



# MEMBERSHIP APPLICATION

Health Insurance Fund of W.A. Ltd (HIF)  
ACN 128 302 161  
An Australian public company limited by guarantee  
A registered private health insurer

60-62 Stirling St, PERTH WA 6000  
HIF, GPO Box X2221, PERTH WA 6847  
Phone: 1300 13 40 60 Fax: (08) 9228 4058  
E-mail: join@hif.com.au Web: www.hif.com.au

Date Cover is to commence (dd/mm/yy):

## A. PRIMARY MEMBER DETAILS

Title  Full Name:

Address

Suburb  State  Postcode  Birth Date (dd/mm/yy)

Home  Work  Mobile

Email

**ONLINE ACCESS**  Yes Preferred method of contact: Post  Email  SMS

By ticking the yes box and providing your email address, we will create your online access to the members centre on the HIF website. This will allow you to view the change details of your membership 24 hours a day. If you do not want this setup, leave the box blank.

## B. TO RECEIVE THE FEDERAL GOVERNMENT REBATE AS A REDUCED PREMIUM

Are all persons listed on the Application form permanent Australian residents and eligible for FULL Medicare benefits?  Yes  No

Do you wish to receive the Federal Government rebate as a reduced premium? (Note: HIF quotes include rebate)  Yes  No

You cannot apply for the rebate until you are entitled to receive full Medicare Benefits. Contact HIF to discuss alternative cover.

Medicare Card No:  Valid to: (mm/yy)

Name on Card:   
First Name Middle Initials Surname

## C. ALL OTHER PERSONS TO BE COVERED

**2** First Name  Middle Name  Surname  Birth Date (dd/mm/yy)

M/F Relationship to Member

**3** First Name  Middle Name  Surname  Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student and 21+: Name of Tertiary Institution  This declaration applies for the year:

**4** First Name  Middle Name  Surname  Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student and 21+: Name of Tertiary Institution  This declaration applies for the year:

**5** First Name  Middle Name  Surname  Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student and 21+: Name of Tertiary Institution  This declaration applies for the year:

**6** First Name  Middle Name  Surname  Birth Date (dd/mm/yy)

M/F Relationship to Member

If Student and 21+: Name of Tertiary Institution  This declaration applies for the year:

**D. TYPE OF COVER**

**Choose your Hospital Cover**

**Top with Private Room**

- GoldStar Hospital (No Excess) H3
- GoldStar Excess 200/400 R3
- GoldStar Excess 400/800 R4
- GoldStar Excess 500/1000 R5

**Top with Shared Room**

- Gold Hospital (No Excess) H2
- Gold Excess 100/200 R2
- Gold Excess 200/400 R6
- Gold Excess 400/800 R7

**Intermediate**

- GoldSaver Hospital Excess 200/400 GS

**Basic**

- GoldStarter Hospital Excess 200/400 GR

**Choose your Ancillary Cover**

**Top with Extras**

- Premium Options A5

**Top**

- Super Options A

**Intermediate**

- Special Options A1

**Basic**

- Saver Options A2

**Overseas Visitors Hospital and Medical**

- Overseas Visitors Hospital and Medical (No Excess)
- Overseas Visitors Hospital and Medical Excess 200/400

**Ex Dependents Only**

Previous HIF membership Number

I wish to have the same cover as my former membership

**Proof of Age**

Under the provisions of the Government’s “Lifetime Health Cover” legislation, all premiums for hospital insurance, for persons over 30 years, may be subject to an age loading. When completing your application to join HIF or add an adult dependant, proof of age is required. Please attach a copy of one of the following documents for all persons over the age of 21 on your policy.

- Passport
- Driver’s Licence
- Birth Certificate
- Proof of Age Card

**E. TRANSFERRING FROM ANOTHER FUND**

If you are transferring from another health fund, HIF can arrange to cancel your existing membership. Simply complete the section below and return to us. If you and your partner are transferring from separate health funds, you will each need to complete a transfer request. (Extra forms can be found on the HIF website. [www.hif.com.au](http://www.hif.com.au))

Title  Full Name:

Current Health Fund  Member No.

Please be advised I wish to cancel my membership from (dd/mm/yy)

This will necessitate the cancellation of all payment arrangements pertaining to this cover. If applicable, any refund of contributions paid in advance of the cancellation date should be sent to the member named above. The Interfund Clearance Certificate should be forwarded to: HIF, GPO Box 2221, PERTH WA 6847.

Please provide information to HIF about:  Myself  My partner  My dependents

Signature of person requiring transfer

Date: (dd/mm/yy)



