Locked Bag 2014
148 Fox Valley Rd
Wahroonga
NSW 2076
Phone 02 9847 3390
or 1300 368 390
Fax 02 9847 3357
Web www.acahealth.com.au

STUDENT DEPENDANT DECLARATION

YEAR: _____

Member Number: _____

I _____ declare that

(Name of policy holder or Authorised Person)

_____

(*Name of dependant*)

meets the conditions of a student dependant below and is eligible to remain under my family ACA Health Benefits Fund policy under the terms and conditions of the ACA Health Benefits Fund Rules.

☐ **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
- Unmarried
- Expected to complete Full Time Study ___/___ (Month/Year)
- A photocopy of his/her student card is attached

☐ **No**

My child no longer qualifies as a student dependant; however I would like to take out the Dependant Extension 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 25 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 want to take up the Dependant Extension cover option. I understand they will be terminated from my membership.

I have provided his/her contact details so that you can invite him/her to take out private health insurance in their own right.

Name: _____

Address: _____

_____

Mobile Phone: _____

Home Phone: _____

Policy Holder or
Authorised person's Signature: _____ Date: _____

Please return to: ACA Health
Locked Bag 2014, WAHROONGA NSW 2076
Fax 02 9847 3357
Email info@acahealth.com.au