healthcare insurance

CHANGE TO POLICY

Member Number: …… Members Name:…….. ……..……..

Address : ……..

……

Please complete the relevant sections.

1. CHANGE TO MEMBERSHIP DETAILS

Change to Surname: ……...

New Address: ……

……...

2. CHANGE TO LEVEL OF COVER

I now require the following cover: **

COMBINED PACKAGES (Hospital & Extras)

☐ Gold Hospital & Premier Extras ☐ Excess of $.....per adult per calendar year

☐ Gold Hospital & Healthy Extras ☐ Excess of $.....per adult per calendar year

☐ Gold Hospital & Active Life Extras ☐ Excess of $.....per adult per calendar year

☐ Bronze Hospital $750/$1,500 excess & Healthy Extras

☐ Bronze Hospital $750/$1,500 excess & Active Life Extras

HOSPITAL COVER ONLY

☐ Gold Hospital ☐ Excess of $.....per adult per calendar year

☐ Bronze Hospital $750/$1,500 excess

EXTRAS COVER ONLY

☐ Healthy Extras ☐ Active Life Extras

**** Due to Federal Government legislation introduced on 1st April 2007, if you currently have a funeral benefit on your policy and make a change to your level of cover, the funeral benefit is no longer available.**

3. CHANGE TO MEMBERSHIP COVER

☐ Me (Single) ☐ We (Couple) ☐ Us (Single Parent) ☐ Me + Us (Family)

☐ Us+ (Extended Single Parent) ☐ All of Us (Extended Family)

I want the following people to be: ☐ Added ☐ Taken off my membership

Given Names (& surname if different from your own)	D.O.B	M/F	Relationship to member
……			
……			

Are all the people on this policy listed on or entitled to a Medicare card? ☐ Yes ☐ No
Please sign the following page of this document to authorise the changes

If you are adding dependants please complete this section:

Are the above dependants financial members of another fund? ☐ Yes ☐ No

Name of fund:…… Member No:…….

Level of cover:……

Please read the waiting period information on the bottom of this form. Waiting periods apply to new dependants, and to people upgrading tables from another fund.

4. CANCELLATION

I wish to cancel my policy with Health Care Insurance effective: …….
✱I understand that I can re-join at any time, subject to waiting periods.

We are continuously looking to enhance our products and services, your opinion valuable to us, you may wish to let us know why you cancelled

- ☐ Cost/contributions
- ☐ Policy does not meet my/my family's needs
- ☐ Customer Service
- ☐ Location
- ☐ Benefits/services offered
- ☐ Moving to another health fund Name of new health fund:……...
- ☐ Other ……

DATE THE ABOVE CHANGES ARE TO COMMENCE:……

I declare all details to be true and correct and agree to be bound by the rules of Health Care Insurance. I have read and understood the waiting periods information below.

MEMBER'S SIGNATURE:	**PARTNER'S SIGNATURE (if required):**
NAME:	**NAME:**
DATE:	**DATE:**

✱WAITING PERIODS

Benefits are payable after 2 months, except for:

ANCILLARY TABLES		HOSPITAL TABLES	
Crowns & Bridges	12 Months	Pre-Existing	12 Months
Dentures	12 Months	Obstetrics	12 Months
Dental Implant Prostheses	12 Months	IVF & Assisted Reproductive Technology	12 Months
Fares & Accommodation	6 Months	Sterilisation	12 Months
Hearing Aids	2 Years		
Medical Appliances	12 Months		
Orthodontics	12 Months		
General Dental	6 Months		
Optical	6 Months		

●**Pre-existing Ailments**
Benefits are not payable during the first 12 months membership of a table for treatment relating to an ailment, illness or condition, the signs or symptoms of which, in the opinion of a medical practitioner appointed by the organisation, existed at any time during the 6 months prior to the date of joining or upgrading to a higher level of cover.

Office Use Only

Accepted by..... Date ...../...../.20.....

Processed by..... Date ...../...../.20.....