GUIDE TO COVER

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The right cover.

Value for money.

Live the now.

Peace of mind.

healthcare insurance

That's my HCI

Contents

Your guide to Health Care Insurance Membership

Health Care Insurance (HCI) extends a warm welcome and thanks you for choosing to explore the many benefits of becoming a member.

As a not-for-profit private health insurer, we are proud of the high level of personal service provided to members and the comprehensive range of health insurance options offered at very competitive rates.

HCI cover provides access to the very best in hospital care and other health care services including dental, optical, physiotherapy, chiropractic and many more.

The information in this Guide is a summary of the rules and policies of HCI and has been designed to clearly explain many of the entitlements and benefits available to you as a member. You should read carefully all documentation provided about your membership and retain for future reference. HCI reserves the right to change the rules at any time. We will advise you of any changes as soon as possible.

For more information or assistance in choosing the right health cover for you, contact us:

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hciltd.com.au

Why have private health cover?

Peace of mind

Protecting and ensuring the health of you and your family is most important. Private health insurance gives you financial peace of mind in knowing that you have guarded against large and unexpected hospital, medical and other health care bills. For those who are on high incomes, private health insurance also helps you avoid paying an additional Medicare Levy Surcharge.

Hospital treatment

Medicare covers you for hospital and medical costs in a public hospital as a public patient. You have no choice of doctor and will usually be treated in a shared ward. In many cases, especially for elective surgery, there may be a substantial waiting time for the type of treatment you need.

By taking out private hospital insurance with HCI, you can be sure that if you or your family require hospital treatment you will have greater control over who, where and when you are treated. In most cases, the waiting time for elective surgery will be significantly less than the public system. HCI provides access to over 500 private hospitals and day hospital facilities and more than 16,000 doctors across Australia.

Other health care treatments

Medicare does not cover the cost of treatment for dental, optical, physiotherapy, chiropractic and many other non-medical type services. HCI offers you extras cover options which are designed to help offset the costs of these non-medical health services.

Lifetime Health Cover (LHC) loading

The aim of the Federal Government's Lifetime Health Cover (LHC) initiative is to encourage people to take out private health insurance hospital cover early in life. If you join earlier in life and continue private hospital cover, you will be rewarded with lower contributions than those who join later in life.

LHC is a financial loading that can be payable in addition to the base rate premium for your private health insurance hospital cover.

To avoid paying a LHC loading, you need to purchase hospital cover by 1 July following your 31st birthday. If you purchase hospital cover after this date you may be required to pay a LHC loading – 2% for each year you are over 30. For instance, if you wait until you are 40, you could be paying an extra 20% on the cost of your hospital cover. If you wait until you are 50, you could pay 40% more. And so on, up to a maximum of 70%. For more information on the LHC, please refer to page 20.

Private Health Insurance Rebate

The Federal Government introduced the Private Health Insurance Rebate to make private health insurance more affordable for Australians who chose to take out private health cover.

Who is eligible for the Rebate?

Most Australians with private health insurance receive a rebate from the Australian Government to help cover the cost of their premiums. However, from July 1 2012 the private insurance rebate is income tested. The rebate applies to hospital and general treatment policies. Please refer to page 19 for more information.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a levy on taxable income of up to 1.5% depending on your level of income. The MLS applies if you do not have an appropriate level of hospital cover and your annual adjustable taxable income exceeds the limit set by the Federal Government. Please refer to page 19 for more information or alternatively visit our website **hciltd.com.au**

Choosing your health cover

Health cover to suit you

Health Care Insurance (HCI) understands what is important to you. Whatever stage you are at its nice to know you and your family have a reliable friend in HCI.

Choose from the following membership categories:

- **Single** covers only one person.
- **Couples** covers you and your partner.
- **Family** covers:
  - you and your partner
  - your children including stepchildren and legally adopted children who are not married or living with a partner up to their 23rd birthday.
  - your children who are full-time students at any school, college or tertiary educational institution in a course approved for the purpose of the Student Youth allowance or any allowance that replaces it. Up to the end of the year of their 25th birthday.
- **Family Dependant Plus** covers:
  - you and your partner
  - your children including stepchildren and legally adopted children who are not married or living with a partner, up to their 25th birthday.
- **Single Parent** covers:
  - you
  - your children including stepchildren and legally adopted children who are not married or living with a partner up to their 23rd birthday.
  - your children who are full time students at any school, college or tertiary educational institution in a course approved for the purpose of the Student Youth Allowance or any other allowance that replaces it. Up to the end of the year of their 25th birthday.
- **Single Parent Plus** covers:
  - you
  - your children including stepchildren and legally adopted children who are not married or living with a partner up to their 25th birthday.

Types of cover

Extras cover

You will be impressed by the generous range of extras including dental, optical, alternate therapies and orthodontics.

HCI has two Extras cover options available:

Premier Extras provides comprehensive cover over an extensive range of services.

Active Life Extras is tailored to give you cover for what you need without breaking the budget. You can combine it with our Premier Hospital for a more comprehensive cover.

Refer to page 5 for a summary of the services that are included under HCI's extras cover options. For more information on the annual limits and services please refer to page 6-9.

Premier hospital cover

We offer comprehensive hospital cover with no excess on day surgery or child admission. That's peace of mind. For more information on hospital cover please refer to page 10.

Packaged cover

Premier Package

For the reassurance of comprehensive cover for you and your family, our Premier Package combines all the benefits of our Premier Hospital Cover including the excess options, with our Premier Extras Cover.

Active Life

You can combine Active Life Extras with our Premier Hospital cover including the excess options, which will provide the security of comprehensive hospital and the tailored benefits of Active Life Extras.

Extras cover

Services	Premier Extras	Active Life Extras
Acupuncture	✓	✓
Ambulance	✓	✗
Audiology (Hearing Tests)	✓	✗
Chiropractic	✓	✓
Dental – General	✓	✓
Dental – Major (excl. Orthodontics)	✓	✓
Diabetes Education	✓	✗
Diabetes Australia Membership	✓	✗
Dietetics	✓	✗
Eye Therapy (Orthoptics)	✓	✗
Funeral [+] (eligible members only)	✓	✗
Health Screening Checks	✓	✗
Hearing Aids	✓	✗
Home Nursing	✓	✗
Hydrotherapy	✓	✗
Laser Eye Surgery	✓	✗
Medical Appliances	✓	✗
Natural Therapy (incl. Remedial Massage) *See separate table below*	✓	✓
Non-surgical Prostheses	✓	✗
Occupational Therapy	✓	✗
Optical	✓	✓
Orthodontics	✓	✗
Orthotics	✓	✗
Osteopathy	✓	✓
Pharmacy	✓	✗
Physiotherapy	✓	✓
Podiatry / Chiropody	✓	✗
Psychology	✓	✗
Quit Smoking Programs	✓	✗
Speech Therapy	✓	✗
Surgical Footwear	✓	✗
Travel and Accommodation *	✓	✗
Weight Loss Programs	✓	✗

* When taken with a hospital cover (for full details refer to page 7)
[+] Please refer to page 9 for special conditions relating to the funeral benefit

Natural Therapy includes:

- Alexander technique
- Aromatherapy
- Bowen Therapy
- Chinese herbal medicine (Consultation only)
- Chiropractor
- Feldenkrais
- Homeopathy
- Iridology
- Kinesiology
- Massage
- Myotherapy
- Naturopathy
- Osteopathy
- Reflexology
- Rolfing
- Shiatsu

Annual Limits and Services

An Annual Limit is the maximum amount of benefits that can be claimed for an individual or group of services within a calendar year. The limits are per person on the policy unless stated otherwise. A service limit is the maximum number of services that can be claimed for an individual service or group of services within a calendar year.

