

# Online Application for health cover



I wish to: (Please mark X)  Join HCF.  Transfer from another fund (Complete Interfund Transfer section).  Change people covered, membership details or present cover.

Source R20802	Deal code FNR	Rate code 20
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FNR G111670 Mar 2010-v.1

## Your personal details. Please use capital letters

Title Given names

Surname Current HCF Membership or Covernote No. Sex M  F

Home address (Please complete your street number, name and suburb)

Postcode Phone work Mobile Phone home

Postal address (Please complete your street number, name and suburb)

Postcode Date of birth (Day/Month/Year) Please tick if you would not like to receive either of our free monthly email newsletters

Date you wish your membership to commence Email

Please mark X  Retain my existing products  Single  Couple/Family  Single Parent Family  Extended Family Cover

## Other persons to be covered. Use another form if space is insufficient

<p>Given names</p> <p>Surname</p> <p>Date of birth (Day/Month/Year)</p> <p>Sex Relationship</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p>	<p>Given names</p> <p>Surname</p> <p>Date of birth (Day/Month/Year)</p> <p>Sex Relationship</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p>
<p>Given names</p> <p>Surname</p> <p>Date of birth (Day/Month/Year)</p> <p>Sex Relationship</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p>	<p>Given names</p> <p>Surname</p> <p>Date of birth (Day/Month/Year)</p> <p>Sex Relationship</p> <p>M <input type="checkbox"/> F <input type="checkbox"/></p>

## Federal Government Rebate

Complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply. Are all people on your membership eligible for full Medicare Benefits?

Yes - Please complete the remainder of this section  No - You cannot apply for the rebate.

Your Medicare card number Date of birth (Day/Month/Year)

Your name exactly as it appears on your Medicare card

## Rebating of claims

If you would like your claims benefit paid directly into your account, please complete the following details:

Account name BSB number Account number



**Interfund transfer** Use another form if space is insufficient

Complete this section if you have been with an Australian Registered health fund at any time since 1/7/2000.

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 payroll deduction) to cancel your deductions. Remember also to sign the Declaration section.

Title	Given names	Name of existing health fund
<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	Membership number	
<input type="text"/>	<input type="text"/>	
Home address (Please complete your street number, name and suburb)		
<input type="text"/>		
<input type="text"/>		Postcode <input type="text"/>
Date of Birth (Day/Month/Year)		I hereby authorise HCF to terminate my membership with your organisation and obtain details about my membership.
<input type="text"/> / <input type="text"/> / <input type="text"/>	Signature <input type="text"/>	Date <input type="text"/> / <input type="text"/> / <input type="text"/>

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



Please complete the application and payment authority and return to:

Health Link Consultants  
PO Box 13107, Law Courts VIC 8010  
Phone: (03) 9670 5555  
Freecall: 1800 808 026