Membership Application

1. I Would Like To Join ACA Health

Start my membership & pay the appropriate contributions from: **Date:** / /

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:
State:	Post Code:	Date of Birth:
Home Phone:		Mobile:
Email:		Gender:

4. Where Did You Hear About Us?

- ☐ Family/Friend
- ☐ Social Media/Advertising
- ☐ The Record
- ☐ Adventist website
- ☐ Google/Search
- ☐ HR/Payroll Office/Employer
- ☐ Past Member/Dependant
- ☐ Sales Representative
- ☐ Members Own Health Funds
- ☐ Other: _____

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 Gold Deluxe, Gold Private Hospital Cover or Silver Plus Hospital. It cannot be taken with Basic Hospital or Bronze Essentials 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	Type of Cover
☐ Gold Deluxe Hospital ☐ Gold Private Hospital Bronze Essentials Hospital ☐ 500 ☐ 750 Silver Plus Hospital ☐ 500 ☐ 750 ☐ Basic Hospital	☐ Complete Ancillary ☐ Ancillary Lite	☐ Single ☐ Single Parent ☐ Single Parent + Dependant Extension* ☐ Family / Couple ☐ 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

Please attach a further listing if space 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.

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):*

Bank Account:

Bank:	Acc Name:
BSB:	Acc Number:

Credit Card:

☐ Visa ☐ Master Card

Name on Card:	Exp Date:
Card Number:	

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: ✕	**Date:** / /

2. PAYROLL DEDUCTIONS

Currently only available to employees of: Sanitarium, 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:

Payroll Officer:	**Signature:** ✕	**Date:** / /
Payroll Officer:	**Signature:** ✕	**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 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 31 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	✕	**Date:**

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.

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 acahealth.com.au.