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.*

***Mid Ancillary Extras cover is only available when purchased in combination with an ACA Health hospital policy.*

#Flex Extras cover is only available for singles cover and when purchased in combination with an ACA Health hospital policy.

Hospital Cover	Extras Cover	Types of Cover	
☐ Gold Deluxe Hospital	☐ Complete Ancillary	☐ Single	☐ Family/Couple
☐ Gold Private Hospital	☐ Mid Ancillary**	☐ Single Parent	☐ Family + Dependant Extension*
☐ Silver Plus Hospital 500	☐ Ancillary Lite	☐ Single Parent + Dependant Extension*	
☐ Silver Plus Hospital 750	☐ Flex#		
☐ Bronze Essentials Hospital 500			
☐ Bronze Essentials Hospital 750			
☐ Basic Hospital			

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: ✕ (Policy Holder or Authorised Persons)	**Date: / /**

Please return to: ACA Health Benefits Fund to info@acahealth.com.au OR Locked Bag 2014 Wahroonga NSW 2076