ACA Health Membership Changes Form

Change details of existing membership #

Please change my membership
and pay the appropriate contributions from / /

2. Policy Holder's Details

Title | Surname | Given names

Mailing address

Suburb | State | Postcode | / / Date of Birth | M / F Gender

Home Phone | Work Phone

Mobile Phone | E-mail Address

Mother's maiden name (to protect your privacy)

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

Relation to member	Surname	Given names	Date of birth	Gender

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 and to make changes on the membership

4. Select your cover

Please tick one hospital and/or one General Treatments cover

Hospital Cover	General Treatments Cover	Membership Type
☐ Deluxe Hospital	☐ Complete Ancillary	☐ Single
☐ Private Hospital	☐ Ancillary Lite	☐ Family
☐ Basic Hospital		

5. Payment Method

Please complete your details overleaf

☐ Bank Account *(direct debit)* | ☐ Credit Card *(direct debit)* | ☐ Payroll Deduction *(limited availability, see overleaf)*

6. Transferring from another Health Fund?

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

Name of previous Fund | Membership #

Cover type | / / Date Joined | / / Date Paid To

7. Pre-Existing Ailments

Do you, or any person on this membership have any illness or condition which may require hospitalisation, medical or major dental treatment? Y / N

If Yes, please provide details

Name	Condition / ailment

8. Proof of Age

With the introduction of the Government incentives such as Lifetime Health Cover and the Federal Government Rebate, all new members must provide a proof of age by way of a copy of a birth certificate, current drivers license or passport.

Office Use: Proof of Age Sighted | Date

9. Declaration

I declare all details provided to be true and correct and agree to be bound by the rules of ACA Health Benefits Fund. I understand the Pre-existing Ailment Rule and Waiting Periods (including pregnancy related services).
I declare students aged between 21 and 25 on this membership are attending an approved full-time course.

Policy Holder or authorised person's signature | Date