

☐ **I wish to authorise______________________________ to have the same rights and obligations as myself to access information in relation to this policy.**
Name of authorised person
However, they are unable to cancel the policy, add or remove a person other than themselves (if applicable).
I acknowledge and understand that I remain responsible for my policy and for the actions of the authorised person and do so at my own risk.

Policy Holder's Signature

Authorised Person's Signature

Choice of cover required

Type of Cover ☐ Singles ☐ Couples ☐ Family ☐ Family Dependant Plus ☐ Single Parent ☐ Single Parent Plus

Packaged Cover ☐ **Premier Package** **Excess Options** (per adult*) ☐ Nil ☐ $250 ☐ $500 ☐ $1,000**

Hospital Cover ☐ **Premier** **Excess Options** (per adult*) ☐ Nil ☐ $250 ☐ $500 ☐ $1,000**

Extras Cover ☐ **Premier Extras** ☐ **Active Life Extras**

* If a dependant is under 18 an excess does not apply. ** Please note by taking an excess greater than $500 per adult you may not be exempt from the Medicare Levy Surcharge (MLS). For more information on the MLS please talk to one of our friendly staff.

Membership Application Form continued

healthcare insurance

Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

Please complete this section to receive the Australian Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums apply.

You may be entitled to a Medicare card if you are:

- a person who lives in Australia, **and**
- an Australian citizen, **or**
- a holder of a permanent resident visa, **or**
- a New Zealand citizen, **or**
- an applicant for a permanent resident visa.

For more information about the Australian Government Rebate on Private Health Insurance, go to **humanservices.gov.au/privatehealth**
Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling **132 011**
or go to: **https://www.humanservices.gov.au/customer/services/medicare/medicare-card**

Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

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

☐ **Yes.** Please complete the remainder of this section ☐ **No.** You cannot apply for the Rebate until you obtain a Medicare card.

Are you covered by the policy?

☐ **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 select from the table below the Tier that is relevant to your estimated income or your family income for the financial year. For information regarding the income thresholds please refer to our Health Cover Premiums information sheet, on our website hciltd.com.au or alternatively you can visit the Australian Taxation Office website ato.gov.au. If you do not nominate a Rebate Tier, the Base Tier will be applied to your policy. 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.

Please select one box only.

Income Threshold (for the 2016/2017 financial year)			
Base: **Single** $90,000 or less **Family*** $180,000 or less ☐	**Tier 1:** **Single** $90,001 - $105,000 **Family*** $180,001 - $210,000 ☐	**Tier 2:** **Single** $105,001 - $140,000 **Family*** $210,001 - $280,000 ☐	**Tier 3:** **Single** $140,001 or more **Family*** $280,001 or more ☐

* If you're a family with children, the income threshold for each tier is increased by $1,500 for every child after your first. Family includes couples and single parent families.

Your Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ **Reference ID** ☐ **Valid to** /

Your name exactly as it appears on your Medicare card

The Australian Government Rebate is income tested and eligibility for the rebate is determined by the taxable income of a single or a family. There are no penalties for nominating an incorrect rebate tier. If the nominated tier is incorrect and there is a difference between the actual entitlement and the rebate claimed, the adjustment will be made through the policyholder's tax return.

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 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 our privacy policy at **http://www.humanservices.gov.au/privacy** or by requesting a copy from the department.

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 (HCI) as amended from time to time. I acknowledge that this application form and brochure does not contain all the Rules of HCI, but I am free to inspect the full copy of the Rules at the office of HCI. 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 HCI 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 HCI Privacy Policy. I consent to the collection, use and disclosure of my personal and sensitive information in the provision by HCI 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 HCI deems necessary to administer my policy. If the information supplied on this application is inaccurate or fraudulent, I acknowledge HCI 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.

A 12 month waiting period applies to **pre-existing conditions**. A pre-existing condition is an ailment, illness or condition the signs or symptoms of which existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. Other waiting periods may apply. For more information on waiting periods refer to page 12.

I understand waiting periods may apply to my policy. I have read and understand the waiting periods, including the pre-existing conditions rule as described on page 12.

Policy Holder's Signature ________ **Date** / /

Partner's Signature (if required) ________ **Date** / /

Payment Options

healthcare insurance

Frequency of Payment

I'd like my premiums to be deducted: ☐ Fortnightly (Not available for accounts) ☐ Monthly ☐ Quarterly ☐ 6 monthly ☐ Annually

Please complete ONE of the options below.

Option 1 - Bank Account Deduction

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.

Name of Financial Institution ______ Branch ______

Name of account holder ______

BSB number ___ ___ ___ / ___ ___ ___ **Account number** ___ ___ ___ ___ ___ ___ ___ ___ ___

☐ **Please use this account for credit of benefit payments.** ☐ **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** ___ ___ ___ ___ ___ ___ ___ ___ ___

Account Holder 1 Signature ______ **Date** / /

Account Holder 2 Signature ______ **Date** / /

Option 2 - Credit Card Deduction

Type of credit card ☐ MasterCard ☐ VISA ☐ American Express

Card number ____ ____ ____ ____

Name on credit card ______ **Expiry date** /

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

Card Holder's Signature ______ **Date** / /

Option 3 - Accounts

Accounts Frequency ☐ Monthly ☐ Quarterly ☐ 6 monthly ☐ Annually **Signature** ______

I wish to receive an account based on the frequency selected above. I undertake to pay all amounts payable by the due date specified on my account.

Telephone and internet banking - BPAY options available. Contact your bank, credit union or building society to make this payment from your cheque, savings or credit card account. For more information go to www.bpay.com.au

Option 4 - Payroll deductions

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

Payroll Frequency ☐ Weekly ☐ Fortnightly ☐ Monthly Commencing Pay Period Ending / / **Payroll ID** ______

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 Certificate Request

healthcare insurance

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**

Postal address

Other persons to be transferred

Name 1

Name 2

☐ All other persons as listed on the policy.

Name of existing health fund

Current Level of cover

Previous member number

Date to which health cover is paid to / /

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

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

☐ Please do not contact me further about this request.

Policy Holder's Signature **Date** / /

The signatory above must have legal responsibility for the health cover at the 'existing fund'.

Partner's Signature (if required) **Date** / /

The signature is required if your partner is covered on the health cover at the 'existing fund'.

I further request you to forward a Clearance Certificate directly to
Health Care Insurance Limited,
PO Box 931,
Burnie, Tas, 7320.
enquiries@hciltd.com.au
Freefax 1800 643 969

Before you send please check

☐ I have completed all the sections and signed all the signature boxes relevant to my application, including the Declaration.

Office Use Only

Member number

Payroll Group (if applicable)

Staff Signature **Date processed** / /