

Online Application for health cover



I wish to: (Please mark X) Join HCF. Transfer from another fund (Complete Interfund Transfer section).
 Change people covered, membership details or present cover.

Source	Deal code	Rate code
R20762	A13	18

APESMA Gi11670 Mar 2009-v.1

Your personal details.

Please use capital letters

Title Given names

Surname Current HCF Membership or Covernote No. Sex M F

Home address (Please complete your street number, name and suburb)

Postcode Phone work Mobile Phone home

Postal address (Please complete your street number, name and suburb)

Postcode Date of birth (Day/Month/Year) / /

Date you wish your membership to commence / / Email

Please mark X Retain my existing products Single Couple/Family Single Parent Family Extended Family Cover

Other persons to be covered.

Use another form if space is insufficient

<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>	<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>
<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>	<p>Given names <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (Day/Month/Year) <input type="text"/> / <input type="text"/> / <input type="text"/></p> <p>Sex M <input type="checkbox"/> F <input type="checkbox"/> Relationship <input type="text"/></p>

Federal Government Rebate

Complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply. Are all people on your membership eligible for full Medicare Benefits?

Yes - Please complete the remainder of this section No - You cannot apply for the rebate.

Your Medicare card number Date of birth (Day/Month/Year) / /

Your name exactly as it appears on your Medicare card

Rebating of claims

If you would like your claims benefit paid directly into your account, please complete the following details:

Account name

BSB number

Account number

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Interfund transfer Use another form if space is insufficient

Complete this section if you have been with an Australian Registered health fund at any time since 1/7/2000.

If you have a direct debit arrangement with your existing health fund please remember to personally advise your bank or your pay office (if you pay by payroll deduction) to cancel your deductions. Remember also to sign the Declaration section.

Title	Given names	Name of existing health fund
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Membership number	
<input type="text"/>	<input type="text"/>	
Home address (Please complete your street number, name and suburb)		
<input type="text"/>		
<input type="text"/>	Postcode	I hereby authorise HCF to terminate my membership with your organisation and obtain details about my membership.
Date of Birth (Day/Month/Year)	Signature	Date
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Please note due to privacy reasons, your existing health fund may send you the clearance certificate, which you will need to forward to HCF.



Complete and return to:
GPO Box 1272, Melbourne, VIC 3001
For more information or assistance phone: **1300 853 352**