



# MEMBERSHIP APPLICATION

Health Insurance Fund of Australia Ltd  
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: hif.com.au

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

## A. PRIMARY MEMBER DETAILS

Title  Given Name:  Surname

Address

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

Home  Work  Mobile

Email

ONLINE MEMBERSHIP 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 and 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

You cannot apply for the rebate until you are entitled to receive full Medicare Benefits. Contact HIF to discuss alternative cover. If you leave this blank we will not apply the rebate – quotes supplied by HIF include the rebate.

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

## C. ALL OTHER PERSONS TO BE COVERED

Title	First Name	Second Name	Surname	DOB	Relation to Member	M/F

Note: Dependants aged of 21-24 must be full time students to be covered by this policy, please indicate tertiary institution for any persons aged 21-24 listed above. 1st  2nd

## E. TRANSFERRING FROM ANOTHER FUND

• If you are transferring from another health fund, HIF can arrange to cancel your existing membership. If you and your partner are transferring from separate health funds, you will each need to complete a transfer request. Forms can be found at [www.hif.com.au](http://www.hif.com.au)

Title  Full Name:  Surname

Current Health Fund  Member No.

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

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

Signature

Date: (dd/mm/yy)

**D. TYPE OF COVER**
**Hospital Cover**
**Top (Private Room)**

 Goldstar Nil  200  400  500 
**Top (Shared Room)**

 Gold Nil  100  200  400 
**Intermediate**

 Goldsaver (includes \$200 excess) 
**Basic**

 Goldstarter (includes \$200 excess) 
**Ancillary Cover**
**Top with Extras**

 Premium 
**Top**

 Super 
**Intermediate**

 Special 
**Basic**

 Saver 
**F. DIRECT DEBIT**
**Step 1 Payment method (Choose one only)**

 Please debit my bank account 

 Please debit my credit card 

 Send me a periodical statement 
**Step 2 Membership activation (payment of 1 months premium is required to activate your membership)**

 Use my Credit card to activate  (complete below)

 Cheque enclosed 

 Money order enclosed 
**Step 3 Payment frequency**
 Fortnightly (*Direct Debit Only*)  Monthly  Quarterly  Six Monthly  Annually

 Preferred date for direct debits:  (you can alternatively choose a day of the week)

**Step 4 Financial Details (When choosing credit card to activate and account to direct debit please complete both fields)**
**Account**

 Institution: 

 BSB Number:  - 

 Account No.: 

 Account Name: 
**Credit Card**

 Type: 

 Card Number: 

 Expiry: 

 Name on Card: 

Please contact the fund for any payroll enquiries.

**DECLARATION**

Where direct debit is chosen, I/we have read the Direct Debit Service Agreement (as found on [www.hif.com.au](http://www.hif.com.au)) and agree to its terms. This request is to remain in force until cancelled, deferred or otherwise altered in accordance with the terms of the Direct Debit Service Agreement. The information provided in this form will be used in accordance with HIF's privacy policy. By supplying my address, telephone and email address, I agree that HIF can use these to keep me updated on my membership and any future products, until such time as I tell HIF otherwise.

I declare that all details are true and correct and agree to be bound by the rules of HIF. I understand the Pre-Existing Ailment Rule, Waiting Periods and Benefit Limitations may be applied to my membership. I declare that students aged 21 to 25 years on this membership are attending a full-time course. I certify that any dates of birth shown on this form are correct. I understand if a date of birth has been stated incorrectly and this resulted in incorrect premiums being paid, HIF reserves the right to deduct the additional premium from the next claim benefit entitlement or to adjust my next payment amount.

**Signature**


 Date: (dd/mm/yy) 

Referred by

Member No.

**SPOUSAL/AGENT AUTHORITY**


 (If not listed on application) - Name 

 Birth Date (dd/mm/yy) 

I authorise the person identified to make changes or alterations to my HIF membership and claim for benefits on my behalf.

**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 proof of age is required. Please attach a copy of a **driver's licence, passport or birth certificate** for all persons over the age of 21 on your policy.