Application and Membership Changes

The Doctors' Health Fund Limited
ABN 68 001 417 527 PO Box 482 St Leonards 1590 **t.** 02 9438 2022 **freecall** 1800 226 126 **f.** 02 9437 9326
w. www.doctorshealthfund.com.au **e.** info@doctorshealthfund.com.au

I am applying to: Please tick appropriate boxes

☐ Join The Doctors' Health Fund
☐ Add a dependent to my membership
☐ Change my level of cover
☐ Change other membership details

I qualify for membership of The Doctors' Health Fund in the following category, please tick appropriate box

☐ Medical Student ☐ Intern ☐ Resident ☐ Registrar, College [Please write here] ☐ CMO's

☐ Specialist, College [Please write here] ☐ GP ☐ Retired Doctor ☐ None of the above - Nature of work [Please write here]

☐ Employee of a medical practice or association [Please write your medical practice or association here]

☐ The partner, child, grandchild, parent, sibling, former partner, or the partner of an adult child or sibling of a person in the above categories

Personal details Please print clearly

Existing Membership No. (if relevant) ____ Date of Birth DD / MM / YYYY Gender Male / Female

Title ____ Surname ____ Given Names ____

Phone: Business ( ) ____ Home ( ) ____ Mobile ____

Street Address Not a Post Office Box address

Suburb ____ State ____ Postcode ____

Mailing address
(if different from above) ____

Suburb ____ State ____ Postcode ____

Email ____

I hereby authorise The Doctors' Health Fund Limited to give [Full name] access to my membership. This will enable them to make enquiries and changes to the policy with the exception of cancelling the policy.

Dependents Your partner and any additional family members to be covered by your policy

	Spouse/Partner	Dependent 1	Dependent 2	Dependent 3
Surname				
Given names				
Date of birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Sex	Male / Female	Male / Female	Male / Female	Male / Female
Relationship to you				
Student dependent cover where the student dependent is 21 years or over				
Name of school/ college/university				
Please tick those dependents who need a Fund card for electronic claiming of extras services				
	☐	☐	☐	☐

Existing medical conditions

If you or any dependents listed on this form have any existing medical conditions/ailments please advise us of the details below. If you require further space please provide details on a separate piece of paper and attach to this form.

Your cover requirements

Please read the product information in our brochure or on our website carefully, and retain a copy of the information about the products you select in your health insurance records.

Hospital Cover

For Singles

- ☐ Top Cover
- ☐ Prime Choice: no excess
- ☐ Prime Choice: $500 excess
- ☐ Smart Starter: $500 excess

For Couples, Families, Sole Parent Families

- ☐ Top Cover
- ☐ Prime Choice: no excess
- ☐ Prime Choice: $1000 excess
- ☐ Smart Starter: $1000 excess (couples only)

Ancillary Cover

For Singles, Couples, Families, Sole Parent Families

- ☐ Total Extras
- ☐ Essential Extras

I would like my membership to commence/ changes to take effect

☐ From the date I sign this application ☐ From this date in the future DD / MM / YYYY

Transferring from another health fund?

We can help you ensure continuity of benefits from another fund. Simply complete the details below, and The Doctors' Health Fund will arrange to cancel your existing membership and obtain a transfer or clearance certificate from the fund. A waiting period may apply to benefits not covered by your previous fund membership, please see our product information brochure or our website for details.

To: Your current fund

Address

Suburb State Postcode

I wish to resign from the Fund effective from DD / MM / YYYY Membership No.

I authorise Write your current fund's name to release the details of my membership including any personal information which is needed to provide a transfer certificate to The Doctors' Health Fund within 14 days as specified in The Private Health Insurance Act 2007 section 99-1 and Private Health Insurance (Complying Product) Rules and amendments.

Name

Address

Suburb State Postcode

Member Signature Date DD / MM / YYYY

Payment frequency

I wish to make my payments: ☐ Yearly ☐ Half-yearly ☐ Quarterly ☐ Monthly

Monthly option available only with Direct Debit. Option 1 A (or) B below

Payment options

Please select from option 1 or 2

OPTION 1. ☐ I would like The Doctors' Health Fund to set up automatic payment of my contributions:

Automatic payments are deducted from your account on the date your contribution is due.

A: ☐ Credit card deductions from my ☐ Visa ☐ Mastercard

Credit Card No Expiry Date /

Cardholder's Name (as shown on card)

Preferred day of month for automatic deduction

I declare the information supplied on this form is true and complete and agree to be bound by the rules of The Doctors' Health Fund. The Doctors' Health Fund is authorised to alter the amount charged if I change my level of cover, or the contributions change.