Benefits are payable at 100% of cost up to the service limit unless otherwise specified.

Services	Extras levels of cover	
	Premier	**Active Life**
Ambulance		
For emergency transport provided by a registered ambulance provider within Australia	Cost	No cover
Alternative Therapies Group Annual Limit	**$500**	**$400**
Chiropractic		
- Annual Limit	$500	$400
- Consultations	$33	$22
- X-Rays	$65	$30
Osteopathy		
- Annual Limit	$500	$400
- Consultations	$33	$22
Acupuncture		
- Annual Limit	$500	$400
- Consultations	$33	$22
Natural Therapy (including massage)		
- Annual Limit	$500	$400
- Consultations	$33	$22
Dental Treatment		
Benefits are paid according to the Australian Dental Association item number used. Benefits are payable at 90% of cost to a set maximum per item. For itemised quote please contact us.		
General Dental Annual Limit	**No Limit**	**$500** (Including major dental)
The maximum number of services in which a benefit will be paid on items 011 - 015 in total is 2 per year and 016 - 017 in total is 2 per year.		
Item 011 - comprehensive oral examination	$38	$27
Item 121 - topical application of remineralisation agent	$22	$13
Item 311 - removal of a tooth	$105	$70
Item 511 - metallic filling 1 surface	$104	$57
Major Dental		
Crowns and Bridgework	up to $1,000	up to $500 (Included in overall dental limit)
Periodontics	up to $700	up to $500 (Included in overall dental limit)
Implants	up to $1000	up to $500 (Included in overall dental limit)
Dentures - (benefits are payable every 2 years)	up to $1200	No cover
Orthodontics		
- Lifetime Limit	$2,700	No cover
- Annual Limit per person	up to $900	No cover

Services	Extras levels of cover	
	Premier	**Active Life**
Hearing Tests and Appliances		
Hearing Aids		
Appliance limit every 3 years with a benefit payable of 90% of cost for:		
- Single hearing aid	up to $1,200	No cover
- Bilateral hearing aid	up to $2,000	No cover
- Repairs (per year)	up to $120	No cover
Audiology (hearing tests)		
- Annual Limit	$200	No cover
- Initial Consultation	$50	No cover
- Subsequent Consultations	$40	No cover
Home Nursing		
For a visit by a home nursing provider approved by the Fund. Visit/treatment must be prescribed by a doctor.		
- Annual Limit	$500	No cover
- Per Visit	$25	No cover
Laser Eye Surgery (LASIK and ASLA eye surgery)		
For laser eye surgery performed in a recognised day surgery facility registered for operation in a State. Annual maximum benefit entitlements per person increase with each completed year of membership, as follows:		
1 year	Nil	No cover
2 years	90% of cost up to $500	No cover
3 years	90% of cost up to $750	No cover
4 + years	90% of cost up to $1000	No cover
Life Choices Annual Limit	**$350**	**No Cover**
Quit Smoking Programs Programs must be approved by the Fund.	90% of cost up to $150	No cover
Weight Loss Programs Programs must be approved by the Fund.	90% of cost up to $150	No cover
Diabetes Education		
- Annual Limit	$200	No cover
- Consultation	$20	No cover
Diabetes Australia Membership	$36	No cover
Health Screening Checks For health checks that are not eligible for Medicare benefits. Screening services must be approved by the Fund.	90% of cost up to $250	No cover
- Annual Limit	$100	No cover
- Per Service		
Medical Appliances (limit for same appliance every 3 years)		
Medical Appliances* Prescribed by a specialist or doctor, including tens machine, nebuliser, glucose monitor, blood pressure monitor.	90% of cost up to $500	No cover
CPAP machine*	90% of cost up to $700	No cover
Non-surgical Prostheses*		
Items prescribed by a specialist or doctor, including breast prosthesis and surgical stockings	90% of cost up to $200	No cover

*** letter required from referred specialist**

Extras cover continued

Services	Extras levels of cover	
	Premier	**Active Life**
Optical		
Annual Limit for supply of glasses and contact lens	**$250**	**$220**
- Single Vision	$200	$170
- Bifocal	$220	$190
- Multifocal	$250	$220
- Contact lenses - 90% of the cost	up to $225	up to $180
Annual Limit for repairs to glasses	**$50**	**$50**
Other Therapies Annual Limit	**$1,000**	**No cover**
Podiatry / Chiropody		
- Annual Limit	$300	No cover
- Initial Consultation	$30	No cover
- Subsequent Consultations	$27	No cover
- Nail surgery (excludes inpatient services)*	$100	No cover
Orthotics Annual Limit	$200	No cover
Orthotic Casting Annual Limit	$100	No cover
Eye Therapy (Orthoptics)		
- Annual Limit	$375	No cover
- Initial Consultation	$30	No cover
- Subsequent Consultations	$25	No cover
- Group Session	$10	No cover
Speech Therapy		
- Annual Limit	$375	No cover
- Initial Consultation	$50	No cover
- Subsequent Consultations	$30	No cover
- Group Session	$10	No cover
Dietetics		
- Annual Limit	$200	No cover
- Initial Consultation	$35	No cover
- Subsequent Consultations	$30	No cover
Occupational Therapy		
- Annual Limit	$375	No cover
- Initial Consultation	$40	No cover
- Subsequent Consultations	$30	No cover
- Group Session	$10	No cover
Pharmacy	**$1,000**	**No cover**
- Per Script	$100	No cover
100% less the applicable co-payment amount. The applicable co-payment is equivalent to the maximum cost for a pharmaceutical benefit item for a general patient under the pharmaceutical benefits scheme as determined by the Federal Government each year. Benefits are excluded for items that can be obtained without a prescription, contraceptives, anabolic steroids and drugs not approved in Australia.	An Annual Limit of $600 applies for prescriptions for the following conditions: weight loss, baldness and male erectile dysfunction	No cover
- Medical Botox (For treatment of a medical condition only.)		
60% of cost up to annual limit.	$600	No cover

*** letter required from referred specialist**

Services	Extras levels of cover	
	Premier	Active Life
Physiotherapy Group Annual Limit	**$750**	**$400**
Physiotherapy		
- Annual Limit	$700	$400
- Consultation	$33	$22
- Group Session	$15	$10
Hydrotherapy		
- Annual Limit	$300	No cover
- Consultation / Treatment	$15	No cover
Psychology	**$250**	**No cover**
- Initial Consultation	$60	No cover
- Subsequent Consultations	$50	No cover
- Group Session	$20	No cover
Surgical Footwear & Custom made support appliances		
For surgical footwear and custom made support appliances prescribed by a specialist or doctor and individually made by a provider approved by the Fund.	90% of cost up to $1,000	No cover
Funeral (eligible members only)*		
This benefit is only payable to members who had entitlement under the Rules in force prior to 1st April 2007. A benefit is payable to eligible members following the death of a member or dependent (refer waiting period).	$1,150	No cover
Travel and Accommodation		
Only payable if taken with a hospital cover. Benefits payable when attending a medical specialist or hospital more than 50kms from normal place of residence within home State.		
Accommodation - per night	$50	No cover
Travel - per km	15 cents	No cover
Travel and Accommodation		
- Maximum Per Trip per person	$125	No cover
- Annual Limit per person	$300	No cover
- Annual Limit per family	$800	No cover

***Note:** Federal Government legislation introduced on 1st April 2007 prohibits health funds from offering funeral benefit as an item in a complying health insurance product attracting the Government rebate. Consequently, members who joined the Premier Extras product on or after 1st April 2007 are not eligible to claim this benefit.

