MEMBERSHIP VARIATION REQUEST FORM

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

Level 4, 100 Stirling St, PERTH WA 6000
HIF, GPO Box X2221, PERTH WA 6847
Phone: 1300 13 40 60 Fax: (08) 9328 3345
E-mail: hello@hif.com.au Web: hif.com.au

Membership Number:

A. PRIMARY MEMBER DETAILS

Title Given names: Surname:

Address

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

Home Work Mobile

Email

Preferred method of contact: Post Email

If you wish to nominate a date in the future that these changes will be effective, please specify (dd/mm/yyyy)

B. ADD OR DELETE MEMBERS

Please complete Section C in addition to this section if adding a member over 30 years of age.

add / delete	First Name	Middle Name	Surname	Birth Date (dd/mm/yy)
	Gender (M/F/O)	Relationship (child / grandchild / foster child / step-child, other)		
	If Student and 21+, Name of Tertiary Institution		This declaration applies for the year:	

add / delete	First Name	Middle Name	Surname	Birth Date (dd/mm/yy)
	Gender (M/F/O)	Relationship (child / grandchild / foster child / step-child, other)		
	If Student and 21+, Name of Tertiary Institution		This declaration applies for the year:	

add / delete	First Name	Middle Name	Surname	Birth Date (dd/mm/yy)
	Gender (M/F/O)	Relationship (child / grandchild / foster child / step-child, other)		
	If Student and 21+, Name of Tertiary Institution		This declaration applies for the year:	

add / delete	First Name	Middle Name	Surname	Birth Date (dd/mm/yy)
	Gender (M/F/O)	Relationship (child / grandchild / foster child / step-child, other)		
	If Student and 21+, Name of Tertiary Institution		This declaration applies for the year:	

If you wish to add more people, please attach a separate list.

Are all persons listed eligible for FULL Medicare Benefits? Yes No

C. 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 variation 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:

D. SPOUSE / PARTNER AUTHORITY

If you have listed a spouse or partner on your cover, this person will automatically be given authority to make changes to your membership. If you do NOT want your spouse or partner to have this authority, please tick this box

FUND RULES APPLICABLE TO VARIATION OF MEMBERSHIP

RULES TO ADD OR DELETE DEPENDENTS

Membership Eligibility: General

Subject to these Fund Rules, any person currently residing in Australia is eligible to be a Fund Member of HIF.

- A person who is not eligible for Medicare Benefits will not receive Access Gap benefits under HIF Domestic covers
- List only those persons to be added or deleted from your cover.
- If any person listed on this Membership Variation Form is transferring from another health fund please complete Section G: Switching Funds. Transfer details from the previous fund must be held by HIF before any claims can be paid.

  From the 1st July 2000 members who join a hospital table will pay an additional 2% of the relevant base rate for each year their age exceeds 30 years, to a maximum of 70%. Those born prior to the 1st July 1934 will be exempt from the additional loading. Where a person is required to pay the higher premium and, because of a lower stated "entry age" than that which should actually apply, HIF reserves the right to take corrective action either by deducting an amount, equal to the additional contributions required or to deduct from the benefit entitlement the additional premium from the next claim, or adjusting the date paid to.
- Proof of age documentation must be attached (ie. photocopy of driver's licence or passport) for any dependants who are over 21 years of age.
- A Student Declaration Form must be completed for all dependants who are fulltime students, aged between 21 - 25 years of age and unmarried.
- When adding a newborn to a single membership, the member of a single membership has one month from the date of birth of the baby to advise the fund of a transfer to a family membership. The family membership will be backdated to the date of the baby's birth. The newborn will not be required to serve any new waiting periods.
- If adding a newborn to a family membership, the member has two years from the date of birth of the baby to register the dependant's details with the fund. The new dependant will not be required to serve any new waiting periods.
- If you are adding a dependant who has been granted permanent Australian Residency and Full Medicare Benefits, documentation to this affect will be required to avoid LHC Loading being applied to the membership. Please note that all persons must be joined within 12 months of receiving permanent status or arriving into the country.
- If you wish to include grandchildren or foster children on this policy, please attach proof of guardianship.

