Application to join Doctors' Health Fund

The Doctors' Health Fund Pty Ltd
ABN 68 001 417 527 PO Box Q1749 Queen Victoria Building NSW 1230
freecall 1800 226 126 **f.** 02 9260 9958 **w.** www.doctorshealthfund.com.au **e.** info@doctorshealthfund.com.au

I am an Australian citizen or permanent resident ☐ Yes ☐ No

If not, unfortunately you are not eligible to join the Doctors' Health Fund.

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

- ☐ Medical Practitioner [Please write specialty here]
- ☐ Health Practitioner (please circle one): medical radiation / optometry / dental / occupational therapy / physiotherapy / psychology
- ☐ an employee of a Medical Practitioner or a Health Practitioner;
- ☐ a person studying to become a Medical or Health Practitioner at an Australian university, medical school or other educational institution;
- ☐ an overseas trained doctor registered for the AMC exams;
- ☐ an officer or employee of the federal, or a state, Australian Medical Association;
- ☐ an officer or employee of an associated or subsidiary organisation of the federal, or a state, Australian Medical Association;
- ☐ an officer or employee of any federal or state association of registered medical practitioners; or
- ☐ an officer or employee (including contractors) of Avant Insurance Limited;
- ☐ The spouse, partner, child, grandchild, parent, sibling, former spouse or partner, niece, nephew, or the partner of an adult child or sibling of a person in the above categories.

Are you a member of: Avant ☐ Yes ☐ No Avant Member ID: ______

Are you are member of: AMA ☐ Yes ☐ No Which state chapter? ______ Optometry Australia ☐ Yes ☐ No

Personal details: Please print clearly

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 ______

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

	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3
Title				
Surname				
Given names				
Date of birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Gender	Male / Female	Male / Female	Male / Female	Male / Female
Relationship to you				

Student dependant cover where the student dependant is 21 years or over

Name of school/ college/university				

Please tick those dependants who need a Fund card for electronic claiming of extras services

	☐	☐	☐	☐

Additional authoriser for this policy

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

Your cover requirements

Please read the product information in our brochure or on our website carefully, and retain a copy of the "Welcome to the Fund" brochure you will receive upon joining.

HOSPITAL COVER

For Singles

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

For Couples, Families, Single Parent Families

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

EXTRAS COVER

For Singles, Couples, Families, Single Parent Families

- ☐ Total Extras
- ☐ Essential Extras
- ☐ Basic Extras (Only with Smart Starter Hospital Cover)

Existing Medical Conditions

If you or any dependants 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.

I would like my membership to commence

☐ 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 your current fund. A waiting period may apply to benefits not covered by your previous fund membership. Please see our 'Welcome to the Fund' brochure or our website for details.

Current Fund Name ____________ Membership No. ____________

I wish to cancel effective from DD / MM / YYYY

I authorise The Doctors' Health Fund 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.

Member Signature X ____________ Date / /

If you wish to add your partner to your Doctors' Health Fund cover:

Was your partner on a different policy ☐ Yes ☐ No

If Yes, please provide their Current Fund Name ____________

and Membership Number ____________

Payment frequency

I wish to make my payments: ☐ Yearly (2.5% discount) ☐ Half-yearly ☐ Quarterly ☐ Monthly (monthly payment only available by direct debit, see option 1 below.)

Payment options: Please select from option 1 or 2

OPTION 1 - by direct debit

Automatic payments are deducted from your credit card or nominated account on the date your contribution is due.

A: ☐ Credit card deductions from my ☐ Visa ☐ Mastercard * Due to compliance reasons we will call you in order to verify your credit card details.

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 Pty Ltd (ID No 324455) to arrange a debit from the credit card or 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) X / /

X / /

OPTION 2 - by invoice

☐ I would like The Doctors' Health Fund to send me an invoice for each contribution payment. I will pay my contributions by credit card, BPay, cheque or money order made payable to The Doctors' Health Fund Pty Ltd.

Claim payments: Faster payment, direct to your account

☐ I would like The Doctors' Health Fund to directly credit into my bank account the benefits payable to me when I make a claim for a doctor or healthcare providers account. 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 Australian 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

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.

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

Private Health Insurance rebate effective from 1 April 2018 to 31 March 2019

Please tick the appropriate tier

Please tick	☐ Base Tier	☐ Tier 1	☐ Tier 2	☐ Tier 3
Singles	$90,000 or less	$90,001 - 105,000	$105,001 - 140,000	$140,001 +
Families	$180,000 or less	$180,001 - 210,000	$210,001 - 280,000	$280,001 +

Age of oldest person to be on your Doctors' Health Fund cover:

Please tick	☐ Base Tier	☐ Tier 1	☐ Tier 2	☐ Tier 3
Under 65	25.415%	16.943%	8.471%	0%
65 - 69	29.651%	21.180%	12.707%	0%
70+	33.887%	25.415%	16.943%	0%

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 first hear about The Doctors' Health Fund? (Pick one answer)

☐ Colleague ☐ Family Event / Conference / Seminar [Please enter event] ☐ Internet advertising or search advertising
☐ Direct mail ☐ Employee of Avant ☐ OA / AMA Promotion ☐ Advertising
☐ Avant 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.
I agree to The Doctor's Health Fund using my personal information in accordance with its Privacy Policy and providing information and marketing material by phone, text message, mail or email.

Signature X ____________________ / /

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**

By entering into this agreement, you agree that The Doctors' Health Fund's strategic partner, the Australian Health Service Alliance ("AHSA") may collect your personal information, including your health information ("your information") and use your information and/or disclose it to The Doctors' Health Fund or your health service provider, for the purposes of providing health services to you and/or managing the funding of those services, or as required by law. AHSA's privacy policy, at **www.ahsa.com.au/web/ahsa/privacy_policy** provides its contact details and explains how you may access and correct your information, or make a complaint.