Hospital cover

When you purchase HCI hospital cover, you have the confidence to say 'yes' to treatment in a private hospital or treatment as a private patient in a public hospital.

HCI Premier Hospital does not have exclusions or benefit limitations for treatment that is clinically necessary and eligible for Medicare benefits. If you have served the relevant waiting periods and any other standard conditions - you're covered.

When deciding what level of hospital cover is best for you, you should consider the following information about treatment options:

A public patient in a public hospital

As an Australian resident, Medicare entitles you to free treatment in a public hospital by a doctor appointed by the hospital at a date and time suitable to the hospital.

A private patient in a public hospital

If you decide to be treated as a private patient in a public hospital, you have the right to choose the doctor who treats you and a private room if available, but there is no guarantee you will be able to avoid the public hospital waiting lists.

A private patient in a private hospital

As a private patient in a private hospital, you will usually gain immediate access to hospital services and be able to choose the doctor who treats you at a time that is convenient to you.

Agreement Hospitals

HCI has entered into agreements with over 500 private hospitals, same day and day hospital facilities around Australia.

For details of contracted hospitals, visit our website at: **http://www.hciltd.com.au/hospital-search**

What is covered:

Up to 100% of the cost of hospital accommodation and theatre fees in all contracted hospitals and day surgery facilities in Australia.
Up to 100% of the cost of surgically implanted prostheses (as listed by the Federal Government).
Private room accommodation (if available).
Up to 100% of the cost of most hospital prescriptions relating to the admission. (Subject to hospital agreement details).
Dental theatre costs for surgical tooth extraction by an oral surgeon.
100% of the cost of the difference between the Medicare refund and the Commonwealth Medical Benefit Scheme (CMBS) fee for medical services provided during a hospital admission.
Up to 100% of the cost of medical services provided during a hospital admission where the doctor charges above the Commonwealth Medical Benefit Scheme (CMBS) fee and chooses to use Access Gap Cover.

What is not covered:

Cosmetic surgery.
Charges for extra services such as physiotherapy not included in the hospital agreement.
Personal expenses such as phone calls.
Hospital benefits where the professional service performed is not eligible for Medicare benefits.
Pharmaceutical items supplied or prescribed on discharge.
Medical Gap.
Surgically Implanted Prosthesis Gap
Medical treatment provided to you whilst you are **not** in hospital, such as surgical procedures conducted in a doctors' room

Doctors' fees, medical gap, out of pockets and Access Gap Cover

Other than the items listed above under "What is not covered" if you are a private patient in a public or private hospital, HCI pays benefits for treatment provided to you by a doctor whilst you are in hospital. However the Federal Government's Commonwealth Medical Benefits Schedule (CMBS) specifies how much both Medicare and HCI pay for that treatment. Indicatively Medicare pays 75% of the amount specified in the schedule and HCI pays 25%.

If your doctor chooses to charge above the CMBS fee you may have to pay the medical gap or "out of pockets" which is the difference between the total fee charged by the doctor and the CMBS fee. HCI does not pay a benefit on out of pockets.

It is in your interest to discuss the issue of fees with your doctor to determine whether they will use HCI's Access Gap Cover which will minimise or eliminate your medical out-of-pocket costs.

Access Gap Cover for cover for medical care in hospital

Should you ever need specialist care in hospital, your doctor can now provide a much simpler billing system by choosing to use HCI's Access Gap Cover.

If your Doctor uses the scheme, you will either:

- Have no out-of-pocket expenses; or
- You will know exactly how much you will have to pay before treatment begins.

Also, your doctor can bill HCI direct, saving you from having to claim from Medicare and HCI yourself.

It is your doctor's choice to use Access GAP Cover. Your special relationship with your doctor and the treatment you receive will not change.

Questions to ask each Doctor…

- Will you treat me under Access Gap Cover?
- Will I have any out-of-pocket expenses, and if so, can you provide a written estimate of how much?
- Will any assisting doctors also use Access Gap Cover and if so, how can I obtain a quote for their services?
- Are you prepared to send the bill to HCI directly?

See **http://www.hciltd.com.au/doctors-search** for registered participating doctors. Lists are subject to change and are updated regularly.

Surgically implanted prostheses

A prosthesis is an artificial substitute for a missing body part, used for functional or cosmetic reasons or both. Surgically implanted prostheses are sometimes required during a medical procedure, such as a replacement lens for a cataract surgery, an artificial hip joint, a pacemaker, or a heart valve.

For medical procedures covered by the Medicare Benefits Schedule (MBS), HCI will fully cover the cost of at least one prosthesis, if required (called a 'no gap' prosthesis).

In some cases, an alternate prosthesis may be available which costs more than the 'no-gap' version. If one of these prostheses is used, you will have to pay the difference between the 'no gap' amount and the total amount charged by the supplier for the prostheses.

The Prostheses Schedule lists prosthetic items, the costs of which will be covered 100% by health funds (no gap) and items that may require you to meet part of the cost (gap).

It is recommended that if you require surgery involving a surgically implanted prosthesis, discuss with your specialist doctor the option of using the prosthesis listed as a no gap item.

Hospital cover excess options

By choosing to include an excess in your hospital cover, the amount you pay will be reduced. The larger the excess, the lower the premium.

Please note the following features about HCI's excess options.

- There is no excess payable on day only admissions.
- There is no excess payable for dependant children under the age of 18 years who are admitted to hospital..
- The excess per adult is the maximum payable in any calendar year.
- If a person covered is under the age of 18 on a single or couple policy they will be required to pay the excess.

The following excess options are available with Premier Hospital or Premier Package:

Membership Category	Per adult excess			Application of Hospital Treatment Excess
	$250	$500	$1000*	Note the maximum excess per policy for all categories except Single is double the adult excess.
Single	✓	✓	✓	The excess payable when admitted to hospital overnight.
Couple	✓	✓	✓	The excess for each person admitted to hospital overnight.
Family	✓	✓	✓	The excess for each of the first two adults admitted to hospital overnight.
Family Dependant Plus	✓	✓	✓	The excess for each of the first two adults admitted to hospital overnight.
Single Parent	✗	✓	✗	The excess for each of the first two adults admitted to hospital overnight. The excess is restricted to $500 per adult.
Single Parent Plus	✗	✓	✗	The excess for each of the first two adults admitted to hospital overnight. The excess is restricted to $500 per adult.

* Not exempt from Medicare levy surcharge

Waiting periods

What are waiting periods?

A waiting period is an initial period of health insurer membership during which no benefit is payable for certain procedures or services. Waiting periods can also apply to any additional benefits when you change (upgrade) your health insurance policy.

Why do waiting periods apply?

In Australia, all health insurers are required by law to provide health insurance for Australian residents regardless of their health status and cannot charge higher premiums based on whether a person is more likely to require treatment. If there were no waiting periods, people could take out hospital insurance or upgrade to a higher policy only when they knew or suspected they might need hospital treatment. Their hospital costs would then have to be paid by the long-term members of the insurer. This would lead to much higher premiums for all insurer members and would not be fair.

Do all health insurers apply the same waiting periods?

Most insurers apply the same waiting periods for hospital policies, but waiting periods do differ between insurers for general treatment (extras).

Benefit limitation periods

Some insurers also apply Benefit Limitation Periods for some types of treatment on some of their hospital policies. These are initial periods of membership during which only a minimal benefit is paid for some types of treatment. HCI does not have any Benefit Limitation Periods included in its hospital products.

First-time health cover

If you are taking out private health insurance for the first time, you will be required to serve full waiting periods before benefits can be paid.

