SWITCHING FUNDS

Health Insurance Fund of Australia 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) 9328 3345
E-mail: info@hif.com.au Web: www.hif.com.au

You may type into this form and save and/or print it.
Please email your completed form to processing@hif.com.au

Please use BLOCK letters and write in black pen

Membership Number:

A. MEMBER DETAILS

Title | Given names: | Surname:

Address

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

Home | Work | Mobile

Email

B. MEMBER DETAILS

If you, or someone you are adding, are transferring from another health fund, HIF can arrange to cancel your/their existing membership on their/your 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.

Please Note:

- 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 serviced after your joining date, with benefits being paid once your Clearance Certificates have 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)

Type name in space above to sign digitally.

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

To be completed by your partner if they are joining HIF from a different fund other than above.

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)

Type name in space above to sign digitally