



Membership Application

Health Insurance Fund of WA (HIF) ARBN 128 302 161
An association incorporated in Western Australia. A registered Private Health Insurer.

Health Insurance Fund of WA
60 Stirling Street, PERTH WA 6000
GPO Box x2221, Perth WA 6847
Phone: 1300 13 40 60 Fax: (08) 9328 3345
E-mail: join@hif.com.au Web: www.hif.com.au

I wish to: Join HIF Change existing membership

Membership Number

If Joining: Date Cover is to commence (dd/mm/yy) / /

Please use BLOCK letters and write in black pen, complete all relevant sections

A. MEMBER DETAILS

Title First Name Surname

Address

Suburb State Postcode

Home () Work () Mobile

Email

B. ALL PERSONS TO BE COVERED (including yourself)

1 First Name Middle Name Surname Birth Date (dd/mm/yy)

A S A B O V E

M/F Relationship to Member

S E L F

2 First Name Middle Name Surname Birth Date (dd/mm/yy)

M/F Relationship to Member

3 First Name Middle Name Surname Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student, Name of Tertiary Institution This declaration applies for the year **2 0**

4 First Name Middle Name Surname Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student, Name of Tertiary Institution This declaration applies for the year **2 0**

5 First Name Middle Name Surname Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student, Name of Tertiary Institution This declaration applies for the year **2 0**

C. SPOUSE/PARTNER AUTHORITY

I hereby authorise the person identified as my Spouse or Partner on this application form to make any changes or alterations to my HIF Membership on my behalf. However, there is no provision for cancellation of this membership by the Spouse / Partner named.

Signature of Member Birth Date (dd/mm/yy)

D. TYPE OF COVER

Step 1 - Choose your Type of Membership

- Family F
- Single S

Step 2 - Choose your Ancillary Option Cover

Top with Complementary Therapies

- Premium Options A5

Top

- Super Options A

Intermediate

- Special Options A1

Basic

- Saver Options A2

Step 3 - Choose your Hospital Cover

Top with Private Room

- GoldStar Hospital (No Excess) H3
- GoldStar Excess 200/400 R3
- GoldStar Excess 400/800 R4
- GoldStar Excess 500/1000 R5

Top with Shared Room

- Gold Hospital (No Excess) H2
- Gold Excess 100/200 R2
- Gold Excess 200/400 R6

Intermediate

- GoldSaver Hospital Excess 200/400 GS

Basic

- GoldStarter Hospital Excess 200/400 GR

TURN OVER AND COMPLETE REVERSE SIDE OF FORM AND SIGN DECLARATION

E. PRIVATE HEALTH INSURANCE REBATE (Available to Permanent Australian Residents Only)

Are all persons listed on the Application form permanent Australian residents and eligible for FULL Medicare benefits? Yes No

If **no**, you cannot apply for the rebate until you are entitled to receive FULL Medicare Benefits. Contact HIF to discuss alternative cover.

If **yes**, do you wish to receive the Federal Government Rebate on Private Health Insurance as a reduced premium? Yes No

Medicare Card No Id Valid to (mm/yyyy) /

Name on Card

Surname First Name

The information provided in this form will be used for the purpose of registering you for the Federal Government Rebate on Private Health Insurance. Its collection is authorised by law and information collected will be disclosed to the Department of Health and Ageing, Medicare Australia and the Australian Taxation Office.

By completing this section, you acknowledge that you understand that there are penalties for giving false or misleading information, and that all persons listed on your policy must be eligible to receive full Medicare for you to receive a rebate.

F. SWITCHING FUNDS

- If you or your partner are transferring from another health fund, HIF can arrange to cancel your existing membership on your behalf. Simply complete both sections below and return it to us. If you and your partner are transferring from separate health funds, you will each need to complete a transfer request.
- Waiting periods you have served with your current fund will be recognised if you join an equivalent or lower level of cover within two (2) months of ceasing cover with that fund.
- Claims for services rendered up to your cancellation date will be paid by your previous fund. HIF will accept claims serviced after your joining date, with benefits being paid once your transfer details have been received from your previous fund.

This section will be sent to your current fund.

First Name Surname
Current Health Fund Member No

Please be advised I wish to cancel my membership from (dd/mm/yy) / /

This will necessitate the cancellation of all payment arrangements pertaining to this cover. If applicable, any refund of contributions paid in advance of the cancellation date should be sent to the member named above. The Interfund Clearance Certificate should be forwarded to: HIF GPO Box X2221, PERTH, WA 6847.

Please provide information to HIF about: Myself My partner My dependents

Signature of Member Birth Date (dd/mm/yy)

Note: HIF requires a minimum of twelve (12) months claim history and previous Health Insurance cover.

DECLARATION

PRIVACY POLICY

I acknowledge that personal information provided herein will be used by HIF to deliver the products and services of my membership. All information will remain confidential. This information may be disclosed to third parties and authorised Government Agencies to deliver services associated with my health insurance. Failure to provide personal information may result in the failure to process or deliver the service requested. I confirm that the information supplied on this application form is provided with the consent of those individuals listed and includes consent from those individuals to act on their behalf.

APPLICATION

I declare that all details are true and correct and agree to be bound by the rules of HIF. I understand the Pre-Existing Ailment Rule, Waiting Periods and Benefit Limitations may be applied to my membership. I declare that child dependants aged 21 to 25 years on this membership are attending a full-time course.

I certify that any dates of birth shown on this form are correct. I understand if a date of birth has been stated incorrectly and this resulted in incorrect premiums being paid, HIF reserves the right to deduct the additional premium from the next claim benefit entitlement or to adjust my next payment amount.

Signature Date (dd/mm/yy) / /

Referred by Member No

Special Offer Code (if applicable)

If you require assistance to complete your Application Form, please phone HIF on 1300 13 40 60 and speak to a Sales Consultant.

Completed Application Forms can be dropped off in person at any HIF Branch or mailed to HIF at GPO Box X2221, PERTH WA 6847.

I hereby opt out of receiving marketing materials from HIF and understand that this will include special offers from Alliance Partners and Internal HIF Promotions.

CHECKLIST

- | | | |
|--|--|---|
| <input type="checkbox"/> A. Member Details | <input type="checkbox"/> D. Type of Cover | <input type="checkbox"/> F. Switching Funds completed |
| <input type="checkbox"/> B. Details of all persons to be covered | <input type="checkbox"/> E. Private Health Insurance Rebate completed | <input type="checkbox"/> G. Payroll Deduction |
| <input type="checkbox"/> C. Spouse / Partner Authority signed (where applicable) | <input type="checkbox"/> Medicare card information completed. | |
| <input type="checkbox"/> Declaration Signed and Dated | <input type="checkbox"/> Supporting documentation attached if new resident | |

G. PAYROLL DEDUCTION

MEMBER DETAILS

Title First Name Surname

Birth Date (dd/mm/yy) / /

PAYROLL DETAILS

Employee Name

Name of Council Department

Payroll ID Number

DEDUCTION AUTHORITY

I hereby authorise and request you to arrange deductions from my salary / wages / superannuation for the amount of

\$ per HIF Table

Should HIF alter the contribution rate of the table under which I am covered, the amount deducted from my salary / wages / superannuation is to be varied accordingly.

Signature Date (dd/mm/yy) / /