Your Membership Application

Health Partners

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**, 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 excess 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 ☐ Mx ☐ Other *(please specify)*

Gender ☐ M ☐ F ☐ Not specified

Given names

Surname

Residential address Postcode

Postal address *(if different from above)* Postcode

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

Mobile Work phone

Home phone

Email

By providing an email address Health Partners will automatically register you for Members Online. It is important that you login and view the information about your health cover. Health Partners will also use this email address to send you communications about matters other than Members Online, including our VIP events, competitions and news that may be of interest for you. If you do not wish to receive these communications from us or register for Members Online please call 1300 113 113. Terms and conditions of the Members Online service are available in the Member Guide.

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 ☐ Mx ☐ Other *(please specify)*

Name *(first name)* *(surname)*

Gender ☐ 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 Member Guide, which includes important information about limits, waiting periods, pre-existing conditions and any exclusions, restrictions or excess which may apply, prior to completing this application.

Please tick all levels of cover required.

Membership: ☐ Single ☐ Couple ☐ Family ☐ Single Parent Family ☐ Extended Family* ☐ Extended Single Parent Family*

**Tick Extended Family if you wish to obtain cover for a Non-Student Dependant who is over 21 (but under 32) 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 Advantage	Excess:	☐ 750		
Silver Hospital Plus Advantage	Excess:	☐ 250	☐ 500	☐ 750
Silver Hospital Plus Lite	Excess:	☐ 500	☐ 750	
Bronze Hospital Plus	Excess:	☐ 500	☐ 750	
Basic Hospital Plus~	Excess:	☐ 500	☐ 750	

Extras Cover (taken with Hospital Cover)^: ☐ Combined Best Extras ☐ Combined Better Extras ☐ Combined Good Extras

^This cover is only available when combined with a Health Partners Hospital Cover and on the same membership. If you cancel your Hospital Cover with us, you will default back to the equivalent standalone product.

Extras Cover only: ☐ Best Extras ☐ Better Extras ☐ Good Extras ☐ Base Extras~

~Only available on single and couple memberships.

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)*	Gender *(M/F/Not Specified)*	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).

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)*	Gender *(M/F/Not Specified)*	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 or current 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 the policy with my current insurer(s) and obtain a transfer certificate. This allows us to waive waiting periods that you may have already served.

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. ***This section is to be completed with the policy holder's information.***

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 and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where law allows or requires it. For more information, go to servicesaustralia.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 people on the policy eligible for Medicare?
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 Green card expiry date /

Your name as it appears on your Medicare card IRN *(No. next to your name)*

OR Interim or Reciprocal Health Care Agreements Card Blue/yellow card expiry date / /

The below details are only to be completed if you are adding someone to the membership.

Is the person being added on the same Medicare card as the policy holder? If not, complete the below with their details. ☐ Yes ☐ No

Medicare card colour Green card expiry date /

OR Interim or Reciprocal Health Care Agreements Card Blue/yellow card expiry date / /

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 *Health Partners will confirm this with your previous fund.*

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 *Health Partners will confirm this with your previous fund.*

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 premiums.

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

I would like to pay my premiums 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 ☐ Monthly ☐ 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 request and authorise Health Partners Ltd ABN 43 128 282 904, User ID 46575, to arrange, through its own financial institution, a debit to my nominated account any amount Health Partners has deemed payable by myself. This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from my account held at the financial institution I have nominated above and will be subject to the terms and conditions of the Direct Debit Request Service Agreement.

Selected billing date *(1st to 28th only. Does not apply for fortnightly debit frequency)*

Bank account details

Name of financial institution Name of branch

Account in the name/s of

BSB number - Account number

☐ I would like to have any benefit payments deposited into this bank account.

Benefit payments can only be made to spouse or dependant accounts for their own personal claims, and if bank account details have been provided. Otherwise benefit payments are simply paid to the policyholder.

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 and agreed to the terms and conditions as set out in this Request and the Health Partners Direct Debit Request Service Agreement available at healthpartners.com.au/members/forms. 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

Member number *(if applicable)*

Signature *(for joint accounts both to sign)* Date / /

Section 10 — Member declaration

- I declare that the information I have provided 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 Member Guide available at healthpartners.com.au/forms-brochures, including important information relating to limits, waiting periods, pre-existing conditions and any exclusions, restrictions, excess 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 ensured that each member is aware of, Health Partners' Privacy Policy, and consent to my personal information being collected and used in accordance with the policy, this may include health and medical information, as well as my Medicare number.
- I understand, that if this is a new membership or I am changing my cover, I will receive written confirmation from Health Partners via email, sent to Members Online, or via mail if no email address supplied.

Signature Date / /

Please note: If you are completing this form electronically, your typed name in the Declaration stands as your signature.

Date membership to commence / /

If date is left blank, cover and rebate commencement date will be based on date of declaration or receipt, whichever is later.

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