It's easier to join online! Go to www.hciltd.com.au/join-hci - easy!

Membership application

Health Care Insurance

I would like to ◯ **Join HCi** ◯ **Transfer to HCi from another fund** **Effective date** dd / mm / yyyy

Your details

Surname / Family name | Title | Sex

Given name(s)

Home address

Postal address (including postcode)

Phone | Mobile | Date of birth (dd / mm / yyyy)

Email (We require your email address to communicate with you. We may not be able to process your application without your email address.)

Please let us know of any additions to your family or new address details via Online Member Services (OMS) or calling us.

Persons to be covered (do not include yourself)

	Family name	Given name(s)	Sex	Date of birth	Relationship to you
1				dd / mm / yyyy	
	Please provide their email address if aged 18 plus				
2				dd / mm / yyyy	
3				dd / mm / yyyy	
4				dd / mm / yyyy	
5				dd / mm / yyyy	

To add more than 5 people, please attach a separate page with their details.
If a dependant is aged 23 or more, they may be subject to additional requirements. Please refer to our website for eligibility details.

Account access nomination

I nominate _____, my relationship to me

to have the same rights and obligations as myself to access information in relation to this policy. This person may also change details and make claims on behalf of any person covered by this policy. However, they are unable to cancel the policy nor 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.

Phone | Email | Date of birth (dd / mm / yyyy)

Policy holder's signature

Choice of cover required

Type of Cover ◯ Single ◯ Couple ◯ Family (including single parent families)

			Choose your excess		
◯	◯ **Total Cover**	◯ Gold Hospital & Premier Extras#	◯ $250*	◯ $500*	◯ $750*
		◯ Silver Plus Advantage & Premier Extras#	◯ $250*	◯ $500*	◯ $750*
		◯ Silver Plus Secure & Premier Extras#	◯ $250*	◯ $500*	◯ $750*
OR					
	◯ **Hospital Cover**	◯ Gold Hospital	◯ $250*	◯ $500*	◯ $750*
		◯ Silver Plus Advantage Hospital	◯ $250*	◯ $500*	◯ $750*
◯		◯ Silver Plus Secure Hospital	◯ $250*	◯ $500*	◯ $750*
		◯ Bronze Plus Hospital			◯ $750*
		◯ Basic Plus Hospital			◯ $750*
	◯ **Extras Cover**	◯ Healthy Extras			
		◯ Active Life			

** If a dependant is under 18 an excess does not apply for their hospital claims.*
 # Premier Extras is only available with Gold or Silver Plus Hospital cover.

Please note: An excess applies per adult per calendar year. Visit our website or your **Guide to Cover** to see how excess levels work for your chosen cover.
Waiting periods may apply, including 12 months for **pre-existing conditions**. A pre-existing condition is an ailment, illness or condition the signs or symptoms of which existed within the 6 months up to the day this policy starts. Read about waiting periods on the HCi website.

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

Please select one only.

◯ I want to receive the Australian Government Rebate on private health insurance as a reduced premium.

◯ I want to pay full premiums and claim the rebate later. Skip to the **Medicare details** section.

Only applicants covered by the policy (or an applicant for a child-only policy) can claim the Government Rebate on Private Health Insurance. Employers and trustees of organisations cannot claim the Private Health Insurance Rebate for policies paid on behalf of employees.
For more information about the Australian Government Rebate on Private Health Insurance, see the **Services Australia** website.

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

◯ **Yes.** Please complete the **Income threshold** section.

◯ **No.** You cannot apply for the Rebate until everyone on the policy has a Medicare card.

You may be entitled to a Medicare card if you live in Australia and are:

- an Australian citizen, **or**
- a holder of a permanent resident visa, **or**
- a New Zealand citizen, **or**
- an applicant for a permanent resident visa.

To ask questions about Medicare eligibility, contact Human Services on 132 011 or at **https://www.humanservices.gov.au/customer/services/medicare**

Are you covered by this HCi policy? ◯ **Yes.** ◯ **No.** Skip to the **Declaration** section.

Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your application and payments, and provide services to you. We only share your information with other parties where you have agreed, or where law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacy**

Income threshold

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 your entitlement and the claimed rebate, an adjustment will be made through your tax return. For information regarding income thresholds, refer to the Australian Taxation Office at ato.gov.au

If you do not nominate a Rebate Tier, the Base Tier will be applied. To change income tier or stop receiving the Rebate as a reduced premium, please notify HCi as soon as possible.

Please select one tier for your estimated family income (for the current financial year).

