HCF CORPORATE Corporate application for health insurance

(Please mark 'X')

- Join HCF health fund – new to private health insurance (complete sections 1-8, excluding 7) ☐
- Transfer to HCF health fund from another fund (complete sections 1-8) ☐
- Add people to my membership (complete sections 1a, 2 and 8) ☐
- Change my level of cover (complete sections 1a, 3 and 8) ☐
- Change my payment details (complete sections 1a, 6 and 8) ☐

Office Use Only
Feb 15
Corp Source code
Deal code
Rate code
Sales Source code

HCF Membership No.

1 a) Your personal details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

To be completed by the Policyholder – see section 8 for definition

Title | First name | Middle initial

Surname | Sex (Please mark 'X') M ☐ F ☐

Home address:
Unit No. | Street No. | Street name

Suburb | State | Postcode

Phone - home | Phone - work | Mobile

Postal address (if different from your home address)

Suburb | State | Postcode

Email

Date of birth (DD MM YYYY) | Date you wish your membership to commence (DD MM YYYY)

b) Choose your cover requirement (Please mark 'X')

- Single (go to Section 3) ☐
- Couple/Family (go to Section 2) ☐
- Single Parent Family (go to Section 2) ☐
- Extended Family Cover (go to Section 2) ☐
- Retain my existing products ☐

2 Other persons to be covered (Use another form if space is insufficient)

If you are unsure of who can be covered on your membership, refer to the HCF Corporate Products Brochure

First name | Surname | Date of birth (DD MM YYYY) | Sex (Please mark 'X') M ☐ F ☐ | Relationship

First name | Surname | Date of birth (DD MM YYYY) | Sex (Please mark 'X') M ☐ F ☐ | Relationship

Office Use Only

First name

Surname

Date of birth (DD MM YYYY)

Sex (Please mark 'X')
M ☐ F ☐

Relationship

First name

Surname

Date of birth (DD MM YYYY)

Sex (Please mark 'X')
M ☐ F ☐

Relationship

3 Product choices (Please mark 'X')

Hospital Cover Options

		Hospital excess options	
☐ Corporate Basic Hospital		$250 ☐	$500 ☐
☐ Corporate Mid Hospital	Nil ☐	$250 ☐	$500 ☐
☐ Executive Hospital	Nil ☐	$250 ☐	$500 ☐
☐ Ultimate Hospital	Nil ☐	$250 ☐	$500 ☐

Extras Cover Options

☐ Basic Extras ☐ Lifestyle Plus

☐ Lifestyle Essentials ☐ Ultimate Extras

☐ Active Lifestyle

Additional Cover – Cash Assist

(See pages 36-41 of the HCF Corporate Products Brochure for further information)

☐ Cash Back Cover

☐ Permanent Disability Benefit Plus*

☐ Kids' Accident Cover†

*Name of person to be covered by Permanent Disability Benefit Plus

†Name/s of children to be covered by Kids' Accident Cover

(Use another form if space is insufficient)

4 Australian Government Rebate as reduced premiums

If all people on this health policy are listed on a Medicare Card or entitled to a Medicare card, you may apply for the Australian Government Rebate on private health insurance as a reduced premium. Please complete the relevant details below:

Your Medicare card number

Sex (Please mark 'X')
M ☐ F ☐

Date of birth (DD MM YYYY)

Your name as it appears in the Medicare card

First name

Surname

Nominate your rebate tier (for information, refer to page 49 of the HCF Corporate Brochure).

Age	No Tier	Tier 1	Tier 2	Tier 3
Under 65	29.040% ☐	19.360% ☐	9.680% ☐	0% ☐
65-69	33.880% ☐	24.200% ☐	14.520% ☐	0% ☐
70+	38.720% ☐	29.040% ☐	19.360% ☐	0% ☐

5 Reimbursing of claims

To have your claims paid directly into your bank account, please complete the following:

Account name

BSB No.

Account No.

6 Payment method (Please mark 'X')

HCF offers you a number of easy ways to pay your premiums. Please fill out one of the options below to pay your premiums automatically.

