Student Dependant Declaration

Policy Holder's Details

Member #:	Name of Policy Holder:

Declaration

I,_________________________________ *(Name of policy holder of authorised person)* declare that_________________ *(Name of Dependant)* meets the conditions of the ACA Health Benefits Fund Rules located in the Policy Booklet (page 7, Definition of a Dependant, (c) Student Dependant). The Policy Booklet can be downloaded from the Forms page at www.acahealth.com.au or you can request a copy by contacting our Customer Service Team on 1300 368 390 or emailing membership@acahealth.com.au.

☐ Yes

- ☐ A full time student at ____ (School/College/University)
- ☐ Under 25 years of age (they must take out their own membership on their 25th birthday)
- ☐ Not expected to earn an income above $20,000 gross per annum
- ☐ Does not have a spouse or de facto partner
- ☐ Expected to complete Full Time Study _____ / _____ (Month/Year)
- ☐ If the conditions for student dependant are no longer met, I agree to notify ACA Health within 30 days
- ☐ **A photocopy of his/her student card or other proof of enrolment is attached**

☐ **No**

My child no longer qualifies as a student dependant; however I would like to take out the Dependant Extension Cover (Only available with combined cover). I understand that a 30% loading will be added to the cost of my family policy effective from ____/_____/_________ and will remain until my dependant turns 31 years, is married, takes out their own cover or I inform ACA Health in writing that this arrangement is to cease.

☐ **No**

My child no longer qualifies as a student dependant and I do not wish to take up the Dependant Extension cover option. I understand they will be terminated from my membership effective ____/_____/_________. I have provided his/her contact details so that you can invite him/her to take out private health insurance in their own right.

☐ **No**

My child no longer qualifies as a student; however, I would like to take out my own policy. I understand that I will have immediate cover for the same or a lower level of cover and I will not need to serve any waiting periods.

Dependant Details

First Name:		Surname:	
Address:			
Suburb:		State:	Post Code:
Phone:	Email:		

Policy Holder or Authorised Person's Signature

Signature:	**Date:** / /

Please return to: ACA Health Benefits Fund to info@acahealth.com.au OR Locked Bag 2014 Wahroonga NSW 2076