



# Application Form

## 1. I Would Like To Join ACA Health

Start my membership & pay the appropriate contributions from:

## 2. Confirming Eligibility (new members only)

- Current or Past Employee of an SDA 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 #:   
 Company Name: (if applicable)
- Past or Transferring Member or Dependant  
 Membership Name:   
 Number:
- Current or Past Church Officer (Treasurer, Deaconess etc.)  
 Church:   
 Position:  Year of Service:
- I declare that this information is true and correct.

## 3. Policy Holder's Details

Title:  Surname:  Given Names:

Address:  Suburb:

Home Phone:  State:  Postcode:  Date of Birth:

Mobile:  Email:  Gender:

Please note we may send you a news email 'HealthyBite' from time to time.

## 4. Where Did You Hear About Us?

- Website  HR/Payroll Office/Employer  Friend  
 Sales Representative  Past Dependant  Other   
 Work Colleague  Past Member  
 Family  Members Own Health Funds

## 5. 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	Extras Cover	Type of Cover
<input type="checkbox"/> Deluxe Hospital	<input type="checkbox"/> Complete Ancillary	<input type="checkbox"/> Single
<input type="checkbox"/> Private Hospital	<input type="checkbox"/> Ancillary Lite	<input type="checkbox"/> Single Parent
<input type="checkbox"/> Bare Essentials Hospital		<input type="checkbox"/> Single Parent + Dependant Extension*
<input type="checkbox"/> Basic Hospital		<input type="checkbox"/> Family / Couple
		<input type="checkbox"/> Family + Dependant Extension*

## 6. Details Of Others To Be Covered Under Your Family Policy

Relation to member	Surname	Given names	Date of birth	Gender	Contact
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.

## 7. Transferring From Another Health Fund?

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

Previous Fund:  Membership #:

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

## 8. 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.*

Bank:  Acc Name:

BSB:  -  Acc Number:

## 9. 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):

<b>Bank Account:</b>	
Bank:	Acc Name:
BSB: -	Acc Number:

OR

<b>Credit Card:</b> <input type="checkbox"/> Visa <input type="checkbox"/> Master Card	
Name on Card:	Exp date:
Card Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

### 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 <input checked="" type="checkbox"/>	Date:
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### 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: <input checked="" type="checkbox"/>	Date:
Policy Holder:	Signature: <input checked="" type="checkbox"/>	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](http://www.acahealth.com.au))
- ✓ By mail or in person, with cash or cheque

## 10. Checklist

Please ensure you've included all necessary attachments to this Application form:

- Photo ID for all Adults on the policy
- Proof of Eligibility (e.g. staff payslip if current employee)
- Government Rebate Application Form (if claiming government rebate)

## 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 <input checked="" type="checkbox"/>	Date:
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## 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](mailto: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](http://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
<b>Singles</b>	under \$90 000	\$90 001 to \$105,000	\$105,001 to \$140,000	over \$140,001
<b>Family/Couples*</b>	under \$180,000	\$180,001 to \$210,000	\$210,001 to \$280,000	over \$280,001
<b>Aged under 65</b>	25.415%	16.943%	8.471%	0%
<b>Aged 65-69</b>	29.651%	21.180%	12.707%	0%
<b>Aged 70+</b>	33.887%	25.415%	16.943%	0%

\*Income thresholds increase by \$1,500 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 [privatehealth.gov.au](http://privatehealth.gov.au).

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

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

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

### Lodgement

Send completed and signed form to your nominated health fund.

### Claimant's Details

Name of Private Health Fund: **ACA Health Benefits Fund**

Office use only  
Membership Number#

Are you covered by the 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

### 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?

If you are unsure whether you are eligible for Medicare, go to <https://www.humanservices.gov.au/customer/services/medicare/medicare-card> for more information.

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

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: <b>X</b>	Date:
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### 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 where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).*

*You can get more information about the way in which the department will manage your personal information, including their privacy policy, at [www.humanservices.gov.au/privacy](http://www.humanservices.gov.au/privacy).*

### Please return this form to:

#### ACA Health Benefits Fund

Locked Bag 2014  
Wahroonga NSW 2076

OR

Email: [info@acahealth.com.au](mailto:info@acahealth.com.au)