

**GMF HEALTH**  
*Member Application*





# GMF HEALTH Member Application

## 1. Member Details

I wish to:  Join GMF Health (Please complete all sections except 2b)  Change Membership/Cover Details (Please complete sections 1, 2a, 2b, 3, 8 & 9)

Date membership to be commenced:  /

Membership Number (if known) Your Password (optional – can be alpha or numeric)

Title Surname Given Name(s)

Date of Birth Gender M/F

Permanent Residential Address State Postcode

Postal Address State Postcode

Home Ph (Silent Number ) Business Ph Mobile Ph

Fax Number Email Address

## 2a. Additional people to be covered by this membership

| Title | Surname | Given Name(s) | Gender M/F | Date of Birth | Relationship to Applicant |
|-------|---------|---------------|------------|---------------|---------------------------|
|       |         |               |            |               |                           |
|       |         |               |            |               |                           |
|       |         |               |            |               |                           |

## 2b. People to be removed from this membership

| Title | Surname | Given Name(s) | Gender M/F | Date of Birth | Reason |
|-------|---------|---------------|------------|---------------|--------|
|       |         |               |            |               |        |
|       |         |               |            |               |        |
|       |         |               |            |               |        |

## 3. Level of Cover Required

Single  Family

**Choice of Cover** Please select the level of cover required.

For **combined** cover of Hospital and Necessities choose from the Combined products list or alternatively select one Hospital and one Necessities product.

| HOSPITAL   | NECESSITIES                                   | COMBINED  |
|--|---|---|
| <input type="checkbox"/> Gold Hospital                             | <input type="checkbox"/> Complete Necessities | <input type="checkbox"/> Family Choice*                           |
| <input type="checkbox"/> Silver Hospital                           | <input type="checkbox"/> Necessities          | <input type="checkbox"/> Young Singles Choice*                    |
| <input type="checkbox"/> Would you like to add on Ambulance cover? | <input type="checkbox"/> Lite Necessities     | <input type="checkbox"/> Bronze Hospital with Bronze Necessities* |

\*Restricted cover for some procedures, please refer to the GMF Health Membership Guide.

Please tick here if you wish to include an excess on your Gold or Silver Hospital:

- Include \$100 excess per person, \$200 maximum per membership
- Include \$300 excess per person, \$600 maximum per membership
- Include \$500 excess per person, \$1000 maximum per membership

## 4. Medicare Details

Are all persons listed on the application form permanent Australian Residents and eligible for FULL Medicare benefits?  Yes  No  
**(Note: Visa holders are not eligible for full Medicare benefits)**

If yes, please supply your Medicare Number and **full name** as it appears on your Medicare card.

Full Name

Medicare Number Expiry If you have recently arrived in Australia please provide your arrival date.

/  /

Partner's Medicare details (only complete if your partner's Medicare Number is different to yours).

Full Name

Medicare Number Expiry If you have recently arrived in Australia please provide your arrival date.

/  /

## 5. Federal Government 30% Rebate on Private Health Insurance

The Federal Government 30% Rebate on Private Health Insurance is only available to permanent Australian residents who are eligible for FULL Medicare benefits. You can only receive the Federal Government 30% Rebate on Private Health Insurance as a reduced premium if all people listed on this Application are eligible for Full Medicare Benefits.

- a) Do you want to claim the Federal Government 30% Rebate on Private Health Insurance as a reduced premium?  Yes  No
- b) If yes, are all people listed on this application entitled to Full Medicare Benefits.  Yes  No
- c) Are you covered by this GMF Health policy?  Yes  No

If no to 5c, you may still register for the rebate if this policy is for your dependant child and you are the parent of that child.

**Important Note:** Employers and trustees of organisations cannot claim the Federal Government 30% Rebate on Private Health Insurance on policies paid on behalf of employees. The information provided on this form will be used for the purposes of registering you for the Federal Government 30% Rebate on Private Health Insurance. Its collection is authorised by law, and information collected may be disclosed to the Department of Health and Ageing, Medicare Australia and the Australian Taxation Office.

## 6. Payment Method Required (only 1 option can be selected)

1.  Direct Debit – from your financial institution or credit card (Note: You must complete the Direct Debit Request on the reverse of this form)
2.  Statement (please indicate payment frequency)  Quarterly  Half Yearly  Yearly
3.  Payroll (complete section 7)

## 7. Payroll Deduction Authority

Company Name \_\_\_\_\_

Surname \_\_\_\_\_ Given Name(s) \_\_\_\_\_

Occupation \_\_\_\_\_ Department or Location \_\_\_\_\_

Pay Number \_\_\_\_\_ Payroll Telephone Number \_\_\_\_\_

I authorise my Pay Office to deduct from my salary/wages each  Week  Fortnight  Month the sum of  commencing from pay period \_\_\_\_\_ and remit deductions to GMF Health, PO Box 513, Kalgoorlie, WA 6433.

These deductions are to commence on the first pay day after your acceptance of this order or as directed by GMF Health and continue until revoked or varied by me in writing. Should GMF Health notify you that it has altered the published contribution rate or premium for the cover I have requested, the amount deducted from my salary/wages pursuant to this order is to be varied accordingly without any further authority from GMF Health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## 8. Previous Policy Details (if applicable)

If transferring from another fund please attach transfer details.

