If you prefer, you can apply online - just visit www.hciltd.com.au/join-hci for the link.

HCi Health Care Insurance

Membership application

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

Your details

Family name | Title | Sex

Given name(s)

Home address

Postal address (including postcode)

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

Email

Please let us know of any additions to your family or new address details via 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	
2				dd / mm / yyyy	
3				dd / mm / yyyy	
4				dd / mm / yyyy	
5				dd / mm / yyyy	

If you need to add more than 5 people, please attach a separate page with their details.
If a dependant is aged between 23 and 31, please refer to our website for more information.

Membership authority

I wish to authorise Name of authorised person

to have the same rights and obligations as myself to access information in relation to 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.

Policy holder's signature | Authorised person's signature

Choice of cover required

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

			Choose your excess		
◯	◯ **Packaged Cover**	◯ Gold Hospital & Premier Extras#	◯ $250*	◯ $500*	◯ $750*
		◯ Silver Plus & Premier Extras#	◯ $250*	◯ $500*	◯ $750*
OR					
◯	◯ **Hospital Cover**	◯ Gold Hospital	◯ $250*	◯ $500*	◯ $750*
		◯ Silver Plus Hospital	◯ $250*	◯ $500*	◯ $750*
		◯ Bronze Hospital			◯ $750*
		◯ Basic 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.

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 within the 6 months up to the day this policy starts. Other waiting periods may apply. For more information on waiting periods refer to 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, go to **humanservices.gov.au/privatehealth**

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 011or at **https://www.humanservices.gov.au/customer/services/medicare**

Are you covered by this HCi policy?

◯ **Yes.**

◯ **No.** Skip to the **Declaration** section.

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 the income thresholds please 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 your policy. If you wish to change income tier or stop receiving the Australian Government Rebate as a reduced premium, you must 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 $90,000 or less	Single $90,001 - $105,000	Single $105,001 - $140,000	Single $140,001 or more
Family* $180,000 or less	Family* $180,001 - $210,000	Family* $210,001 - $280,000	Family* $280,001 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 read the full the Rules at the office of HCi.

◯ 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 provided information is true and accurate to the best of my knowledge. If the information supplied 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.

◯ 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

Partner's signature (if required)

Date dd / mm / yyyy

Payment options

Frequency of payment

I'd like my premiums to be deducted ◯ Fortnightly *(not available for manual payments)* ◯ 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.

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 money to be debited from my/our nominated account at the Financial Institution shown below according to the instructions specified and the Service Agreement available at www.hciltd.com.au/terms.

Name of financial institution

Branch

Name of account holder(s)

BSB number

Account number

Account holder 1's signature

Account holder 2's signature (if required)

Date dd / mm / yyyy

Date dd / mm / yyyy

◯ 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

Option 2 Credit card deduction

Type of credit card: ◯ MasterCard ◯ VISA ◯ American Express

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 receive an invoice every: ◯ Month ◯ Quarter ◯ 6 months

I undertake to pay all amounts payable by the due date specified on the invoice. I can make payments via BPAY, cheque, credit card, phone banking or internet banking.

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 Clearance Certificate request

You must complete this section if you or somebody covered by your membership is transferring from another health fund. HCi will cancel your existing health fund membership for you and request a Clearance Certificate. As long as you have signed this authorisation, the Clearance Certificate from your current fund allows us to correctly transfer your waiting periods, benefit entitlements and Lifetime Health Cover loading and days of absence (if any). You will need to complete a certificate request for each fund you and/or your dependants are switching from.

NOTE: If you have a direct debit or payroll deduction arrangement with your existing fund, **please remember to cancel those payments**.

Name of existing health fund

Current cover level

Existing member number

Date to which health cover is paid to dd / mm / yyyy

Members to be transferred

◯ Everyone listed on the policy, **or** ◯ Myself and member(s) listed below, **or** ◯ Just the member(s) listed below

Name 1

Name 2

Transfer authorisation

I hereby authorise HCi to cancel my membership from dd / mm / yyyy 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 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 the 'existing fund'.

Partner's signature (if required)

Date dd / mm / yyyy

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.

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