◯ **Base**	◯ **Tier 1**	◯ **Tier 2**	◯ **Tier 3**
Single $84,000 or less	Single $84,001 - $97,000	Single $97,001 - $130,000	Single $130,001 or more
Family* $168,000 or less	Family* $168,001 - $194,000	Family* $194,001 - $260,000	Family* $260,001 or more

** The income threshold for each tier is increased by $1,500 for every child after your first. Family includes one and two parent families.*

Medicare details

Your name exactly as it appears on your Medicare card

Your Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

1 Dependant's name as it appears on their Medicare card

Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

2 Dependant's name as it appears on their Medicare card

Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

3 Dependant's name as it appears on their Medicare card

Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

4 Dependant's name as it appears on their Medicare card

Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

5 Dependant's name as it appears on their Medicare card

Medicare card number | | | | | | | | | | Reference ID | Valid to dd / mm / yyyy

Declaration

◯ I agree to abide by the rules of Health Care Insurance Ltd (HCi) as amended from time to time. I acknowledge this application form does not contain all the Rules of HCi, but I can request a copy of the Rules from HCi at any time.

◯ I have read the HCi Privacy Policy and I will inform any dependants on this application 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 my dependants in this application. I authorise the release of personal and sensitive information from my previous health fund, if any, and from any hospital, medical practitioner or other health service provider that HCi deems necessary to administer my policy.

◯ I declare the information provided is complete and correct. I understand that giving false or misleading information is a serious offence. If the information supplied is inaccurate or fraudulent, I know HCi may refuse to pay a claim, cancel the policy or require payment of an additional premium loading under Lifetime Health Cover legislation.

◯ I understand waiting periods may apply to my policy. I have read and understand the waiting periods, including the pre-existing conditions rule.

Member's signature

Date dd / mm / yyyy

Payment options

I'd like my premiums to be deducted ◯ Monthly ◯ Quarterly ◯ 6 monthly

This authorisation extends to any changes to my contributions that HCi may make from time to time. This authority applies until it is withdrawn by me in writing. If I do not make a choice, premiums will be deducted monthly by default.

Please complete ONE of the options below.

Option 1 Bank account deduction

I/we authorise Health Care Insurance (HCi) Limited (Debit user ID 16895) to arrange for money to be debited from my/our nominated account according to the instructions specified and the Service Agreement available at www.hciltd.com.au/terms.

Name of financial institution

Name of account holder(s) | BSB number | Account number

Account holder 1's signature | Account holder 2's signature (if applicable)

Date (dd / mm / yyyy) | Date (dd / mm / yyyy)

For claims payable, please credit ◯ the above account. ◯ the following account.

Name of account holder | BSB number | Account number

Option 2 Credit card deduction

Type of credit card: ◯ MasterCard ◯ VISA

Name on credit card | Card number | Expiry date (dd / mm / yyyy)

I/we acknowledge that this Direct Debit arrangement is governed by the terms of the Direct Debit Request - Service Agreement available at **www.hciltd.com.au/terms**

Card holder's signature | Date (dd / mm / yyyy)

Option 3 Manual payments

◯ I wish to make my payments manually in advance, and undertake to pay all amounts by the relevant due dates. I understand that I'm required to ensure my HCi account is paid for a minimum of 30 days in advance at all times. I understand I can pay via BPAY or credit card, including via HCi's Online Member Services (OMS).

Option 4 Payroll deductions

I authorise the pay officer of (Name of business or organisation) to deduct ($)

from my pay each ◯ Week ◯ Fortnight ◯ Month Commencing pay period ending (dd / mm / yyyy)

Signature | Date (dd / mm / yyyy)

Switching details

Name of current health fund

Current cover level

Current member number

Date health cover is paid up to

dd / mm / yyyy

People to be transferred

Everyone listed on this policy, **or**

Just myself, **or**

Myself and dependant(s) listed below, **or**

Just the member(s) listed below

Full name of person 1

Full name of person 2

Switching authorisation for previous fund

I hereby authorise HCi to cancel my old fund's membership from dd / mm / yyyy

I will send a Clearance Certificate to HCi, or authorise HCi to obtain details about my membership via a Clearance Certificate sent directly to HCi Limited, enquiries@hciltd.com.au

I request a refund for any premiums paid beyond my termination date.

I do not want the old fund to contact me further about this request.

Policy holder's name

Policy holder's date of birth

dd / mm / yyyy

Policy holder's postal address

Policy holder's signature

Date

dd / mm / yyyy

The signatory above must have legal responsibility for the health cover at your previous fund.

Partner's signature (if required)

Date

dd / mm / yyyy

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

Final 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

dd / mm / yyyy