Ezipay Direct Debit (please complete Section 6a) ☐

Credit Card Authority (please complete Section 6b) ☐

Group Payroll Deduction (please complete Section 6c) ☐

a) Ezipay Direct Debit Request

I/We authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from my/our account and as prescribed below through the Bulk Electronic Clearing System (BECS).

(Please mark 'X')

Weekly ☐ Fortnightly ☐ Monthly* ☐ Quarterly* ☐ Half yearly* ☐ Yearly* ☐

Please debit on the ____ day* of the month. First debit* to occur on (DD MM YYYY) ____

(*Please nominate a day and note that the 28,29,30 and 31 dates are only available for weekly and fortnightly debits.)

Details of account to be debited (all details must be supplied)

Name of financial institution

BSB No.

Account No.

Branch

Account holder name (first initial and surname)

This authorisation is to remain in force in accordance with the terms described in the HCF Direct Debit Customer Service Agreement.

b) Credit Card Authority

Cardholder name (exactly as it appears on your card)

Type of card (Please mark 'X')

Visa ☐ Mastercard ☐ American Express ☐

Debit frequency (Please mark 'X')

Fortnightly* ☐ Monthly* ☐ Quarterly* ☐ Half yearly* ☐ Yearly* ☐

Credit card No.

Expiry date (MM YY)

Please debit my account on the ____ day* of the month

(*Please nominate day: **Debit dates of 28, 29, 30 and 31 are not available**)

This authorisation is to remain in force in accordance with the terms described in the HCF Direct Debit Customer Service Agreement.

c) Group Payroll Deduction Authority

Payroll deductions are available only when your employer has an arrangement with HCF.

Employer's name

Payroll or employee ID

I hereby authorise my employer to deduct from my wages or salary. (Please mark 'X')

Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Yearly ☐

Employee's details

Title

First name

Middle initial

Membership No. (if already a member)

Surname

Date marking the end of the first deduction pay period (DD MM YYYY)

Total contribution deductions (if known)

Health **$**

Cash Assist **$**

Total $

Other contribution details

If you wish to pay for other HCF memberships please give their details below:

Membership No.

Surname

Membership No.

Surname

7 Interfund transfer (Complete this section if you have been registered with an Australian Registered health fund at any time since 1 July 2000)

Complete the following details and we'll take care of the transfer for you.

I authorise HCF to terminate my membership with my existing health fund and obtain details concerning (Please mark 'X'):

Myself ☐ All persons covered ☐

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 paywroll deduction) to cancel your deductions.

Title | First name | Middle initial | Date of birth (DD MM YYYY)

Surname

Name of existing health fund | Membership No.

Home address:

Unit No. | Street No. | Street name

Suburb | State | Postcode | Cancellation effective from (DD MM YYYY)

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

Existing fund policy owner signature

Signature x

8 Declaration (Please read and sign)

I acknowledge and agree that:

- I have the authority to act on behalf of other persons to be covered under the policy, to provide their information (including sensitive information) and to receive from HCF their information for the purposes of the policy;
- I am the policyholder who is responsible for payment of the contribution rates, the ongoing maintenance of the policy, and the receipt of all policy correspondence;
- I am bound by the Health Fund rules of The Hospitals Contribution Fund of Australia Limited (available in HCF branches); and
- HCF deals with personal information of all members in accordance with the HCF Privacy Policy (available on the HCF website and from HCF branches) and I have informed them of this.

I confirm that I have read and understand:

- this declaration and the information relating to my product choice and members' privacy (including the HCF Privacy Policy at hcf.com.au and the Privacy Statement in the HCF Corporate Brochure); and
- the Product Disclosure Statement and Financial Services Guide provided to me with this application, for any Cash Assist options I have chosen.

I authorise payment by the method indicated on the form and have the authority to do so.

I agree that my insurance will commence once my application is accepted.

I declare the information provided to be true and complete.

Signature x | Date (DD MM YYYY)