

# 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

I have carefully read and considered the Health Partners Brochure (Policy Document) before making decisions about my required level of cover.

- 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"/>

- 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

PLEASE TURN OVER

Member Services 76 Pirie St, Adelaide SA 5000 Reply Paid 1493 Adelaide SA 5001

Ph 1300 113 113 Fax (08) 8223 1108 Health Partners Ltd ABN 43 128 282 904

**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, and have provided information about each member with their consent. I have carefully read and considered the Health Partners Brochure (Policy Document) before deciding to apply for the health cover indicated above. I agree, if not already a member, to become a member of Health Partners Limited (ABN 43 128 282 904) and be bound by the rules and constitution of Health Partners. I have read and understood, and ensured that each member is aware of, Health Partners Privacy Policy and 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.

Please do not contact me about this request.

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 \_\_\_\_/\_\_\_\_/\_\_\_\_