

Your Membership

Application



If you require more information, or help filling out your form please call us on **1300 113 113**. Once you've finished, fax your completed application form to **(08) 8223 1108** or mail to **Health Partners, Reply Paid 1493, Adelaide SA 5001**.

Section 1 – I wish to

- Join Health Partners and/or transfer from another health fund: Complete sections 2, 3, 4, 6, 7, 8, 9, 10, 11
- Add/remove someone to/from my membership: Complete sections 2, 4, 6, 9
- Change my level of cover: Complete sections 2, 3, 9
- Update my personal details: Complete sections 2, 5, 6, 9

Section 2 – Member details

Title Mr Ms Mrs Miss Dr Other _____
 Given names _____
 Surname _____
 Residential address _____

 _____ Postcode _____
 Postal address (if different from above) _____
 _____ Postcode _____
 Date of birth (dd/mm/yyyy) ____/____/____

Health Partners Member Number (if applicable) _____
 Home phone _____
 Is your home phone a silent number? Yes No
 Mobile _____ Work phone _____
 Email _____
 Is this a corporate membership? Yes No
 Corporation Name _____
 Member Number (if applicable) _____
 I do not wish to receive material for the purposes of marketing, promotions or member research.

Section 3 – Cover required

- Membership:** Single Couple Family Sole Parent Family Family Focus Sole Parent Family Focus
- Extras Cover:** Gold Extras Silver Extras Bronze Extras National Extras
 Natural Plus (only available with Gold, Silver, Bronze or National Extras cover)
- and/or
- Hospital Cover:** Gold Hospital Silver Hospital 250 Bronze Hospital 500
 Gold Hospital 25 Silver Hospital 500
 Gold Hospital 50

Section 4 – Details of family members to be included in my cover

Title	Given names	Surname	Date of Birth (dd/mm/yy)	Sex (M/F)	Relationship to member	New Member	Remove Member
			/ /			<input type="checkbox"/>	<input type="checkbox"/>
			/ /			<input type="checkbox"/>	<input type="checkbox"/>
			/ /			<input type="checkbox"/>	<input type="checkbox"/>
			/ /			<input type="checkbox"/>	<input type="checkbox"/>
			/ /			<input type="checkbox"/>	<input type="checkbox"/>
			/ /			<input type="checkbox"/>	<input type="checkbox"/>

If you wish to authorise your partner, as named above, to operate this membership please tick this box (ring for further details).

FOR OFFICE USE ONLY BELOW

Section 5 – Change of Name

Former name _____ Former Medicare number

Please supply a copy of your marriage or change-of-name certificate.

Section 6 – Application for Federal Government 30% Rebate

Please complete this section to receive the Federal Government 30% Rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums will apply.

Are all the people included in this membership entitled to or listed on your Medicare Card? Yes No

Are you covered by this membership? Yes No If No, employers and trustees of organisations cannot claim the Federal Government Rebate on policies paid on behalf of employees.

Your Medicare card number Valid to ____/____/____

Your name exactly as it appears on your Medicare card _____

Are you a permanent resident of Australia? Yes No

Section 7 – Lifetime Health Cover Details

If you (or your partner, if applicable) are over 30 and have not previously held private health insurance, you will have to pay a loading on your hospital cover. Please ring for further details.

Have you had continuous private health cover since 1 July 2000? Yes No

If you are transferring from another fund, do you currently have a Lifetime Health Cover loading? Yes No If yes, please specify _____

If you do not provide confirmation that you (or your partner) are exempt from Lifetime Health Cover loading, your (and your partner's) date of birth will be used to calculate the loading that applies to your contribution.

Section 8 – Payment Options

I would like to pay my contributions by: Direct-debit [bank account or credit card] (please complete the *Direct-debit request* below)

Account notice Payroll (please complete *Section 11 – Payroll Deduction Authority* below)

At a frequency of: Fortnightly (direct-debit account/payroll only) Monthly Quarterly ½ Yearly Yearly

Direct-Debit Request

By completing this form your premiums will be automatically paid from your nominated account or credit card.

I/We request Health Partners (User ID 46575) ABN 43 128 282 904 to debit funds from my/our nominated account/credit card according to the details specified below. I understand Health Partners may deduct an initial payment after receiving this application form that will cover me until my membership commencement date.

Bank account details

Direct-debit my account on: 1st 8th 15th 22nd of the month.

Name of financial institution where account is held _____

Name of branch _____

Name on account _____

BSB number -

Account number

If debiting from a joint bank account, all signatures will be required.

OR Credit card details (not available for fortnightly payments)

Mastercard Visa Amex Diners

Card number

Expiry date ____/____/____

Name on credit card _____

Signature _____

Your authorisation (please complete for bank or credit card debits)

I have read and understand the Health Partners Direct-Debit Request (DDR) Service Agreement. In the event of changes to my/our rates, level of cover, or arrears, I/we also authorise Health Partners to alter the amount of deductions from the appropriate date in accordance with such changes.

Name _____

Address _____

Postcode _____

Membership No. _____

Signature _____

Signature _____

Section 9 – Member Declaration

I declare the statements in this application are true and complete. I apply for the health cover indicated above and if not already a member, to become a member of Health Partners Limited (ABN 43 128 282 904) and I will be bound by the rules and constitution of Health Partners Limited. I have read and agree with important information relating to waiting periods.

Signature _____ Date ____/____/____ Date membership to commence ____/____/____ (current or future date only)

Section 10 – Transferring from another Fund

Previous fund name _____

I wish to resign from your Fund effective ____/____/____

Membership number _____

Please forward to Health Partners a letter of clearance specifying details relating to my membership of your health fund.

Name _____

Address _____

Postcode _____

Date of birth (dd/mm/yyyy) ____/____/____

Signature _____

Date ____/____/____

Section 11 – Payroll Deduction Authority

Name of employer _____

Address of employer _____

Postcode _____

I hereby authorise you to pay Health Partners out of any sum of money due to me by my employer as long as I remain a member of the said fund, such varied amount as notified to the paymaster on my behalf by Health Partners from time to time.

Payroll number _____

Signature _____

Date ____/____/____