

Membership application

I would like to

☐

Join HcI

☐

Transfer to HcI from another fund

Start date

dd / mm / yyyy

Your details

Surname / Family name

Title

Sex

Given name(s)

Home address

Postal address (including postcode)

Phone

Mobile

Date of birth

dd / mm / yyyy

Email (We require your email address to communicate with you. We may not be able to process your application without your email address.)

Please let us know of any new address details via [Online Member Services \(OMS\)](#) or calling us.

Additional persons to be covered (do not include yourself)

Note that everyone on the policy must be on, or be eligible to be on, a green Medicare card. You can add people later if they are waiting for Medicare eligibility.

	Family name	Given name(s)	Sex	Date of birth	Relationship to you
1				dd / mm / yyyy	
	Please provide their email address if aged 16 plus				
2				dd / mm / yyyy	
	Please provide their email address if aged 16 plus				
3				dd / mm / yyyy	
4				dd / mm / yyyy	

To add more than 4 people, please attach a separate page with their details. Dependants aged 16 or more can have an individual login for OMS if we have their unique email address. If a dependant is aged 23 or more, they may be subject to additional requirements. Please [refer to our website for eligibility details](#).

Who can access my account (optional)

I nominate , my

to have the same rights and obligations as myself to access information in relation to this policy. Only an authorised partner/spouse dependant will have access to all account details in OMS. This person may also change details and make claims on behalf of any person covered by this policy. However, they are unable to cancel the policy nor 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(s) and do so at my own risk.

Phone	Email	Date of birth
		dd / mm / yyyy

Policy holder's signature

Choice of cover required

Type of Cover

☐ Single

☐ Couple

☐ Family (including single parent families)

Hospital Cover

Select your mandatory excess

\$250*

\$500*

\$750*

None

Choose your extras

Top

Healthy

ActiveLife

Basic#

☐ Silver Plus Secure Hospital

☐

☐

☐

☐

☐

☐

☐

☐ Bronze Plus Hospital

☐

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☐

☐ Basic Plus Hospital#

☐

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☐

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* If a dependant is under 18, an excess does not apply for their hospital claims.
Basic Extras and Basic Plus Hospital are available to Singles and Couples only.

Please note: An excess applies per adult per calendar year. Visit our website or your [Member Guide](#) to see how excess levels work for your chosen cover.

Waiting periods may apply, including 12 months for **pre-existing conditions**. A pre-existing condition is an ailment, illness or condition the signs or symptoms of which existed within the 6 months up to the day this policy starts. Read about [waiting periods](#) on the HCl website.

Australian Government Private Health Insurance Rebate application

Please select one only.

☐ I want to receive the Australian Government Private Health Insurance Rebate as a reduced premium.

☐ I want to pay full premiums and claim the rebate later. Skip to the [Medicare details](#) section.

Only applicants covered by the policy (or an applicant for a child-only policy) can claim the Government Private Health Insurance Rebate. You can also register for the rebate via OMS. Employers and trustees of organisations cannot claim the Private Health Insurance Rebate for policies paid on behalf of employees.

For more information about the Australian Government Private Health Insurance Rebate, see the [Services Australia](#) website.

Are all the people on the policy eligible for the rebate (that is, are they listed on a green Medicare card or entitled to a green Medicare card)?

☐ Yes. Please complete the [Income threshold](#) section.

☐ No. You cannot apply for the Rebate until everyone on the policy is enrolled for a green Medicare card.

Are you covered by this HCl policy? ☐ Yes. ☐ No. Skip to the [Declaration](#) section.

Income threshold

The Australian Government Private Health Insurance 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 your entitlement and the claimed rebate, an adjustment will be made through your tax return. For information regarding income thresholds, refer to the [Australian Taxation Office](#) website.

If you do not nominate a Rebate Tier, the Base Tier will be applied. To change income tier or stop receiving the Rebate as a reduced premium, please notify HCl as soon as possible. You can adjust the tier at any time within OMS.

Please select one tier for your estimated family income (for the current financial year).

☐ Base

Single \$105,000 or less
Family* \$210,000 or less

☐ Tier 1

Single \$105,001 - \$123,000
Family* \$210,001 - \$246,000

☐ Tier 2

Single \$123,001 - \$164,000
Family* \$246,001 - \$328,000

☐ Tier 3

Single \$164,001 or more
Family* \$328,001 or more

* The income threshold for each tier is increased by \$1,500 for every child after your first. Family includes one and two parent families.

contact 1800 804 950 enquiries@hcilt.com.au

www.hcilt.com.au

Medicare details (All people on the policy must be on, or be eligible to be on, a green Medicare card.)

