ACA Health Application Form

1. I wish to...

☐ Join ACA Health

☐ Change details of existing membership: Membership #

2. Commencement date

Please start/change my membership & pay the appropriate contributions from:

3. Confirming eligibility (new members only)

☐ Current or past employee of an Adventist Church company — Company name: *(please include proof of employment (e.g. ID card, payslip)*

☐ Relative of eligible person — Eligible persons full name: / Phone number: / Membership number: *(if applicable)* / Company name: *(if applicable)*

☐ Past or transferring member or dependant — Membership name: Number:

4. Policy holder's details

Title: Surname: Given names:

Mailing address:

Suburb: State: Postcode: Date of Birth: Gender:

Home phone: Mobile/other phone:

Email address: *(please note we may send you a news email 'Healthybite' from time to time)*

Mothers maiden name (for privacy):

5. Where did you hear about us?

☐ HR/Payroll office ☐ Family ☐ Sales Representative
☐ Friend ☐ Work colleague ☐ Other _____

6. Select your cover

Please tick one Hospital **and/or** one General Treatments cover.

Dependant Extension must be taken in conjunction with a General Treatments **and Deluxe or Private Hospital Cover. It cannot be taken with Basic Hospital. Children aged 21-25 who are not studying full time can stay on your family policy with a 30% loading.*

Hospital Cover	General Treatments Cover	Membership Type
☐ Deluxe Hospital	☐ Complete Ancillary	☐ Single
☐ Private Hospital	☐ Ancillary Lite	☐ Single Parent
☐ Bare Essentials Hospital		☐ Single Parent + Dependant Extension*
☐ Basic Hospital		☐ Family
		☐ Family + Dependant Extension*

7. Details of others to be covered under your family policy

Relation to member	Surname	Given names	Date of birth	Gender	Contact

Please attach a further listing if space is insufficient.

☐ Please make my partner an Authorised Benefit Recipient on the policy. I understand this allows them to claim benefits directly, ask questions and to make changes on the membership.

8. Transferring from another health fund?

If yes, please provide your clearance certificate and complete the following:

Name of previous Fund: Membership #

☐ Please request a transfer certificate on my behalf to be sent to ACA Health. Signature:

9. Claiming benefits by direct credit

I request ACA Health Benefits Fund to arrange for benefits claimed to be credited to my nominated account at the financial institution shown below. I agree that if the nominated bank account changes, the Fund must be notified in writing; where incorrect payment details have been provided I am responsible for all costs associated with the recovery of the payment. If I am unwilling to pay the cost to recover the amounts paid by the fund in satisfaction of the claim, the benefit entitlement is considered extinguished by the health fund.

*Note: Benefit payments can only be made to **bank accounts**, not credit cards.*

Name of Financial Institution: Account Name:

BSB: ☐☐☐-☐☐☐ Account Number:

10. Payment options

Please choose one of the below 3 options:

1. DIRECT DEBIT

I request ACA Health Benefits Fund user ID 031606 to arrange for funds to be debited from my nominated account at the financial institution shown below according to the specified schedule. I agree that in the event of changes to premiums, transfer of product or arrears payment, I authorise ACA Health to alter the amount from the appropriate date in accordance with such changes. I agree that if the nominated bank account changes, the Fund must be notified in writing.

Please nominate ONE account to be debited (bank account or credit card):

Bank Account:

Name of financial institution: Account name:

BSB: ☐☐☐ - ☐☐☐ Account number:

OR

Credit Card: ☐ Visa ☐ MasterCard

Name on card: Exp date:

Card number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Select frequency:

☐ Monthly ☐ Quarterly ☐ Yearly

Premiums are deducted in advance on the 20th of the month, or the next working day.

Account Holder's Signature ✕ Date:

2. PAYROLL DEDUCTIONS

Currently only available to employees of: Sydney Adventist Hospital, Sanitarium, Signs Publishing, South Australian Conference, Elizabeth Lodge ARV. Please have your payroll officer sign below to authorise payments.

I hereby give authority for payroll deductions for my appropriate premiums to be made as follows:

	Signature: ✕	Date:
Policy Holder:	Signature: ✕	Date:

3. INDIVIDUAL PAYMENTS

☐ I would like to self-manage my payments by using any of the following methods. I understand that this means I am responsible for keeping my premium payments up to date.

- By BPAY (contact us for more details)
- By credit card - telephone payment
- By credit card - internet payment (Login to Online Member Services at www.acahealth.com.au)
- By mail or in person, with cash or cheque

11. Declaration & signature

To complete your application, please check the following details and sign below:

- I have attached proof of age (driver's license, birth certificate or passport) for all adults on my policy.
- I declare that any students on my policy aged 21 to 25 are studying full-time, OR a 30% loading will be charged to my membership according to the Dependant Extension rules.
- I understand all hospital admissions within the first 12 months of joining or upgrading my cover are subject to the Pre-existing Ailment confirmation process, as determined by the Medical Advisor appointed by the Fund.
- I understand the Waiting Periods (including pregnancy related services).
- I declare all details provided to be true and correct and agree to be bound by the rules of ACA Health.
- I have read and understood the below Privacy Statement.