Fund Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Date Joined \_\_\_\_\_ Date Paid To \_\_\_\_\_

I authorise my previous fund to release to GMF Health all information relating to my former level of cover.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Partner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Please ensure that all adult members covered under this policy sign this form.

Please cancel my level of cover from: \_\_\_\_\_

## 9. Declaration and Signature

I declare the above to be true and complete, and agree to be bound by GMF Health's Fund Rules (available on request). I understand that there are restrictions and co-payments relating to my level of cover, pre-existing ailments and waiting periods referred to in the GMF Health Membership Guide brochure.

Signature \_\_\_\_\_ Date \_\_\_\_\_

GMF Health will occasionally contact you with information on special offers, discounts or promotions that we feel may be of interest to you.

If you would prefer not to receive this information, please tick this box:

Did you hear about GMF Health through the services of a broker?  Yes  No

**PLEASE DETACH AND RETAIN THIS SECTION FOR YOUR RECORDS**

## Privacy

A complete statement about how GMF Health will deal with your personal information is included in the GMF Health Membership Guide. That statement applies to the information collected on this form.



### 1. Payment Frequency

Please indicate one of the following payment options.

Fortnightly\*  
  Monthly\*  
  Quarterly  
  Half yearly  
  Yearly

\*Please nominate what date you would like deductions to commence.

### 2. Direct Debit Request

The Schedule - Details of account to be debited.

Name of Financial Institution \_\_\_\_\_ Branch \_\_\_\_\_

Account in the name of \_\_\_\_\_

NB: Direct Debit is not available from all accounts, please check with your bank/financial institution.

Account Details  Cheque  Savings

BSB/Financial Institution Number  
   -

Account Number

I/We authorise and request GMF Health User ID: 159206 (Debit User), until further notice in writing, to arrange for my/our account described in the schedule above, to be debited with any amounts which the Debit User may properly debit or charge me/us through the Direct Debit System.

I/We:

1. authorise and request that this Direct Debit Request remain in force until cancelled, deferred or otherwise altered in accordance with the Service Agreement;
2. have read and understand the Service Agreement attached and agree to its terms; and
3. agree that an electronic reproduction of this document, or any other information in this document, will have the same legal effect as the original of this document.

Please ensure account details are correct and that this request is signed by the required number of authorised signatories.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### 3. OR Credit Card Details

#### Credit Card Details

Credit Card in the name of \_\_\_\_\_  MasterCard  Visa

Credit Card Number

Expiry Date  
  /

Signature \_\_\_\_\_ Date \_\_\_\_\_

**GMF Health Head Office** 130 Egan Street, Kalgoorlie WA 6430. **Postal Address** PO Box 513, Kalgoorlie WA 6433.  
**Telephone Enquiries: 1300 653 099** Monday to Friday 7am to 5pm (WST). **Internet:** gmfhealth.com.au  
 HealthGuard Health Benefits Fund Limited ABN 26 054 321 274, carrying on business as GMF Health and under other business names.

**PLEASE DETACH AND RETAIN THIS SECTION FOR YOUR RECORDS**

### Direct Debit Service Agreement

1. HealthGuard Health Benefits Fund Limited trading as GMF Health User ID: - 159206 (Debit User) will initiate direct debit payments in the manner referred to in the Schedule.
2. Debit payments will be made when due. GMF Health will not issue individual confirmation of payments made.
3. GMF Health will give the customer at least 14 days written notice if GMF Health proposes to vary details of this arrangement, including the amount and frequency of payments.
4. If the customer wishes to defer any payment or alter any of the details referred to in the Schedule, the customer must either telephone GMF Health on 1300 653 099 or write to GMF Health at PO Box 513, Kalgoorlie WA 6433.
5. Any queries concerning disputed debit payments must be directed to GMF Health in the first instance. Customers may obtain details of the claims process by contacting GMF Health on 1300 653 099 or write to GMF Health at PO Box 513, Kalgoorlie WA 6433.
6. Direct debiting is not available on the full range of accounts at all financial institutions. If in doubt, the customer should check with their financial institution at which the account is held.
7. The customer should ensure that the account details given in the Schedule are correct by checking them against a recent statement from the financial institution at which the account is held.
8. By signing the Direct Debit Request, the customer warrants and represents that he/she/they is/are duly authorised to request the debiting of payments from the account described in the Schedule.
9. It is the customers responsibility to have sufficient funds available in the account to be debited to enable debit payments to be made in accordance with their Direct Debit Request.
10. If a debit payment falls due on any day which is not a business day, the payment will be made on the next business day.
11. If a debit payment is returned unpaid, the customer may be charged a fee for each unpaid item.
12. Customers wishing to cancel their Direct Debit Request or to stop individual payments must contact GMF Health by telephoning 1300 653 099 or by writing to GMF Health at PO Box 513 Kalgoorlie WA 6433 before the day their payment is due to be debited.
13. Except to the extent that disclosure is necessary in order to process debit payments, investigate and resolve disputed transactions or is otherwise required by law, GMF Health will keep details of the customer's account and debit payments confidential.