Transferring from another health fund (portability)

If you already have health cover with another health fund, you can transfer to HCI at any time.

If you join within 2 months of the expiration of your cover with your previous fund, you will not have to serve any new waiting periods for the same or lower level of cover with HCI.

HCI's normal waiting periods will be applied, including the pre-existing ailments rule, to benefits not covered by your previous fund cover. Under the Federal Government's Lifetime Health Cover initiative, your "certified age at entry" with your previous fund will be recognised by HCI if you join immediately after the expiration of your cover with your previous fund.

Accidents

There is no waiting period for treatment as a result of an accident sustained after joining us. An accident is categorised as an unforeseen event or incident which results in an injury and requires immediate treatment.

Changing your HCI cover

You can vary your level of cover to meet your changing needs at any time. If you increase your level of cover by adding a new benefit type, or by increasing your benefit level, or moving from an excess product to a lower or excess free product, waiting periods will apply to the higher benefits of your new cover. You will, however, be entitled to the benefit levels of your previous cover.

Psychiatric services and rehabilitation

Psychiatric services and rehabilitation only require a 2 month waiting period, even if the condition is pre-existing. This means you can be covered 2 months after commencing a policy.

Pre-existing conditions

If you have less than 12 months membership on your current level of cover, you should contact us on **1800 804 950** before arranging hospital treatment to find out whether the pre-existing condition rule applies to you.

A pre-existing condition is defined as any ailment, illness, or condition where, in the opinion of a medical adviser appointed by the health insurer, the signs or symptoms of that illness, ailment or condition existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. The pre-existing condition waiting period applies to new members and members upgrading their policy to any higher level benefits under the new policy.

The test applied under the law relies on the presence of signs or symptoms of the illness, ailment or condition; not on a diagnosis. It is not necessary for the member or their doctor to know what their condition is, or for it to be diagnosed. In forming an opinion about whether or not an illness is a pre-existing condition, the health insurer appointed medical practitioner who makes the decision must take into account information provided by the member's treating doctor.

Waiting periods continued

Why is there a waiting period for pre-existing conditions?

If there were no waiting period for pre-existing conditions, people could take out hospital cover or upgrade to comprehensive cover only when they knew or suspected that they might need hospital treatment and immediately make a hospital claim. If these new members then ceased their membership or downgraded to a lower level policy, their hospital costs would have to be paid for by the long-term members who remain on their previous hospital policy. This would not be fair to long-term members.

New and upgrading members who do have pre-existing conditions can still seek treatment for these conditions in a public hospital under Medicare.

Key Points for pre-existing conditions

- Only applies to hospital tables.
- It is the health insurer's medical practitioner who decides if an ailment, illness or condition is pre-existing, NOT the member's treating doctor. The insurer's medical practitioner must also consider any information regarding signs and symptoms provided by the treating medical practitioner(s).
- Whether or not a member has a pre-existing condition must always be assessed in relation to that person's individual circumstance. It is not allowable to say that certain conditions are always pre-existing.
- The medical practitioner appointed by the health insurer must be satisfied that there is a direct link between the ailment, illness or condition that requires hospital treatment and the signs and symptoms that existed in the 6 month period prior to the member joining or upgrading hospital cover.
- It is not necessary for the ailment, illness or condition, to have been diagnosed in the 6 month period – only that signs or symptoms were, or would have been, evident.
- These signs and symptoms should have been reasonably apparent to either the member, or a reasonable general practitioner had the member been examined in this 6 month period.

Obstetrics (pregnancy and birth related services - including IVF and assisted reproductive services)

- A 12 month wait applies to any obstetric related services.
- Services which occur outside of a hospital admission, including consultations and tests, may be claimable on Medicare or paid out of your own pocket.
- A person with single membership is eligible for obstetric benefits provided she has been a member of a hospital table for 12 months or more.

Always check with the hospital, HCI and your doctor before proceeding with a hospital booking to ensure you will be covered and to discuss what costs you may incur.

IVF and assisted reproductive technology

In vitro fertilisation (IVF) treatment is a process to treat infertility. IVF and other assisted reproductive services aren't automatically covered on policies that cover natural births and obstetrics. Even on policies which include IVF, the treatment has several steps and only the component which involves an admission to hospital can be covered under private hospital insurance.

Check with HCI before proceeding with IVF or similar treatments to confirm what services you will be required to pay for and that you have completed any required waiting periods. The standard waiting period of IVF treatment is 12 months. Check with your doctor and IVF clinic for more information and quotes.

Waiting periods for new born babies

When a newborn child added is to a family or single parent policy, the child is deemed to have served the same waiting periods as the policy holder, providing that:

- the child is added to the policy within 2 months of their date of birth; and
- all contributions with respect to that policy are paid up-to-date and effective from the date of birth.

Note: Where the policy is a single or couples policy prior to the birth, the addition of the newborn child will require the policy to be upgraded to a family or single parent policy from the date of birth.

If you haven't been covered by family hospital cover for 12 months prior to becoming pregnant, we suggest you give us a call on **1800 804 950** to check you and your baby's benefit entitlements.

Waiting periods

Health Care Insurance applies the following waiting periods:

Hospital treatment or Hospital substitute

Services	Waiting Period (months)
Pre- existing conditions	12
Obstetrics (pregnancy related services)	12
IVF and assisted reproduction technology	12
Sterilisation including reversal	12
Psychiatric Care, rehabilitation or palliative care	2
All other hospital treatment services	2

Extras cover

Services	Waiting Period (months)
Acupuncture	2
Ambulance	2
Audiology (Hearing Tests)	2
Chiropractic	2
Dental – General	6
Dental – Major (incl. Orthodontics)	12
Diabetes Education	2
Diabetes Australia Membership	2
Dietetics	2
Eye Therapy (Orthoptics)	2
First Aid Training	2
Funeral [+] (eligible members only)	120
Health Screening Checks	2
Hearing Aids	24
Home Nursing	2
Hydrotherapy	2
Laser Eye Surgery	12
Medical Appliances	12
Natural Therapy	2
Non-surgical Prostheses	12
Occupational Therapy	2
Optical	6
Orthodontics	12
Orthotics	2
Osteopathy	2
Pharmacy	2
Physiotherapy	2
Podiatry / Chiropody	2
Psychology	2
Quit Smoking Programs	2
Speech Therapy	2
Surgical Footwear	2
Travel & Accommodation *	6
Weight Loss Programs	2

*When taken with a hospital cover (for full details refer to page 9)

[+]Please refer to page 9 for special conditions relating to the funeral benefit

Claiming options

Lodging a claim?

Extras claims

Electronic claiming (HICAPS)

HCI members have access to a simple and convenient way to claim benefits. Electronic claiming systems such as HICAPS lets you claim your extras benefit right there, on the spot, after the consultation with your health service provider such as dentists, optometrists, chiropractors, physiotherapists, podiatrists and a number of other therapies.

With one swipe of your HCI membership card through an EFTPOS style terminal your health service provider can have the cost of your consultation assessed electronically. Based on your level of cover, entitlements will be authorised on the spot. You will need to pay the difference (if any) between your extras benefit, which HCI pays directly to the practitioner, and the fee charged.

To find a practitioner who uses HCI's electronic claiming system, you can search using HICAPS link on our website at **hciltd.com.au**

If your claims are not processed at the point of treatment through an electronic swipe card system such as HICAPS, you can forward your claims to us by:

- **Mail** to PO Box 931 Burnie, TAS 7320
- **Fax** to 1800 643 969
- **In person** at 25 Cattley Street, Burnie
- **Email to** enquiries@hciltd.com.au
- **Smart phone App** - please see our website for more details

In most cases Extras claims are processed on the day they are received, assuming they include all the necessary information.

