Membership Changes

1. I Wish To Change Details Of An Existing Membership

Membership #:

Please change my membership & pay the appropriate contributions from: Date:

2. 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

Relation to member	Surname	Given names	Date of birth	Gender	Contact

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.

3. 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
☐ Deluxe Hospital ☐ Private Hospital ☐ Bare Essentials Hospital ☐ Basic Hospital	☐ Complete Ancillary ☐ Ancillary Lite	☐ Single ☐ Single Parent ☐ Single Parent + Dependant Extension* ☐ Family / Couple ☐ Family + Dependant Extension*

4. 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:

5. Transferring From Another Health Fund?

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

Previous Fund: Membership #:

Cover Type: Date Joined: Date Paid To:

6. 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 new adults on my policy.

☐ I declare students aged 21 to 25 on this membership 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 12mths of joining or upgrading my cover are subject to the Pre-existing Ailment confirmation process, as determined by the Medical Advisor of 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.

Policy Holder or Authorised Person's Signature ✕ Date: