

Membership Changes

Section 1: Policy Holder's Details

Member #:	Name of Policy Holder:		
Please change my membership & pay the appropriate contributions from:		Date:	/ /
Address:			
Suburb:	State:	Post Code:	
Home Phone:	Mobile:		
Email:			

Details of others to be covered under your family policy

Relation to member	Surname	Given Names	Date of Birth	Gender	Contact
			/ /		
			/ /		
			/ /		

Please attach a further list if spacing is insufficient

- Please make my partner an Authorised Member Assistance on the Policy. I understand this allows them to claim benefits directly, ask questions and to make changes and have equal authority on the membership.

Section 2: 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 Gold Deluxe, Gold Private or Silver Plus Hospital Cover. It cannot be taken with Bronze or Basic Hospital. Children aged 21-31 who are not studying full time can stay on your family policy with a 30% loading.*

Hospital Cover	Extras Cover	Types of Cover	
<input type="checkbox"/> Gold Deluxe Hospital <input type="checkbox"/> Gold Private Hospital <input type="checkbox"/> Silver Plus Hospital 500 <input type="checkbox"/> Silver Plus Hospital 750 <input type="checkbox"/> Bronze Essentials Hospital 500 <input type="checkbox"/> Bronze Essentials Hospital 750 <input type="checkbox"/> Basic Hospital	<input type="checkbox"/> Complete Ancillary <input type="checkbox"/> Ancillary Lite	<input type="checkbox"/> Single <input type="checkbox"/> Single Parent <input type="checkbox"/> Single Parent + Dependant Extension*	<input type="checkbox"/> Family/Couple <input type="checkbox"/> Family + Dependant Extension*

Section 3: 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:	Account Name:
BSB:	Account Number:

Section 4: 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: / /
Please request a transfer certificate on my behalf to be sent to ACA Health		

Section 5: Declaration & Signature

To complete your application, please check the following details and sign below:

- I have attached proof of age (driver's licence, birth certificate or passport) for all new adults on my policy.
- I declare students aged 21 to 24 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 12 months 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.

Signature: X (Policy Holder or Authorised Persons)	Date: / /
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