Lodging a claim

- All accounts and receipts must include the appropriate item number and/or a full description of the services / products being claimed and must be accompanied with a completed claim form.
- All services / products must be provided by practitioners who are operating in private practice and who are approved by HCI.
- Claims must be lodged within 2 years of the date of service.
- Benefit payments are calculated on the date services / products are provided.

Hospital and Medical Claims

Hospital claims

In most cases, when you are discharged from hospital, the hospital staff will forward the account for your hospital treatment direct to HCI. Ask the hospital before you leave.

Medical claims for treatment received whilst in hospital

If you receive bills from your doctor for medical treatment you received whilst in hospital, you must lodge your medical claims at a Medicare office first, before submitting with us.

Please note you cannot claim your out-of-pocket expenses and HCI does not pay benefits for medical treatment provided to you whilst you are not in hospital, such as procedures conducted in a doctor's room.

Receiving benefit payments

You can receive your benefits by:

- **Direct Credit**

  If you have paid the account, your benefit can be paid electronically into your nominated bank account. You will receive separate notification as to the payment details.

- **Cheque**

  If you have paid the account, a cheque will be made payable to you, or if you have not paid the account, a cheque will be made payable to the practitioner who provided the treatment.

Payment options

Paying your premiums

You can select what suits your finances by either paying fortnightly, monthly, quarterly or half yearly.

Direct Debit

You can have your premium automatically debited from your bank, building society, credit union or credit card account. Simply complete the relevant section on the membership application form.

Payroll Deduction

Where your employer offers a payroll deduction facility, you may also be able to pay by salary deduction. Check with your pay office or contact Health Care Insurance for more information. An authority to deduct from salary form is included in the membership application form.

BPAY®

You can pay by BPAY® using your financial institution's telephone or internet banking. Renewal notices sent to members paying monthly, quarterly or half yearly, will display a BPAY® Biller Code and reference number. This information will be required when paying your renewal through BPAY®.

For more information on BPAY® contact your bank, building society or credit union or visit bpay.com.au.

Cheque

Please make cheques payable to Health Care Insurance Ltd.

Credit Card

You can pay in person or over the telephone using MasterCard, Visa or American Express.

In Person

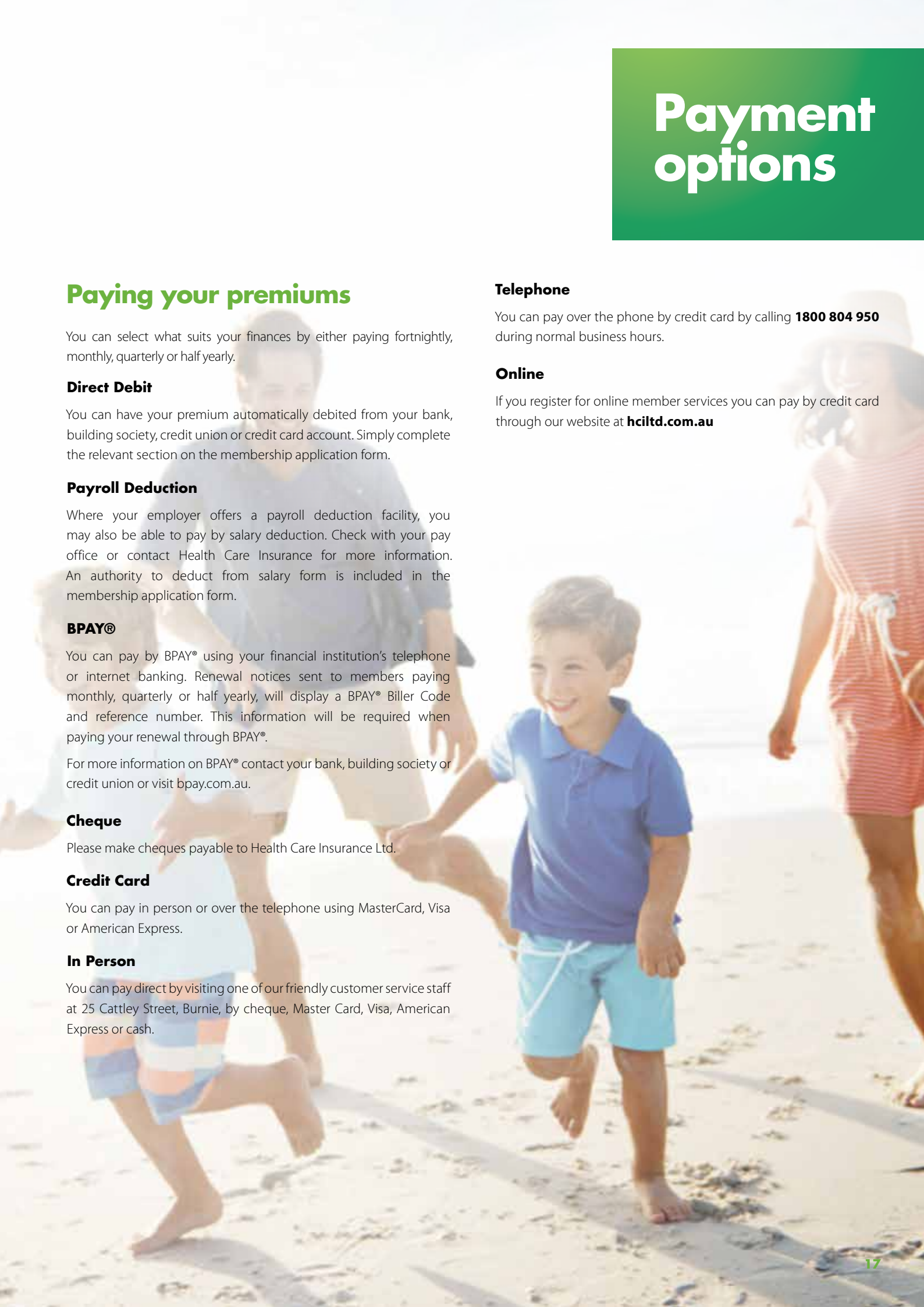
You can pay direct by visiting one of our friendly customer service staff at 25 Cattley Street, Burnie, by cheque, Master Card, Visa, American Express or cash.

Telephone

You can pay over the phone by credit card by calling **1800 804 950** during normal business hours.

Online

If you register for online member services you can pay by credit card through our website at **hciltd.com.au**



Health Care Insurance online

Our website **hciltd.com.au** is a great source of all your private health information, for example you can:

- Choose the best level of cover for you
- Get a quote
- Join Health Care Insurance
- Download all HCI's forms and brochures
- Read our online newsletter, Healthy and Happy
- Find a healthcare provider (Hospital, Access Gap doctor or HICAPS provider
- Organise travel insurance

Online Member Services

If you are a HCI member you are also able to access HCI's secure Online Member Services (OMS) to manage your membership at your convenience. OMS gives you the option to:

- Look at your membership details
- Change your address, level of cover or contact details
- Make credit card payments
- Order a new membership card
- Print your tax statement

To register for OMS visit our website **hciltd.com.au** and select the members services link. All information passed through the secure site along with access to your membership details is protected by the use of your own chosen password.

Key information

Private Health Insurance Rebate

The Federal Government introduced the Private Health Insurance Rebate to make private health insurance more affordable for Australians who chose to take out private health cover.

As of 1st July 2012 the rebate became subject to income testing by the Federal Government, this means the amount of rebate you are entitled to is based on which income tier you fall under. The income thresholds are indexed every financial year. For more information on the income threshold please refer to our health cover premiums, our website **hciltd.com.au** or alternatively you can visit to the Australia Taxation Office website **ato.com.au**.

