Your Membership
Application

If you require more information, or help filling out your form, please call us on **1300 113 113**. Scan and email your completed application form to **ask@healthpartners.com.au**, fax to **(08) 8113 2259** or mail to **Health Partners, Reply Paid 1493, Adelaide SA 5001**. Alternatively, join online at **healthpartners.com.au**.

Please read and consider the Health Partners Member Guide, which includes important information about limits, waiting periods, pre-existing conditions and any exclusions, restrictions or excesses which may apply, prior to completing this application.

Section 1 – I wish to

☐ Join Health Partners and/or transfer from another health fund: Complete sections 2, 4, 5, 6, 7, 8, 9, 10.
☐ Add someone to my membership: Complete sections 2, 5, 6, 7, 8 10.
☐ Remove someone from my membership: Complete sections 2, 5, 7, 10.
☐ Change my level of cover: Complete sections 2, 4, 7, 10.
☐ Change my name: Complete sections 2, 3, 7, 10.
Update your address, phone and email details at Members Online at **healthpartners.com.au**.

Section 2 – Member details

Health Partners member number *(if applicable)*

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Dr ☐ Other *(please specify)*

Sex ☐ M ☐ F ☐ Not specified

Given names

Surname

Residential address Postcode

Postal address *(if different from above)* Postcode

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

Home phone Is your home phone a silent number? ☐ Yes ☐ No

Mobile Work phone

Email

By providing an email address you will automatically be registered for Members Online, where you can login and view information about your health cover. You will also receive Health Insurance related information (including but not limited to Tax Statements, Cover Detail Statements, Account notices, letters regarding your rates, Member Benefit Statements and Standard Information Statements) via your Members Online mailbox. You can update your settings or opt-out by logging into Members Online. Terms and conditions of this service are available at healthpartners.com.au/Terms-and-Conditions

From time to time we will send you communications about our VIP events, competitions and news that may be of interest for you. If you do not wish to receive these communications, please contact 1300 113 113.

How did you hear about Health Partners?

Promo code

Is this a corporate membership? ☐ Yes ☐ No

Organisation name Staff/Member number

Section 3 – Change of name (new details)

Title ☐ Mr ☐ Ms ☐ Mrs ☐ Miss ☐ Dr ☐ Other *(please specify)*

Name (first name) *(surname)*

Sex ☐ M ☐ F ☐ Not specified

☐ I have attached a Change of Name Certificate (Birth Certificate or Marriage Certificate is also accepted).

Section 4 – Cover required

I have carefully read and considered the Product Information and PDS, which includes important information about limits, waiting periods, pre-existing conditions and any exclusions, restrictions or excesses which may apply, prior to completing this application.

Please tick all levels of cover required.

Membership: ☐ Single ☐ Couple ☐ Family ☐ Sole Parent Family ☐ Family Focus* ☐ Sole Parent Family Focus*

**Tick Family Focus if you wish to obtain cover for a dependant child who is over 21 (but under 25) and who is not studying full time (please call us for further details).*

Please note not all membership types are available for all levels of cover.

Hospital Cover: ☐ Gold Hospital | Gold Value Hospital *(with maternity)* Excess: ☐ 250 ☐ 500 | Gold Value Hospital *(excluding maternity)* Excess: ☐ 250 ☐ 500 | ☐ Silver Hospital | ☐ Bronze Hospital

and/or Extras Cover: ☐ Gold Extras ☐ Silver Extras ☐ Bronze Extras ☐ National Extras

☐ Natural Plus *(only available with Gold, Silver, Bronze or National Extras cover)*

Section 5 – Details of family members to be included in my cover (do not include yourself)

Spouse/Partner

Title	Given names	Surname	D.O.B *(dd/mm/yy)*	Sex *(M/F)*	Relationship to member	New member	Remove member
			/ /			☐	☐

☐ My above-named partner's addresses are different to the addresses listed in Section 2 (please provide details on a separate piece of paper). This information is required for Tax purposes.

Please note: Unless otherwise revoked by you (as the policyholder), the partner/spouse you have included in this application will also be able to manage most aspects of the membership such as making enquiries or changes to contact details, level of cover, payment method, making claims, suspending and reactivating the membership, adding or removing dependants and accessing claims histories which could include personal health information such as medical conditions. This 'Delegation of Authority' does not allow a partner/spouse to cancel the membership, remove or change the status of the policyholder or nominate further delegated authorities.

Dependants

Title	Given names	Surname	D.O.B *(dd/mm/yy)*	Sex *(M/F)*	Relationship to member	New member	Remove member
			/ /			☐	☐
			/ /			☐	☐
			/ /			☐	☐
			/ /			☐	☐
			/ /			☐	☐

If you need space for additional dependants, please attach a separate piece of paper.