Cardholder's Signature ✗ Date DD / MM / YYYY

B: ☐ Direct Debit from my bank/building society/credit union

Name of Financial Institution

Name(s) of account holder(s)

BSB No – Account No

Preferred day of month for automatic deduction

I/We request The Doctors' Health Fund Limited (ID No 324455) to arrange a debit from the account nominated above in accordance with the terms and conditions of the Direct Debit Request Service Agreement in the Fund's product brochure and on the Fund's website.

Account Holder(s) signature(s) ✗ Date DD / MM / YYYY

✗ Date DD / MM / YYYY

OPTION 2. ☐ I would like The Doctors' Health Fund to send me a request for each contribution payment.
I will pay my contributions by credit card, BPay, cheque or money order made payable to The Doctors' Health Fund Limited.

Initial Payment

Your insurance will not be effective until an initial payment is made

☐ Please deduct the payment from the source specified for my automatic payments

☐ Please find enclosed my cheque or money order

☐ Please deduct the initial payment from my ☐ Visa ☐ Mastercard

Credit Card No Expiry Date /

Cardholder's Name (as shown on card)

Cardholder's Signature ✗ Date DD / MM / YYYY

Claim payments

Faster payment, direct to your account

☐ I would like The Doctors' Health Fund to direct credit into my bank account the benefits paid to me when I make a claim for a doctor or other healthcare providers accounts which I have already paid. Please note that direct credit is not available to credit card accounts.

Account Name Not a Credit Card Account

BSB No – Account No

I want to receive the Commonwealth government rebate as a reduction on my contributions

If you do not complete this section, full contribution payments will apply.

Your name as it appears on your Medicare card	Medicare card no.	Expiry date

☐ Please tick here to confirm that all persons on your application meet the following requirements.

The information provided by you on this form will be used for the purposes of registering you for the Commonwealth 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.

To claim the rebate all persons on your membership must be listed on a Medicare card and the Medicare cards must be current, not expired.

If you don't have a Medicare card and you are entitled to one, or your card has expired, please obtain a current card from Medicare before claiming the rebate. If you have any questions about eligibility to claim the rebate, call the Department of Health and Ageing on 1800 676 296.

Lifetime Health Cover *If you are over 30 years old this may apply to you*

Lifetime Health Cover is a government initiative designed to encourage people to take out and maintain hospital insurance. Those who delay will pay a 2% loading on top of their contribution payments for every year they are aged over 30 when they first take out hospital cover. Any LHC loading that you pay for ten (10) continuous years will be removed from your hospital cover premium as long as you retain your hospital cover.

Have you or your partner turned 31 since 1 July 2000? ☐ Yes ☐ No
(If you ticked yes, LHC may apply)

Have you had private health insurance hospital cover since you turned 31? ☐ Yes ☐ No
(If you ticked no, LHC may apply)

Did you or your partner acquire full Medicare cover status for the first time more than 12 months ago? ☐ Yes ☐ No
(If you ticked no, we require your Medicare eligibility letter/s for confirmation, If you ticked yes,LHC may apply)

Did you have private health insurance hospital cover within 12 months of acquiring full Medicare status? ☐ Yes ☐ No
(If you ticked yes, we require your Medicare eligibility letter/s for confirmation, If you ticked no, LHC may apply)

How did you hear about The Doctors' Health Fund?

☐ Colleague ☐ Family ☐ Hospital event ☐ Student event ☐ Conference / seminar ☐ Internet advertising or search ☐ Advertising ☐ Direct mail

☐ iSelect ☐ Other (please specify) ____________

Declaration *Please read carefully, then sign this declaration*

I declare the information provided on this form is true, complete and correct. I will notify The Doctors' Health Fund of any changes.

I agree to be bound by the rules of The Doctors' Health Fund, which may change from time to time, including changes to rates and benefits.

Signature ✗ ____________ Date DD / MM / YYYY

Before you send us the application please check that you have signed all the signature boxes relevant to your application, including the declaration above.

Your privacy is important to us

The Doctors' Health Fund is committed to meeting the requirements of the Commonwealth Privacy Act 1988, as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act) and the National Privacy Principles which form part of the Act. We only collect personal information we need to provide you with health insurance services. We share relevant personal information with other parties bound by the same privacy standards who are involved in your healthcare to provide you with health insurance services. We do not sell your personal information to anyone. For complete information about our privacy policy please visit www.doctorshealthfund.com.au.