The level of rebate you may be entitled to also depends on the age of the oldest person covered by your policy, as the rebate increases when you turn 65 and again at age 70.

How can I claim the rebate?

You can claim your rebate in one of two ways:

- as a reduction in your contributions; or
- as an income tax offset on your income tax return.

For convenience and certainty that you receive your full rebate entitlement, we recommend you register to have your rebate taken off the contributions you pay to HCI.

Medicare Levy Surcharge

The Medicare Levy Surcharge (MLS) is a levy on taxable income of up to 1.5% depending on your level of income. The MLS applies if you do not have an appropriate level of hospital cover and your annual adjustable taxable income exceeds the limit set by the Federal Government for single, single parent, couple and family memberships. For more information visit our website **hciltd.com.au**

	MEDICARE LEVY SURCHARGE			
	No Change	Tier 1	Tier 2	Tier 3
All Ages	0.0%	1.0%	1.25%	1.5%

Key information continued

Lifetime Health Cover (LHC)

Lifetime Health Cover (LHC) is a Government initiative that started on 1 July 2000. It was designed to encourage people to take out hospital insurance earlier in life, and to maintain their cover. In Australia, private health insurance is not 'risk-rated' like most forms of insurance. Private health insurers cannot refuse to insure any person, and must charge everyone the same premium for the same level of cover, despite their risk profile and likelihood of using health services.

LHC is a financial loading that can be payable in addition to the base rate premium for your private health insurance hospital cover. If you purchase hospital cover earlier in life, and keep it, you will pay lower premiums compared to someone who joins when they are older.

LHC loadings apply only to hospital cover. It does not apply to private health insurance general treatment cover (also known as ancillary or extras cover).

To avoid paying a LHC loading, you need to purchase hospital cover by 1 July following your 31st birthday. If you purchase hospital cover after this date you may be required to pay a LHC loading – 2% for each year you are over 30.

For example, John turns 31 on 1 April 2016. If he purchases hospital cover by 1 July 2016, he will pay the base contribution rate. If he purchases hospital cover on the 2 July 2016, he will pay a 2% loading. If he further delays purchasing hospital cover, he will pay an extra 2% for each year he delays.

If you are a new migrant to Australia, and are aged 31 or over, you will not have to pay a LHC loading if you purchase hospital cover within 12 months of being registered for full Medicare benefits.

If you delay purchasing hospital cover for more than 12 months after your registration, you will have to pay 2% more for each year you are aged over 30 when you purchase your hospital cover.

Any LHC loading that you pay will be removed from your hospital cover premium after you have held hospital cover for 10 continuous years. However, if you cancel your hospital cover after the LHC loading has been removed, you may become liable to pay a LHC loading again in the future.

If you were born on or before 1 July 1934, you are exempt from the LHC loading. You can purchase hospital cover at any time and pay the base rate premium.

Permitted days without hospital cover

You are able to stop your hospital cover for a cumulative period of 1094 days in your lifetime without affecting your certified age at entry. However, after the 1094 days aggregated absence, your certified age at entry will be increased by one year.

Suspending membership

Suspending your cover

Members may apply for suspension of their membership, if at the time of application, they have held private health insurance cover for at least 12 months and paid all contributions due by them at the date of application.

Application for suspension of membership can only be made on one of the following grounds:

- the member's absence from Australia for travel reasons for a period not less than 28 days and not more than 2 years ; or
- the member's financial hardship for a period not less than 1 month and not more than 6 months.

Periods of suspension of hospital cover do not count towards the 1,094 days cumulative absence allowed by Lifetime Health Cover legislation.

If a member reinstates membership within 30 days of the period of suspension ending and pays contributions from the end of the suspension period, there will be no new waiting periods to be served.

Ceasing membership

If you choose to cease your hospital cover, your future hospital health cover premiums will be subject to the Lifetime Health Cover provisions dealing with periods of absence (refer to page 20).

Please note that high income earners will be subject to the Medicare Levy Surcharge (MLS) during a period of suspended hospital cover (refer to page 19 for details of the MLS).

For details of what information you will need to provide in your application for suspension of membership, please call us on **1800 804 950**.

Standard information statements

Federal Government legislation requires health insurers to provide a document called a Standard Information Statement (SIS) which provides a brief summary of a member's level of cover. Health Insurers are required to send a Standard Information Statement to every member once a year. The Standard Information Statement is aimed at assisting members to better understand the many and varied private health insurance product options offered by all registered health funds.

For further information about Standard Information Statements you can phone on **1800 804 950** or visit our website at **hciltd.com.au**

You can view each health fund's Standard Information Statements by visiting the website **privatehealth.gov.au**

Recognised / approved providers of treatment

To help ensure the propriety of services offered to members by health care providers, benefits will only be paid for services rendered to members by providers who are recognised and approved by HCI.

Recognition of providers by HCI is subject to change without notice. If you are not sure about a providers approved status with HCI, please call us on **1800 804 950** to check before arranging treatment.

Services provided by family members

Unless a member has received prior approval from the General Manager, HCI will not pay benefits for services or goods provided to a person covered by a membership where those services or goods are supplied by a family member.

Overseas treatment

HCI will not pay a benefit for services, treatment or appliances provided or purchased overseas. HCI will only pay a benefit towards services, treatment and appliances by approved providers and/or suppliers registered within Australia only.

Compensation and damages

HCI does not pay benefits for services or treatment where you are entitled to receive compensation or damages from another source.

Where an accident or illness is caused by the actions of another party, HCI expects that you will pursue a claim for compensation or damages from the party concerned.

HCI may, however, make provisional payments where compensation or damages are claimable by you, provided you agree to repay such payments from your final settlement.

If you become involved in circumstances where compensation or damages may be claimable by you, please call us on **1800 804 950** to seek clarification of your benefit entitlements.

30 day money back guarantee

A cooling off period of 30 days applies to all new applicants for HCI membership. Any member who has not made a claim within 30 days from the commencement date of their health cover is entitled to cancel the policy and receive a full refund of any contributions paid.

Payment default

Should your contributions fall more than two months in arrears, your membership may be ceased. Acceptance of arrears payments after two months is not automatic, so please talk to us if you need time to pay. It should be noted that benefits are not payable for treatment if your contributions are in arrears and do not cover the date(s) you received the treatment.

Key information continued

Feedback

We welcome and value your comments on our products and service. If you require further explanation or have problems on matters affecting any aspect of your health insurance cover, please call us to discuss your concerns. We will endeavour to resolve all issues of concern to your satisfaction as quickly as possible. However, if you believe we have not addressed your issues satisfactorily, you can contact us on **1800 804 950**, email us **enquires@hciltd.com.au**, or visit our website **hciltd.com.au**. You can also obtain independent free advice from the Private Health Insurance Ombudsmen (PHIO) you can visit their website **www.ombudsman.gov.au** or contact them on **1300 362 072**.

Private Health Insurance Industry Code of Conduct

HCI is a signatory to the Private Health Insurance Industry Code of Conduct. The code was developed by the industry and is designed to set benchmarks of standards of service to members to be achieved by all Private Health Insurers.

The aims of the code are to ensure:

- you receive the correct information on private health insurance from appropriately trained HCI staff;
- you are aware of the dispute resolution procedures available in the event that you have a dispute with HCI;
- policy documentation contains all the information you require to make a fully informed decision about your health insurance purchase and that all communications between you and HCI are conducted in plain easy to understand language;
- all information between you and HCI is protected in accordance with national and state privacy principles.

