

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)

Premier Package Excess of \$.....per adult per calendar year*

Active Life Package Excess of \$.....per adult per calendar year*

HOSPITAL COVER ONLY

Premier Hospital Excess of \$.....per adult per calendar year*

***Please note:** When choosing an excess greater than \$500 per adult you may not be exempt from the Medicare Levy Surcharge (MLS). If you would like more information regarding the MLS please talk to one of our friendly staff.

EXTRAS COVER ONLY

Active Life Extras

3. CHANGE TO MEMBERSHIP COVER

Me + Us (Family)

We (Couple)

Me (Single)

Us (Single Parent)

All of Us (Family dependant plus)

Us+ (Single parent plus)

I want the following people to be:

Added

Taken off my membership

Given Names

D.O.B

M/F

Relationship to member

(& surname if different from your own)

.....

.....

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
- 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

Crowns & Bridges	12 Months
Dentures	12 Months
Dental Implant Prosthesis	12 Months
Fares & Accommodation	6 Months
Hearing Aids	2 Years
Medical Appliances	12 Months
Orthodontics	12 Months
General Dental	6 Months
Optical	6 Months

HOSPITAL TABLES

Pre-Existing	12 Months
Obstetrics	12 Months
IVF & Assisted Reproductive Technology	12 Months
Sterilisation	12 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.....