Your name exactly as it appears on your Medicare card

Your Medicare card number

Reference ID

Valid to

dd / mm / yyyy

1 Dependant's name as it appears on their Medicare card

Medicare card number

Reference ID

Valid to

dd / mm / yyyy

2 Dependant's name as it appears on their Medicare card

Medicare card number

Reference ID

Valid to

dd / mm / yyyy

3 Dependant's name as it appears on their Medicare card

Medicare card number

Reference ID

Valid to

dd / mm / yyyy

4 Dependant's name as it appears on their Medicare card

Medicare card number

Reference ID

Valid to

dd / mm / yyyy

5 Dependant's name as it appears on their Medicare card

Medicare card number

Reference ID

Valid to

dd / mm / yyyy

Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your application and payments, and provide services to you. We only share your information with other parties where you have agreed, or where law allows or requires it. For more information, go to servicesaustralia.gov.au/privacy

Declaration

- ☐ I agree to abide by the rules of HCl as amended from time to time. I acknowledge this application form does not contain all the rules of HCl, but I can request a copy of the rules from HCl at any time.
- ☐ I have read the [HCl Privacy Policy](#) and I will inform any dependants on this application of the HCl Privacy Policy. I consent to the collection, use and disclosure of my personal and sensitive information in the provision by HCl of a health insurance service and I have authority to provide and consent to the release of personal and sensitive information on behalf of my dependants in this application. I authorise the release of personal and sensitive information from my previous health fund, if any, and from any hospital, medical practitioner or other health service provider that HCl deems necessary to administer my policy.
- ☐ I declare the information provided is complete and correct. I understand that giving false or misleading information is a serious offence. If the information supplied is inaccurate or fraudulent, I know HCl may refuse to pay a claim, cancel the policy or require payment of an additional premium loading under Lifetime Health Cover legislation.
- ☐ I understand waiting periods may apply to my policy. I have [read about and understand the waiting periods](#), including the pre-existing conditions rule.

Member's signature

Date

Payment options

This authorisation extends to any changes to my contributions that HCl may make from time to time. This authority applies until it is withdrawn by me in writing. If I do not make a choice, premiums will be deducted monthly by default.

I'd like my premiums to be deducted ☐ Monthly ☐ Quarterly ☐ 6 monthly ☐ Annually

Please complete **ONE** of the options below.

Option 1 Bank account deduction

☐ I/we authorise Health Care Insurance (HCl) Limited (Debit user ID 16895) to arrange for money to be debited from my/our nominated account according to the instructions specified and the Service Agreement available at www.hciltld.com.au/direct-debit-terms/

Name of financial institution

Name of account holder(s)

BSB number

Account number

Account holder 1's signature

Account holder 2's signature (if applicable)

Date

dd / mm / yyyy

Date

dd / mm / yyyy

Option 2 Credit card deduction

Type of credit card: ☐ MasterCard ☐ VISA

Name on credit card

Card number

Expiry date

dd / mm / yyyy

☐ I/we acknowledge that this Direct Debit arrangement is governed by the terms of the Direct Debit Request - Service Agreement available at www.hciltld.com.au/direct-debit-terms/

Card holder's signature

Date

dd / mm / yyyy

Option 3 Manual payments

☐ I wish to make my payments manually in advance, and undertake to pay all amounts by the relevant due dates. I understand that I'm required to ensure my HCl account is paid for a minimum of 14 days in advance at all times. I understand I can pay via BPAY or credit card, including via HCl's [Online Member Services \(OMS\)](#).

Receiving claim payments

When you make a claim, we will pay into your bank account. Note we cannot pay claims into a credit card account.

For claim payments, please pay the money into the ☐ bank account in Option 1, or ☐ following account.

Name of account holder

BSB number

Account number

Switching details

If you have switched in the last year, please provide details of all previous funds/accounts or call us on 1800 804 950.

Name of current health fund

Current cover level

Current member number

Date health cover is paid up to

dd / mm / yyyy

People to be transferred

☐ Everyone listed on this policy, **or** ☐ Just myself, **or** ☐ Myself and dependant(s) listed below, **or** ☐ Just the member(s) listed below

Full name of person 1

Full name of person 2

Switching authorisation for previous fund

I hereby authorise HCl to cancel my old fund's membership from

dd / mm / yyyy

☐ I will send a Clearance Certificate to HCl, or authorise HCl to obtain details about my membership via a Clearance Certificate sent directly to HCl Limited, enquiries@hcilt.com.au

☐ I request a refund for any premiums paid beyond my termination date.

☐ I do not want the old fund to contact me further about this request.

Policy holder's name

Policy holder's date of birth

dd / mm / yyyy

Policy holder's postal address

Policy holder's signature

Partner's signature (if required)

Date

dd / mm / yyyy

The signatory above must have legal responsibility for the health cover at your previous fund.

Date

dd / mm / yyyy

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

Final 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

dd / mm / yyyy