A copy of the code is available at

privatehealthcareaustralia.org.au/codeofconduct

Benefit Limitation Period

Some private health funds apply a Benefit Limitation Period (BLP) which is similar to a waiting period, however if you haven't served your BLP your health fund will still pay a benefit. This benefit is a limited amount and is usually restricted to what they would pay at a public hospital.

Some waiting periods applied are regulated and set by the Australian Government; however a BLP is applied and set by the individual health fund.

HCI does not apply a BLP.

Privacy Statement

HCI respects your privacy and is committed to keeping your personal information safe through compliance with the *Commonwealth Privacy Act 1988* and the National Privacy Principles which form part of the Act.

Why is my information needed?

HCI collects information that is necessary to assist the fund to meet your health insurance needs. This includes:

- Establishing your membership.
- Receiving contributions.
- Paying benefits.

Your personal information is not collected unless we first ask you for it.

How is my information protected?

HCI exercises great care to protect the personal information that is held.

This protection includes:

- Document storage security policies.
- Document access controlled and limited to only those that require it to administer your policy.
- Internal electronic security access systems.
- Secure disposal of waste.

What information is disclosed?

HCI will only disclose your information to third parties in the following circumstances:

- To administer your insurance policy, this includes to:
  - Practitioners and professionals who are providing your health care treatment; and
  - Hospitals in relation to membership eligibility checking.
- To a third party who performs core business activities on our behalf and with whom we have a confidentiality agreement.
- If required by law.

Can I see my information?

You may access your personal details by requesting to do so in writing.

Your dependants and their privacy

To protect the privacy of all persons covered under your membership, you are required to inform any dependants aged 16 years and over of HCI's privacy policy, and obtain their consent before providing HCI with their personal information. As such, any reference in your health policy to 'you' should be taken to be a reference to both you and your dependants.

Need more information?

If you wish to obtain more information about HCI's Privacy Policy, please contact our Privacy Officer on **1800 804 950** or refer to our web site at **hciltd.com.au**

How do I complain if my privacy is breached?

HCI will do everything possible to ensure that your privacy is not breached. However, if you believe we have breached your privacy, you may write to:

HCI Privacy Officer
PO Box 931
BURNIE TAS 7320

We will endeavour to resolve the matter amicably with you. However, if you consider we have not resolved the matter to your satisfaction, you may contact the Privacy Commissioner's Office at:

The Director of Compliance
Office of the Privacy Commissioner
GPO Box 5218
SYDNEY NSW 2001

Membership Application Form

healthcare insurance

I would like to

☐ **Join HCI.** **Effective Date** / /

☐ **Transfer to HCI from another fund.** If you are transferring from another fund please complete the Clearance Certificate Request on page 26 in the Guide to Cover.

Your details

Title		**Date of birth**	/ / **Sex** ☐ Male ☐ Female
Surname		**Given Names**	
Postal address		**Home address**	
Suburb		**Suburb**	
State	**Postcode**	**State**	**Postcode**
Mobile		**Daytime Phone**	
Email			

Persons to be covered (do not include yourself)

If you need to add more than 8 people, please attach a separate page with their details.

Surname	Given names	Sex M/F	D.O.B	Relationship to member
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

** If a dependant is aged between 23 and 25, please refer to page 4 in the Guide to Cover for more information.*

Membership authority

☐ **I wish to authorise**_____ **to have the same rights and obligations as myself to access information in relation to this policy.**
Name of authorised person

However, they are unable to cancel the policy, add or remove a person other than themselves (if applicable).

I acknowledge and understand that I remain responsible for my policy and for the actions of the authorised person and do so at my own risk.

Policy Holder's Signature **Authorised Person's Signature**

Choice of cover required

Type of Cover ☐ Singles ☐ Couples ☐ Family ☐ Family Dependant Plus ☐ Single Parent ☐ Single Parent Plus

Packaged Cover ☐ **Premier Package** **Excess Options** (per adult*) ☐ Nil ☐ $250 ☐ $500 ☐ $1,000**

Hospital Cover ☐ **Premier** **Excess Options** (per adult*) ☐ Nil ☐ $250 ☐ $500 ☐ $1,000**

Extras Cover ☐ **Premier Extras** ☐ **Active Life Extras**

* If a dependant is under 18 an excess does not apply. ** Please note by taking an excess greater than $500 per adult you may not be exempt from the Medicare Levy Surcharge (MLS). For more information on the MLS please talk to one of our friendly staff.

healthcare insurance

Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

Please complete this section to receive the Australian Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums apply.

You may be entitled to a Medicare card if you are:
· a person who lives in Australia, **and**
· an Australian citizen, **or**
· a holder of a permanent resident visa, **or**
· a New Zealand citizen, **or**
· an applicant for a permanent resident visa.

For more information about the Australian Government Rebate on Private Health Insurance, go to **humanservices.gov.au/privatehealth**
Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling **132 011**
or go to: **https://www.humanservices.gov.au/customer/services/medicare/medicare-card**

Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

☐ **Yes.** Please complete the remainder of this section ☐ **No.** You cannot apply for the Rebate until you obtain a Medicare card.

Are you covered by the policy?

☐ **Yes.** ☐ **No.** (If No) Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Please select from the table below the Tier that is relevant to your estimated income or your family income for the financial year. For information regarding the income thresholds please refer to our Health Cover Premiums information sheet, on our website hciltd.com.au or alternatively you can visit the Australian Taxation Office website ato.gov.au. If you do not nominate a Rebate Tier, the Base Tier will be applied to your policy. If at any stage you wish to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible.

Please select one box only.

Income Threshold (for the 2016/2017 financial year)			
Base: **Single** $90,000 or less **Family*** $180,000 or less ☐	**Tier 1:** **Single** $90,001 - $105,000 **Family*** $180,001 - $210,000 ☐	**Tier 2:** **Single** $105,001 - $140,000 **Family*** $210,001 - $280,000 ☐	**Tier 3:** **Single** $140,001 or more **Family*** $280,001 or more ☐

* If you're a family with children, the income threshold for each tier is increased by $1,500 for every child after your first. Family includes couples and single parent families.

Your Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ **Reference ID** ☐ **Valid to** /

Your name exactly as it appears on your Medicare card

The Australian Government Rebate is income tested and eligibility for the rebate is determined by the taxable income of a single or a family. There are no penalties for nominating an incorrect rebate tier. If the nominated tier is incorrect and there is a difference between the actual entitlement and the rebate claimed, the adjustment will be made through the policyholder's tax return.

Privacy Notice

Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim. Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law. You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at **http://www.humanservices.gov.au/privacy** or by requesting a copy from the department.

Declaration

I hereby declare the above statements to be true and complete and agree to abide by health benefit fund rules of Health Care Insurance Ltd (HCI) as amended from time to time. I acknowledge that this application form and brochure does not contain all the Rules of HCI, but I am free to inspect the full copy of the Rules at the office of HCI. I also acknowledge my membership is subject to the pre-existing Rule, waiting periods and eligibility criteria as explained in this brochure. I acknowledge that HCI has a Privacy Policy which I may view upon request, and I will inform any dependants referred to on this application of the existence of the HCI Privacy Policy. I consent to the collection, use and disclosure of my personal and sensitive information in the provision by HCI of a health insurance service and I have authority to provide and consent to the release of personal and sensitive information on behalf of the dependants referred to in this application. I authorise the release of personal and sensitive information from my previous health fund, and from any hospital, medical practitioner or other health service provider that HCI deems necessary to administer my policy. If the information supplied on this application is inaccurate or fraudulent, I acknowledge HCI may refuse to pay a claim, cancel the policy or require payment of any additional premium loading payable in accordance with the Lifetime Health Cover legislation.

