Clearance Certificate Request

Please complete this form to transfer somebody covered by your HCi membership from another health fund. When we receive your signed form, HCi 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 that arrangement**. Your current fund's Clearance Certificate ensures that waiting periods, entitlements, Lifetime Health Cover loadings and any days of absence are correctly switched.

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

Surname **Given Names**

Postal address

Email address

Transfer details

Name of existing health fund

Current Level of cover

Previous member number

Date to which health cover is paid to / /

I hereby authorise HCi 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 transfer ☐ All other persons as listed on the policy. ☐ Myself and those named below ☐ Just the persons named below

Name 1

Name 2

☐ 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
HCi Limited,
PO Box 931,
Burnie, Tas, 7320.
enquiries@hciltd.com.au

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** / /