

# Personal Review Request

## 1 Personal details

Surname:

.....

Given Name:

.....

Date of Birth:

Partner's Date of Birth:

.....

Contact Phone:

.....

Email Address:

.....

Postal Address:

.....

State:

Postcode:

.....

University:

.....

## 2 Tell us about your current health insurance

Name of current health fund:

.....

Current premium:

\$ ..... per

.....

Level of cover:

.....

Do you have a Lifetime Health Cover Loading?

No

Yes



..... % (If known)

## 3 Tell us what type of cover are you interested in?

Family

Couple

Single

Single parent

Hospital

Extras

Both

## 4 Cover options

Hospital cover - Tick your preferences

|                                    | Private hospital required | Public hospital only     | Don't need cover         |
|------------------------------------|---------------------------|--------------------------|--------------------------|
| Maternity / Obstetrics             | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Assisted Reproductive Services     | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Reconstruction (i.e. Knee)   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement (i.e. Hip)       | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Surgery (e.g. Cataract)        | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric Services               | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Dialysis for Chronic Renal Failure | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Services / Coronary Care   | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |

Extras cover - Tick your preferences

|                           | Must have                | May need                 | Don't need               |
|---------------------------|--------------------------|--------------------------|--------------------------|
| General Dental Treatment  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Major Dental treatment    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Orthodontic               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Optical                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Naturopathy               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Acupuncture               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physiotherapy             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Podiatry                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chiropractic / Osteopathy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: .....              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## 5 Return the form

Post: Reply Paid 13107  
Health Link Consultants  
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Law Courts VIC 8010

Fax: 03 9642 8999

Email: [advice@health-link.com.au](mailto:advice@health-link.com.au)