A 12 month waiting period applies to **pre-existing conditions**. A pre-existing condition is an ailment, illness or condition the signs or symptoms of which existed at any time in the period of 6 months ending on the day on which the person became insured under the policy. Other waiting periods may apply. For more information on waiting periods refer to page 12.

I understand waiting periods may apply to my policy. I have read and understand the waiting periods, including the pre-existing conditions rule as described on page 12.

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

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

Payment Options

healthcare insurance

Frequency of Payment

I'd like my premiums to be deducted: ☐ Fortnightly (Not available for accounts) ☐ Monthly ☐ Quarterly ☐ 6 monthly

Please complete ONE of the options below.

Option 1 - Bank Account Deduction

I/we authorise Health Care Insurance Limited (Debit user ID 16895) to arrange for funds to be debited from my/our nominated account at the Financial Institution shown below according to the instructions specified.

Name of Financial Institution _____ Branch _____

Name of account holder _____

BSB number ___ / ___ **Account number** _____

☐ **Please use this account for credit of benefit payments.** ☐ **Please use alternative account details for credit of benefit payments (as detailed below)**

Name of Financial Institution _____ Branch _____

Name of account holder _____

BSB number ___ / ___ **Account number** _____

Account Holder 1 Signature _____ **Date** / /

Account Holder 2 Signature _____ **Date** / /

Option 2 - Credit Card Deduction

Type of credit card ☐ MasterCard ☐ VISA ☐ American Express

Card number _____

Name on credit card _____ **Expiry date** /

I/we acknowledge that this Direct Debit arrangement is governed by the terms of the Direct Debit Request – Service Agreement received from you.

Card Holder's Signature _____ **Date** / /

Option 3 - Accounts

Accounts Frequency ☐ Monthly ☐ Quarterly ☐ 6 monthly **Signature** _____

I wish to receive an account based on the frequency selected above. I undertake to pay all amounts payable by the due date specified on my account.

Telephone and internet banking - BPAY options available. Contact your bank, credit union or building society to make this payment from your cheque, savings or credit card account. For more information go to www.bpay.com.au

Option 4 - Payroll deductions

I authorise the pay officer of _____ to deduct from my pay $ _____

Payroll Frequency ☐ Weekly ☐ Fortnightly ☐ Monthly Commencing Pay Period Ending / / **Payroll ID** _____

This authorisation extends to any changes to my contributions that the Fund may make from time to time.
This authority is to continue until such time as it is withdrawn by me in writing.

Signature _____ **Date** / /

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** / /

Direct Debit Request - Service Agreement

The following is your Direct Debit Service Agreement with **Health Care Insurance Ltd**. The agreement is designed to explain what your obligations are when undertaking a Direct Debit arrangement with us. It also details what our obligations are to you as your Direct Debit Provider.

We recommend you keep this agreement in a safe place for future reference. It forms part of the terms and conditions of your Direct Debit Request (DDR) and should be read in conjunction with your DDR form.

Definitions

- ***account*** means the account held at your financial institution from which we are authorised to arrange for funds to be debited.
- ***agreement*** means this Direct Debit Request Service Agreement between you and us.
- ***banking day*** means a day other than a Saturday or a Sunday or a public holiday listed throughout Australia.
- ***debit day*** means the day that payment by you to us is due.
- ***debit payment*** means a particular transaction where a debit is made.
- ***direct debit request*** means the Direct Debit Request between us and you.
- ***us*** or ***we*** means **Health Care Insurance Ltd**, (the Debit User) you have authorised by signing a direct debit request.
- ***you*** means the customer who signed the Direct Debit Request.
- ***your financial institution*** means the financial institution nominated by you on the DDR at which the account is maintained.

1. Debiting your account

By signing a *Direct Debit Request*, you have authorised us to arrange for funds to be debited from *your account*. You should refer to the *Direct Debit Request* and this agreement for the terms of the arrangement between us and you.

We will only arrange for funds to be debited from your account as authorised in the *Direct Debit Request*.

If the *debit day* falls on a day that is not a *banking day, we* may direct your *financial institution* to debit *your account* on the following *banking day*. If you are unsure about which day *your account* has or will be debited you should ask your *financial institution*.

2. Amendments by us

We may vary any details of this agreement or a *Direct Debit Request* at any time by giving you at least fourteen **(14) days'** written notice.

3. Amendments by you

You may change, stop or defer a debit payment, or terminate this agreement by providing us with at least seven **(7 days)** notification by writing to: Health Care Insurance, Attn: Membership Department, PO Box 931, Burnie TAS 7320 or **enquiries@hciltd.com.au** or by telephoning us on **1800 804 950** during business hours or arranging it through your own financial institution.

4. Your obligations

Is *your* responsibility to ensure that there are sufficient clear funds available in *your* account to allow a *debit payment* to be made in accordance with the *Direct Debit Request*.

If there are insufficient clear funds in *your account* to meet a *debit payment*:

(a) *you* may be charged a fee and/or interest by your *financial institution*;

(b) *you* may also incur fees or charges imposed or incurred by *us*; and

(c) *you* must arrange for the *debit payment* to be made by another method or arrange for sufficient clear funds to be in *your account* by an agreed time so that we can process the *debit payment*.

You should check *your account* statement to verify that the amounts debited from *your account* are correct

If **Health Care Insurance Ltd** is liable to pay goods and services tax ("GST") on a supply made in connection with this *agreement*, then you agree to pay **Health Care Insurance Ltd** on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5. Dispute

If *you* believe that there has been an error in debiting your *account*, *you* should notify us directly on **1800 804 950** and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly. Alternatively you can take it up with your financial institution direct.

If *we* conclude as a result of our investigations that *your account* has been incorrectly debited we will respond to *your* query by arranging for *your financial institution* to adjust *your* account (including interest and charges) accordingly. We will also notify you in writing of the amount by which *your account* has been adjusted.

If *we* conclude as a result of our investigations that *your account* has not been incorrectly debited *we* will respond to *your* query by providing *you* with reasons and any evidence for this finding in writing.

6. Accounts

You should check:

(a) with *your financial institution* whether direct debiting is available from *your account* as direct debiting is not available on all accounts offered by financial institutions.

(b) *your* account details which you have provided to us are correct by checking them against a recent *account* statement; and

(c) with *your financial institution* before completing the *Direct Debit Request* if you have any queries about how to complete the *Direct Debit Request*.

7. Confidentiality

We will keep any information (including *your account* details) in your *Direct Debit Request* confidential. *We* will make reasonable efforts to keep any such information that we have about *you* secure and to ensure that any of *our* employees or agents who have access to information about *you* do not make any unauthorised use, modification, reproduction or disclosure of that information.

We will only disclose information that we have about *you*:

(a) to the extent specifically required by law; or

(b) for the purposes of this *agreement* (including disclosing information in connection with any query or claim).

8. Notice

If you wish to notify us in writing about anything relating to this *agreement*, you should write Health Care Insurance, Attn: Membership Department, PO Box 931, Burnie TAS 7320 or **enquiries@hciltd.com.au**.

We will notify you by sending a notice in the ordinary post to the address you have given us in the *Direct Debit Request*.

Any notice will be deemed to have been received on the third *banking day* after posting.

healthcare insurance

That's my HCI

A Registered Private Health Insurer ABN 43 009 579 088

Phone 1800 804 950 Fax 1800 643 969
Email enquiries@hciltd.com.au
Postal Address PO Box 931, Burnie, Tasmania 7320
Street Address 25 Cattley Street, Burnie, Tasmania 7320

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