Section 6 – Transferring from another fund

Please complete this form if you authorise Health Partners to terminate your current health fund membership on your behalf. If you currently have health insurance with more than one fund, please attach this information on a separate piece of paper.

Previous fund name _____ Membership number _____

Name of cover ☐ Hospital & Extras ☐ Hospital only ☐ Extras only

Persons covered on membership _____

I wish to resign from your Fund effective / / ☐ Please do not contact me about this request.

Given names _____ Surname _____

Address _____ Postcode _____

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

I authorise Health Partners to terminate my membership from the date specified above and obtain details about my membership and claims for the last 12 months.

Signature _____ Date / /

Section 7 – Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

If you do not complete this section full premiums will apply. All people listed on the policy must be eligible for Medicare for you to receive the rebate as a reduced premium.

If you are unsure whether you are eligible for Medicare, go to **www.humanservices.gov.au/customer/services/medicare/medicare-card** for more information. Questions about Medicare eligibility can be made at any Human Services' Centre or by calling 132 011. Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

For more information about the Australian Government Rebate on Private Health Insurance, go to **www.privatehealth.gov.au**
If at any stage you wish to nominate a new Income Tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible.

Privacy Notice: Your personal information is protected by law (including the Privacy Act 1988) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the department will manage your personal information, including their privacy policy, at **www.humanservices.gov.au/privacy**

I would like to receive the Australian Government Rebate on private health insurance as a reduced premium ☐ Yes ☐ No

I would like to nominate the following Income Tier ☐ Base Tier ☐ Tier 1 ☐ Tier 2 ☐ Tier 3

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?
If no, you cannot apply for the Rebate until you obtain a Medicare card. ☐ Yes ☐ No

What type of Medicare card do you hold?
The colour of your Medicare card indicates your entitlements. ☐ Green ☐ Blue ☐ Yellow ☐ None

Are you covered by the policy?
If No, Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees. ☐ Yes ☐ No

Your Medicare card number Valid to / /

Your name exactly as it appears on your Medicare card

Section 8 – Lifetime Health Cover details

If you (or your partner, if applicable) are over 30 and have not previously held private hospital insurance, you have to pay a loading on your hospital cover. For more details, including information on Lifetime Health Cover exemption, please call us.

About you

Have you had continuous private hospital cover since 1 July following your 31st birthday or for 10 continuous years since 1 July 2000? ☐ Yes ☐ No ☐ NA

If you are transferring from another fund, do you currently have a Lifetime Health Cover loading? ☐ Yes ☐ No

If Yes, please specify *You will need to supply confirmation from your previous fund of your Lifetime Health Cover loading.*

About your partner *(if applicable)*

Has your partner had continuous private hospital cover since 1 July following their 31st birthday or for 10 continuous years since 1 July 2000? ☐ Yes ☐ No ☐ NA

If your partner is transferring from another fund, do they currently have a Lifetime Health Cover loading? ☐ Yes ☐ No

If Yes, please specify *You will need to supply confirmation from your previous fund of your Lifetime Health Cover loading.*

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 contributions.

Section 9 – Payment options *(3% discount when paying via direct debit)*

I would like to pay my contributions by

☐ Direct debit via bank account or credit card - *receive a 3% discount (please complete the Direct Debit Request below).*

At a frequency of ☐ Fortnightly *(Fridays only)* ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly

OR

☐ Account notice

At a frequency of ☐ Quarterly ☐ Half Yearly ☐ Yearly

Direct Debit Request

When you complete 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/We understand Health Partners may deduct an initial payment after receiving this application form that will cover me from my membership commencement date.

Direct debit account on ☐ 1st ☐ 8th ☐ 15th ☐ 22nd of the month.

Bank account details

Name of financial institution Name of branch

Account in the name/s of

BSB number - Account number

OR

Credit card details

Type of credit card ☐ MasterCard ☐ Visa Card ☐ Amex Expiry date /

Name on credit card

Card number

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

I/we have read and understood the Health Partners Direct-Debit request 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.

Given names Surname

Address Postcode

Member number *(if applicable)*

Signature Date / /

Section 10 — Member declaration

- I declare that the information I have provided in this form is complete and correct.
- I understand that giving false or misleading information is a serious offence.
- I have carefully read and considered the Product Information and PDS available at healthpartners.com.au/pds, including important information relating to limits, waiting periods, pre-existing conditions and any exclusions, restrictions, excesses or co-payments, before making decisions about my required level of cover.
- 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.
- I understand, that if this is a new membership or I am changing my cover, I will receive written confirmation from Health Partners once the application has been processed.

Signature Date / /

Date membership to commence / /

HPA32-1812