Online Application for health cover

FIRST NATIONAL REAL ESTATE
We put you first.

HCF

I wish to: (Please mark X) ☐ Join HCF. ☐ Transfer from another fund (Complete Interfund Transfer section). ☐ Change people covered, membership details or present cover.

Source	Deal code	Rate code
R20802	FNR	20

FNR Gi11136 APR 2008-v.1

Your personal details. Please use capital letters

Title | Given names

Surname | Current HCF Membership or Covernote No. | Sex M ☐ F ☐

Home address (Please complete your street number, name and suburb)

Postcode | Phone work | Mobile | Phone home

Postal address (Please complete your street number, name and suburb)

Postcode | Date of birth (Day/Month/Year) / /

Please tick if you would not like to receive either of our free monthly email newsletters ☐

Date you wish your membership to commence / /

Email

Please mark X ☐ Retain my existing products ☐ Single ☐ Couple/Family ☐ Single Parent Family ☐ Extended Family Cover

Other persons to be covered. Use another form if space is insufficient

Given names

Surname

Date of birth (Day/Month/Year) / /

Sex M ☐ F ☐

Relationship

Given names

Surname

Date of birth (Day/Month/Year) / /

Sex M ☐ F ☐

Relationship

Given names

Surname

Date of birth (Day/Month/Year) / /

Sex M ☐ F ☐

Relationship

Given names

Surname

Date of birth (Day/Month/Year) / /

Sex M ☐ F ☐

Relationship

Federal Government Rebate

Complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply. Are all people on your membership eligible for full Medicare Benefits?

☐ Yes - Please complete the remainder of this section ☐ No - You cannot apply for the rebate.

Your Medicare card number | Date of birth (Day/Month/Year) / /

Your name exactly as it appears on your Medicare card

Rebating of claims

If you would like your claims benefit paid directly into your account, please complete the following details:

BSB number –

Account name | Account number

Continued next page

HCF Product Choices. Please mark X

HCF Levels of Cover Please see pages 10-28 of Main Brochure for further information			Hospital Excess Options	HCF Stand Alone Products	
1	☐ Level 1	Hospital Advanced Savings + General Extras Plus	$50 x 8	☐ Hospital Advanced Savings	$50 x 8
2	☐ Level 2	Hospital Advanced Savings + Multicover	$50 x 8	☐ Top Plus	$50 x 8
5	☐ Level 5	Top Plus + Multicover	$50 x 8	☐ Multicover Only	
6	☐ Level 6	Top Plus + Super Multicover	$50 x 8	☐ Ambulance Cover Only	

More Protection Please see pages 36-41 of Main Brochure for further information

- ☐ Accident Cash Advantage ▵
- ☐ Health and Life Premium Insurance
- ☐ Cash Back Cover
- ☐ Permanent Disability Benefit Plus ▵
- ☐ Kids' Accident Cover*

▵Name of person to be covered by these products for HCF contributions insurance

*Name/s of children to be covered by Kids' Accident Cover

Payment method. Please mark X

☐ Ezipay (complete Ezipay Direct Debit Request below)

☐ Credit Card Authority (complete Credit Card Authority below)

Ezipay Direct Debit Request

I/We authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System (BECS).

Please mark X ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Yearly

on the ☐☐ day* of the month

(Please note: debit dates of 28, 29, 30 and 31 are not available)

***Please nominate your first debit day.**

This authorisation is to remain in force in accordance with the terms described in the HCF Direct Debit Customer Service Agreement.

Details of the account to be debited (All details must be supplied)

Name of financial institution

Branch

Account holder name (first initial and surname)

BSB number ☐☐☐ – ☐☐☐ Account number

Credit Card Authority Cardholder name (exactly as it appears on your card)

Type of card (please mark X)

☐ Visa ☐ Mastercard ☐ American Express

Debit frequency (please mark X)

☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Yearly

Expiry date ☐☐ / ☐☐

Credit card number

Please debit my account on the ☐☐ day* of the due month.

(Please note: debit dates of 28, 29, 30 and 31 are not available)

Declaration All applicants please read and sign

By supplying my address, telephone and email details, I agree that HCF can use these to keep me informed of future products and services, until such time as I tell HCF otherwise. All persons covered are permanent residents of Australia and entitled to full Australian Medicare. I agree to be bound by the rules of the Hospitals Contribution Fund of Australia Limited. For any HCF Life More Protection Options I have chosen, I have read and understood the Product Disclosure Statement and Financial Services Guide. Where payment method requested is Ezipay or Credit Card Deductions, I authorise HCF to debit the account nominated.

I understand and acknowledge the following conditions – please mark X in boxes below

☐ Hospital per night excess ☐ Obstetrics, pregnancy & birth related services ☐ Waiting periods ☐ Pre-existing ailments or conditions ☐ Minimum Benefits

(A pre-existing ailment is an ailment or condition where the signs or symptoms existed any time during the six months before you joined or upgraded to a higher level of cover. See definition on page 31 of "Your simple guide to choosing health insurance" brochure. **(A waiting period of 12 months applies to pre-existing conditions).**

Please check you have crossed the boxes above before signing this declaration. **I confirm that I have read and understood this declaration and the information in the brochure including pages 29-35. I declare the information provided to be true and correct.**

Signature Date ☐☐ / ☐☐ / ☐☐☐☐

Office use only

IDENTIFICATION – One of ☐ Photo licence ☐ Passport ☐ Govt Employers ID

Number

Other photo number

Batch number

Other number (attach details)

User ID

Continued next page

Interfund transfer Use another form if space is insufficient

Complete this section if you have been with an Australian Registered health fund at any time since 1/7/2000.
If you have a direct debit arrangement with your existing health fund please remember to personally advise your bank or your pay office (if you pay by payroll deduction) to cancel your deductions. Remember also to sign the Declaration section.

Title

Given names

Name of existing health fund

Surname

Membership number

Home address (Please complete your street number, name and suburb)

Postcode

I hereby authorise HCF to terminate my membership with your organisation and obtain details about my membership.

Date of Birth (Day/Month/Year)

/ /

Signature

Date / /

Please note due to privacy reasons, your existing health fund may send you the clearance certificate, which you will need to forward to HCF.

adma
DIRECT MARKETING CODE COMPLIANT

Please complete the application and payment authority and return to:

Health Link Consultants
PO Box 13107, Law Courts VIC 8010
Phone: (03) 9670 5555
Freecall: 1800 808 026