

# Student Dependant Declaration



## Policy Holder's Details

Member #:	Name of Policy Holder:
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## 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](http://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](mailto: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 \$30,000 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:     /     /
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Please return to: ACA Health Benefits Fund to [info@acahealth.com.au](mailto:info@acahealth.com.au) OR Locked Bag 2014 Wahroonga NSW 2076