Deakin University Alumni Program Health Plan Application

Orgx: 311065

Membership details

☐ New member ☐ Change to existing membership Membership no. (if known)______________________

Your details

Title__________ Family name ______________ Given names ______________ ☐ Male ☐ Female Date of birth ____/____/____

Employee number ________________

Residential address ______________________________________ Postcode__________

Postal address (if different to above)______________________________ Postcode __________

Home Ph. ( )______________ Work Ph. ( ) ______________ Mobile Ph. ______________ Email ______________

Identification type (please choose one and supply number)

☐ Passport ☐ Driver's Licence ☐ Medicare card ☐ Birth certificate Identification Number______________________

☐ I have current private health insurance Name of current fund______________________ Member No. ______________

Paid until ____/____/____ ☐ In the past I have had private health insurance My Certified Entry Age is: ______________

Your partner's details

Title__________ Family name ______________ Given names ______________ ☐ Male ☐ Female Date of birth ____/____/____

Identification type (please choose one and supply number)

☐ Passport ☐ Driver's Licence ☐ Medicare card ☐ Birth certificate Identification Number______________________

☐ I have current private health insurance Name of current fund______________________ Member No. ______________

Paid until ____/____/____ ☐ In the past I have had private health insurance My Certified Entry Age is: ______________

Dependants

Family name	Given names	Date of birth	Sex	Student Y/N
		/ /		
		/ /		
		/ /		
		/ /		

All dependants will be covered on a family membership until the age of 17. Full time student dependants can be covered up to the age of 25.

I would like to choose one of the following covers:

Hospital Cover Options

☐ Corporate Hospital Top Level 2

☐ Corporate Hospital Intermediate Level 2

☐ Corporate Hospital Saver Level 2

Extras Cover Options

☐ Corporate Extras

☐ Executive Extras

☐ Platinum Extras

☐ Gold Extras

☐ Silver Extras

☐ Your Choice Extras (list your 4 choices below)

1.______________ 2.______________

3.______________ 4. ______________

☐ Standard Extras

☐ General Dental

Packaged Cover Options

☐ Young Couples Choice

☐ Young Singles Choice

☐ Young Singles Saver

☐ Active Sports Saver

Membership required

☐ Single ☐ Single Parent ☐ Family ☐ Family Plus Please commence my cover on: ____/____/____

Declaration

Do you or any person on this membership have an existing illness, injury or medical ailment?

☐ If yes, please provide details ______________________________________

I am transferring from another fund (Please present current membership record)

Name of fund ______________ Level of cover ______________ Membership No. ______________

Date joined: ____/____/____ Date paid until: ____/____/____

☐ In the past I have had private health insurance Member No.______________________ Paid until ____/____/____

I accept the rules of HBA/Mutual Community and I understand the conditions regarding the pre-existing rule, Waiting Periods, exclusions and Restricted Benefits. I hereby declare that the information provided is true and correct. I have read and understood, and have made the other people on this application aware of, the information in the Privacy Disclosure Statement (overleaf). I acknowledge that, where practicable, information is provided with consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person named on this application form. I understand that if my employer pays premiums on my behalf, it is my responsibility to ensure that premiums are paid, for example during periods of unpaid absence or if my employment ceases. I hereby authorise HBA/Mutual Community to obtain details of any previous membership on my behalf from other health funds as applicable.

Signature ______________________ Date ____/____/____

Continued overleaf

Direct Debit Request

1. Direct debit from my financial institution account (statement account only)
I authorise HBA/Mutual Community to deduct from my specified account as follows (please tick and complete as applicable. Allow 14 days for processing).

☐ Monthly Start my deductions on ____/____/____. I understand HBA/Mutual Community will deduct an initial payment after receiving this application form that will cover me until my nominated start date. I will monitor my account and ensure the correct payments are being deducted.

1a. Form of request for debiting account by the Direct Debit System
To the manager,
Name of institution ____________ Branch ____________ Date ____/____/____

Institution address ____________ Postcode ____________

I, family name ____________ Given names ____________

of address ____________ Postcode ____________

request that you, until further notice, in writing, debit from the account detailed below, any amount which BUPA Australia Health Pty Ltd ABN 50 003 098 655 trading as HBA/Mutual Community may debit or charge me through the Direct Debit System. I understand and acknowledge that;

1. The financial institution may, in its absolute discretion, determine the priority of payment by it or any monies in accordance with this request or any authority, or mandate.
2. The financial institution may, in its absolute discretion, at any time by giving notice in writing to me, terminate this request as to future debits.
3. In the event of changes to my rates/cover I authorise HBA/Mutual Community to alter the amount of deductions without prior notice.

1b. Please complete your account details and sign
Account name ____________ BSB (6 digits) ____________ Account number ____________

Signature ____________ Date ____/____/____

2. Direct Debit my credit card
Direct Debit payments from your credit card can only be arranged in SA and NT for the 7th, 14th, 21st or 28th day of every month (or closest business day). In all other states, payment can only be arranged for the 7th, 15th, 21st or 28th day of every month (or closest business day).
Please debit my ☐ Mastercard ☐ Visa For single payment only for ________ (months). Please debit my credit card on the following day every month:

☐ 7th ☐ 14th ☐ 21st ☐ 28th (SA and NT only). Or ☐ 7th ☐ 15th ☐ 21st ☐ 28th (all other states).