RULES TO AMEND MEMBERSHIP

General Information

Waiting periods, Benefit Limitations and the Pre-existing ailment rule apply to all new members who join the fund, or upgrade their level of cover. Members who transfer from another registered health fund will not be subject to new waiting periods or benefit limitation periods provided these periods have already been served on an equivalent level of cover with their previous fund. Where a benefit or service is not covered with your previous fund the applicable waiting period will be required to be served with HIF prior to benefits being paid.

A policy document detailing your level of cover selected and the relevant waiting periods, benefit limitation periods and the pre-existing ailment rule will be forwarded to you upon processing your request. HIF recommends that you read these policy documents carefully to ensure you are aware of your entitlements and or applicable waiting periods, benefit limitation periods and the pre-existing ailment rule.

E. CHANGE TYPE OF COVER

Choose your Hospital Cover

Top with Private Room

- ☐ GoldStar Hospital (No Excess)
- ☐ GoldStar Hospital (Excess 200/400)
- ☐ GoldStar Hospital (Excess 400/800)
- ☐ GoldStar Hospital (Excess 500/1000)

Top with Shared Room

- ☐ Gold Hospital (No Excess)
- ☐ Gold Hospital (Excess 100/200)
- ☐ Gold Hospital (Excess 200/400)
- ☐ Gold Hospital (Excess 400/800)

Intermediate

- ☐ GoldSaver Hospital (Excess 200/400)

Basic

- ☐ GoldStarter Hospital (Excess 200/400)
- ☐ GoldVital Hospital (Excess 500/1000)

Choose your Extras Cover

Top

- ☐ Premium Options
- ☐ Super Options

Intermediate

- ☐ Special Options

Basic

- ☐ Saver Options
- ☐ Vital Options

Choose your Overseas Visitors Hospital & Medical Cover

Working Visa Cover

- ☐ **Comprehensive** (Excess 500/1000)
- ☐ **Comprehensive** (No Excess)
- ☐ **Intermediate** (No Excess)
- ☐ **Essentials** (No Excess)

Non-Working Visa Cover

- ☐ **Visitor Saver** (Excess 250/500)
- ☐ **Visitor Value** (Excess 250/500)

F. CHANGE IN PAYMENT METHOD

☐ **Manual Invoice** Frequency ☐ Monthly ☐ Quarterly ☐ Six Monthly ☐ Annually

☐ **Direct Debit** from a financial institution or Credit Card (Complete a separate Direct Debit Request form)

☐ **Payroll Deduction** (contact Fund for eligibility) Employer:

DECLARATION

PRIVACY

I acknowledge that personal information provided herein will be used by HIF to deliver the products and services of my membership. All information will remain confidential. This information may be disclosed to third parties and authorised Government Agencies to deliver services associated with my health insurance. Failure to provide personal information may result in the failure to process or deliver the service requested. I confirm that the information supplied on this variation form is provided with the consent of those individuals listed on this form and includes consent from those individuals to act on their behalf.

VARIATION

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/yyyy)

If you require assistance to complete your Variation Form, please phone HIF on 1300 13 40 60 and speak to a Membership Consultant. Completed variation forms can be dropped off in person at 60-62 Stirling Street, Perth or mailed to HIF at GPO Box X2221, PERTH WA 6847.

SPOUSAL/AGENT AUTHORITY ☐

(If not listed on variation - Name BirthDate: (dd/mm/yy)

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

G. SWITCHING FUNDS

- If you, or someone you are adding, are transferring from another health fund, HIF can arrange to cancel your existing membership on their behalf. 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.
- Waiting periods you have served with your current fund will be recognised if you join an equivalent or lower level of cover within two (2) months of ceasing cover with that fund.
- Claims for services rendered up to your cancellation date will be paid by your previous fund. HIF will accept claims for services provided after your joining date, with benefits being paid once your Clearance Certificate has been received from your previous fund.

This section will be sent to your current fund.

Title ☐☐☐☐ Given names: ☐☐☐☐☐☐☐☐☐☐☐☐ Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐

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 X2221, PERTH WA 6847.

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

Signature of person requiring transfer Date: (dd/mm/yyyy) ☐☐☐☐☐☐☐☐

Note: HIF requires a minimum of twelve (12) months claims history and previous health insurance cover.