# HCF Resume my membership

Complete and send to:
**HCF**
**GPO Box 4242,**
**Sydney, NSW 2001**
or fax to:
**02 9290 0128**
or email:
**ezipay@hcf.com.au**

HCF Membership No.

## Membership details (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Complete if your details have changed

Title | First name | Middle initial

Surname

Sex (Please mark 'X')
M ☐ F ☐

Home address:
Unit No. | Street No. | Street name

Suburb | State | Postcode

Phone - home | Phone - work | Mobile

Postal address (if different from your home address)

Suburb | State | Postcode

Email @ . .

## Complete Section A or B

**A. Resumption – Overseas Travel**

I have returned to Australia on:
(DD MM YYYY)

Please resume my membership from this date

Evidence of departure and return dates is attached (i.e. copies of passport page(s), airline tickets, travel itinerary, boarding passes, etc.) ☐

**B. Resumption – Unemployment/Sickness Benefits**

I ceased claiming unemployment/sickness benefits on:
(DD MM YYYY)

Please resume my membership from this date

Evidence of date of benefits ceasing is attached (i.e. evidence of period of Centrelink entitlement or letter from employer noting date of employment.) ☐

## Complete Section C and Declaration

**C. Payment Method.** (PLEASE MARK X)

I agree that HCF can recommence my payment method previously authorised ☐ or;

Or alternatively, payment can be made by one of the following methods:

- completing the enclosed Payment Authority Form
- visiting an HCF branch
- automate your payments by calling 13 13 34
- pay online by logging into the members section at hcf.com.au

**Declaration**

I agree to have my membership resumed and declare all information stated on this form to be true and complete.

I declare that I and all persons covered by the policy are aware that they are bound by the Health Fund Rules of The Hospitals Contribution Fund of Australia Limited and the HCF Privacy Policy (available on the HCF website at hcf.com.au, in HCF branches or by calling 13 13 34), in accordance with which all members' personal information is dealt, including requests for access to, correction of and complaints about their personal information. I also understand that if my cover or premium rate has changed, the new premium rate is to be paid to HCF.

The signature must be of the Policyholder or Partner listed on the policy.

Signature X | Date (DD MM YYYY)