I understand that HBA/Mutual Community will deduct an initial payment after receiving this application form that will cover me until my nominated start date. I will monitor my account and ensure the correct payments are being deducted. Please read the Direct Debit Customer Service Agreement.

Cardholder's name ____________ Credit card no. (16 digits) ____________ Expiry date ____/____/____

Signature ____________ Date ____/____/____

Application to receive the Federal Government Rebate as a reduced premium

Membership no. (if known)____________

Please complete and sign this section so as to receive the Federal Government Rebate as a reduced premium. For those aged under 65, the rebate is 30%. If you are aged 65 to 69, the rebate is 35% and if you are aged 70 and over, it is 40%. All people listed under your membership number must be listed on a current Medicare card or be entitled to a Medicare card for you to receive the rebate.

Your Medicare card number Valid to Your name **exactly** as it appears on your Medicare card

☐☐☐☐ ☐☐☐☐☐ ☐ ____/____ ____________

Are all of the dependants under the membership listed on a Medicare card? ☐ Yes ☐ No

Declaration
I declare the information I have provided is correct. I understand there are penalties for giving false or misleading information.

Signature ____________ Date ____/____/____

The information provided by you on this form will be used for the purposes of registering you for the Federal Government Rebate on private health insurance. Its collection is authorised by law, and information collected will be disclosed to the Department of Health and Ageing, the Health Insurance Commission and the Australian Taxation Office.

Direct Debit Customer Service Agreement

This service agreement outlines the responsibilities of both HBA/Mutual Community and you the member, to ensure the smooth and secure operation of our direct debit agreement.

Our responsibilites:
We will only deduct premiums from your nominated account. Your policy schedule shows the premium amount and how often we have agreed to deduct it. We assure you that we will not disclose your bank details to anyone else, unless you have agreed in writing that we can, or unless the law requires or allows us to do this. If the payment date is a weekend or a public holiday, we will debit your account on the closest business day.

Your responsibilities
Before sending us your account details, please check with your bank or financial institution that direct debit deductions are allowed on the account you have chosen. Please make sure that you have enough money in your account to cover payment of your premiums when due. Your bank or financial institution may charge a fee if the payment cannot be met. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You must advise us if the nominated account is transferred or closed.

Changing your payment details
You may cancel or change your direct debit deductions at any time by contacting our Customer Service Centre on 1800 649 406. These changes may include: deferring the debit, altering the debit dates, stopping an individual debit, suspending the Direct Debit agreement, or cancelling the Direct Debit completely.

Can we help?
If you have any queries about your direct debit agreement please contact our Customer Service Centre on 1800 649 406. We undertake to respond to queries concerning disputed transactions within 5 working days of notification.

Continued overleaf

Privacy – Use and disclosure of health and personal information

Your privacy rights are important to you and HBA/Mutual Community. We'll only collect health and personal information about you and others on your membership that's necessary for the purposes of providing the appropriate health cover and verifying that it has been provided according to law and with our policies. This may include health information collected about you from health service providers. If the information you give us is not complete or accurate, we may not be able to provide you with the health cover you request. HBA/Mutual Community may need to disclose your health or personal information to other parties, such as health care providers and associations, business partners, government authorities, other health funds or other industry bodies. We may also use information for internal purposes such as staff training, claims auditing and compliance monitoring. If you're the owner of the membership, you're responsible for ensuring everyone on your membership is aware that HBA/Mutual Community may collect, use and disclose their personal and health information for the purposes of providing their cover and verifying that appropriate benefits are paid. Each person on the membership aged 17 and over must complete a 'Keeping it Confidential' form indicating their preferences regarding who should receive information about their personal claims. If not completed, all claim information will be sent to the individual it relates to. All cheques and non cash payments will be sent to the owner of the membership. You're entitled to request reasonable access to your personal and health information. HBA/Mutual Community reserves the right to charge an administration fee for collating such information. If you or any other person on your membership does not consent to the collection or the way we use and disclose personal and health information, we may not be able to provide you with cover. You're welcome to read our Privacy Policy by visiting hba.com.au or calling 1800 649 406. We may contact you about new products or special offers and this is your consent to receive telemarketing calls from us for an indefinite period. If you do not wish to receive this information you can opt out by calling 1800 649 406.

Return completed application form to:
Customer Administration: Reply Paid 14639, Melbourne, 3001
Or fax: 1800 613 058

For further information contact Corporate Customer Service on 1800 649 406

Clearance/Cancellation Certificate Request

HBA/Mutual Community Member No. ______________________ Please complete these details to authorise HBA/Mutual Community to cancel your membership and obtain details of your existing health funds membership. NB: If your contributions for your existing health fund are being deducted from your wages you should notify your paymaster to stop these deductions.

Title__________ Family name __________________ Given names __________________ ☐ Male ☐ Female Date of birth ____/____/______

Residential address____ Postcode______________

Other persons transferring to HBA/Mutual Community from existing fund.

Existing Health Fund Details

Fund name ____________________ Membership number ____________________ Cancellation date ___/___/___

I hereby authorise HBA/Mutual Community to terminate my membership with your organisation and/or obtain details about my membership, including a fully itemised claims statement for the previous 12 months. Please forward a clearance certificate direct to HBA/Mutual Community and if applicable, any refund of contributions paid in advance of the cancellation date should be forwarded to the contributor of the policy.

Signature ______________________ Date ____/____/______

Effective date July 2008
BUPA Australia Health Pty Ltd ABN 50 003 098 655 Trading as HBA and Mutual Community