POLICY UPDATES

Health Care Insurance

Member Number: …… Member's name: ……

Address: ……

……

Commencement date for the following changes: ……/……/20……

Please complete the relevant sections then sign page 2 to authorise the changes.

1. CHANGE TO MEMBER DETAILS

Change to Surname: ……
(evidence required)

New Address: ……

……

2. CHANGE TO LEVEL OF COVER

I now require the following cover: **

COMBINED PACKAGES (Hospital & Extras)

☐ Gold Hospital & Premier Extras with $250/$500/$750 excess per adult per calendar year

☐ Silver Plus Hospital & Premier Extras with $250/$500/$750 excess per adult per calendar year

HOSPITAL COVER

☐ Gold Hospital with $250/$500/$750 excess per adult per calendar year

☐ Silver Plus Hospital with $250/$500/$750 excess per adult per calendar year

☐ Bronze Hospital $750/$1,500 excess per adult per calendar year

☐ Basic Hospital $750/$1,500 excess per adult per calendar year

Please note: Some excess options attract a day excess, please ask HCi staff if unsure.

EXTRAS COVER

☐ Healthy Extras ☐ Active Life Extras

** Note that any funeral benefits will cease if you change to your level of cover,

3. CHANGE TO MEMBERSHIP COVER

Change to ☐ Single ☐ Couple ☐ Family

I want the following people to be: ☐ Added ☐ Taken off my membership

Given Names (& surname if different from your own)	D.O.B.	M/F	Relationship to member

Are all the people on this policy listed on or entitled to a Medicare card? ☐ Yes ☐ No

Are the additional dependants financial members of another fund? ☐ Yes ☐ No

Name of fund: ……Member No: ……

Level of cover: ……

Please read the waiting period information on the bottom of this form. Waiting periods apply to new dependants, and to people upgrading tables from another fund.

4. CANCELLATION

I wish to cancel my policy with HCi effective: ……

I understand that I can re-join at any time, but will be subject to waiting periods.

To assist HCi enhance their products and services, I/we are cancelling because:

- ☐ Cost/contributions
- ☐ Policy does not meet my/my family's needs
- ☐ Customer Service
- ☐ Location
- ☐ Benefits/services offered
- ☐ Moving to another health fund – please name the fund ……
- ☐ Other ……

I declare all details to be true and correct and agree to be bound by the rules of HCi. I have read and understood the waiting periods information below.

MEMBER'S SIGNATURE:	**PARTNER'S SIGNATURE (if required):**
NAME:	**NAME:**
DATE:	**DATE:**

Waiting periods

Benefits are payable after 2 months, except for:

Extras cover		Hospital cover	
Crowns & Bridges	12 Months	Pre-Existing	12 Months
Dentures	12 Months	Obstetrics	12 Months
Dental Implant Prostheses	12 Months	IVF & Assisted Reproductive Technology	12 Months
Fares & Accommodation	6 Months	Sterilisation	12 Months
Hearing Aids	2 Years		
Medical Appliances	12 Months		
Orthodontics	12 Months		
General Dental	2 Months		
Optical	6 Months		

Pre-existing Ailments

Benefits are not payable during the first 12 months membership of a table for treatment relating to an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the organisation, existed at any time during the 6 months prior to the date of joining or upgrading to a higher level of cover.

Office Use Only

Accepted by…… Date ……/……/.20……

Processed by…… Date ……/……/.20……