Clearance Certificate Request

healthcare insurance

You need only complete this section if you or somebody covered by your Health Care Insurance membership is transferring from another health fund. When we receive your form, Health Care Insurance will cancel your existing health fund membership for you and request a Clearance Certificate. If you have a direct debit or payroll deduction arrangement with your existing fund, **please remember to personally cease the arrangement**. Remember also to sign the authorisation below. We need the Clearance Certificate from your current fund in order to ensure that waiting periods, benefit entitlements and Lifetime Health Cover loading and days of absence (if any) are correctly identified.

Title **Date of birth** / / **Sex** ☐ Male ☐ Female

Surname **Given Names**

Postal address

Other persons to be transferred

Name 1

Name 2

☐ All other persons as listed on the policy.

Name of existing health fund

Current Level of cover

Previous member number

Date to which health cover is paid to / /

I hereby authorise Health Care Insurance to cancel my membership from / / and obtain details about my membership.

I request a refund for any premiums paid in advance of my termination date / /

☐ Please do not contact me further about this request.

Policy Holder's Signature **Date** / /

The signatory above must have legal responsibility for the health cover at the 'existing fund'.

Partner's Signature (if required) **Date** / /

The signature is required if your partner is covered on the health cover at the 'existing fund'.

I further request you to forward a Clearance Certificate directly to
Health Care Insurance Limited,
PO Box 931,
Burnie, Tas, 7320.
enquiries@hciltd.com.au
Freefax 1800 643 969

Before you send please check

☐ I have completed all the sections and signed all the signature boxes relevant to my application, including the Declaration.

Office Use Only

Member number

Payroll Group (if applicable)

Staff Signature **Date processed** / /