Policy holder or authorised person's signature ✕ Date:

Privacy Statement

ACA Health Benefits Fund Limited (ACA Health) collects personal information about you, such as your name, address, contact details, health information, and your family and domestic relationships. ACA Health collects payment information and information about your employer, your income and other information relevant to your eligibility for private health insurance with ACA Health and eligibility for any government rebates and incentives (including your Medicare number). ACA Health collects personal information (including health information) about you from other sources such as health service providers and your previous private health insurer.

If you are seeking to be insured under a policy that covers more than one person, ACA Health may collect information about you from another person covered by the policy. If you provide personal information about another person (including in this application form), you must first obtain their consent to do so and make them aware of the matters set out in this privacy statement.

ACA Health collects personal information in order to provide and administer its products and services. If we do not collect personal information about you, or other persons covered by the policy, we will not be able to provide private health insurance cover. We may disclose your personal information to health service providers, health management providers, government agencies (such as Medicare or the ATO), and other third parties as set out in our Privacy Policy. We may also use and disclose your personal information to inform you about products and services which may be of interest to you. You can opt-out of direct marketing communications at any time by contacting us on 1300 368 390 or by emailing info@acahealth.com.au.

Information about how you can access and correct your personal information, or make a complaint about how we have handled your personal information, is included in our Privacy Policy available on our website. ACA Health can be contacted on 1300 368 390 or visit our website www.acahealth.com.au.

Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

Important information

- Complete this form and lodge it with your health fund to receive the Australian Government Rebate on Private Health Insurance as a reduced premium.
- All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium.
- Policy holders must nominate the level of rebate they believe they are entitled to.

	Base Tier	Tier 1	Tier 2	Tier 3
Singles	under $90 000	$90 001 to $105,000	$105,001 to $140,000	over $140,001
Family/Couples*	under $180,000	$180,001 to $210,000	$210,001 to $280,000	over $280,001
Aged under 65	25.934%	17.289%	8.644%	0%
Aged 65-69	30.256%	21.612%	12.966%	0%
Aged 70+	34.579%	25.934%	17.289%	0%

**Income thresholds increase by $1500 for every child after the first.*

- If a policy holder claims a rebate level above their actual entitlement a recovery of monies will occur through the Australian Taxation Office (ATO) as a tax debt.
- If a policy holder claims a rebate level below their actual entitlement a refund will occur through the ATO as a tax credit.
- If at any stage you wish to stop receiving or wish to nominate a new income tier for the Australian Government Rebate on Private Health Insurance as a reduced premium, you must notify your health fund as soon as possible.

Assistance

For more information about the Australian Government Rebate on Private Health Insurance, go to humanservices.gov.au/privatehealth

Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling 132 011.

or go to:
https://www.humanservices.gov.au/customer/services/medicare/medicare-card

Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

Lodgement

Send completed and signed form to your nominated health fund.

Claimant's details

Name of private health fund: ACA Health

Office use only
Membership Number#

Are you covered by this policy?

Yes ☐ Date premium reduction to commence __ __ / __ __ / __ __ __ __

No ☐ Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Medicare card number _____ Ref No. ____

Medicare card valid until: __ __ / __ __ / __ __ __ __

Your name as it appears on your Medicare card:

Surname: Given names:

Address:

Suburb: Post code: State:

Daytime Phone Number: Date of Birth: Gender:

Postal address, if different from above:

Address:

Post code: State:

Nominate your level of rebate

You must select a box. See the table on the left for rebate level details.

- ☐ Base Tier
- ☐ Tier 1
- ☐ Tier 2
- ☐ Tier 3

Continue over page >>>

Details of people covered by policy

Note: Provide details of all people covered by the policy (do not include yourself). Attach a separate sheet(s) to identify additional people covered by the policy if there is insufficient space on this form.

Family Name	Given Names	Date of Birth	Gender	Dependant Child (Y/N)	Contact (Optional)

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

You may be entitled to a Medicare card if you are:

- a person who lives in Australia, and
- an Australian citizen, or
- a holder of a permanent resident visa, or
- a New Zealand citizen, or
- an applicant for a permanent resident visa.

☐ Yes

☐ No

Declaration

I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Signature: ✕	Date:

Privacy note

Privacy notice

Your personal information is protected by law, including the Privacy Act 1988, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at www.humanservices.gov.au/privacy or by requesting a copy from the department.

Please return this form to ACA Health Benefits Fund
Post: Locked Bag 2014, Wahroonga, NSW 2076 Email: info@acahealth.com.au Fax: 02 9847 3357