



Member Application Form



1. Member Details

Date membership to be commenced:

Membership Number Your Password (alpha or numeric)

Title Given Name(s) Surname

Date of Birth Gender M F

Residential Address State Postcode

Postal Address State Postcode

Home Phone Work Phone

Mobile Email

2. Persons to be Covered

Title	Given Name(s)	Surname	Gender M/F	Date of Birth	Relationship to Applicant
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Level of Cover Required

Single Family

Please select the level of cover required. For **combined** cover choose from one Hospital and one Extras product.

HOSPITAL

Complete Hospital

Mid Hospital

Lite Hospital

EXCESS

\$0

\$300 / \$600

\$500 / \$1000

EXTRAS

Complete Extras

Mid Extras

Lite Extras

4. Medicare Details

Are all persons listed on the application form permanent Australian Residents and eligible for 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 Date /

If you have recently arrived in Australia please provide your arrival date: Day Month Year

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

Full Name

Medicare number Expiry Date /

If you have recently arrived in Australia please provide your arrival date: Day Month Year



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 information provided 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 relating to my level of cover, pre-existing ailments and waiting periods referred to in the GMF Your Health Cover Options 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 If yes, please specify _____

Privacy

A complete statement about how GMF Health will deal with your personal information is included in the GMF Your Rights and Obligations brochure. That statement applies to the information collected on this form.

DIRECT DEBIT REQUEST

1. Payment Frequency

Please indicate one of the following payment options.

Fortnightly Monthly Quarterly Half Yearly Yearly

If you selected fortnightly or monthly payment frequency please nominate a date between 1 and 28 days you would like deductions to commence / /

Please note that your initial deduction may include an adjustment to ensure your membership is financial or to coincide with your nominated date.

2. Direct Debit Details

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

OR Credit Card Details

Credit Card in the name of _____

Mastercard VISA

Credit Card number Expiry Date /

I/We authorise and request HealthGuard Health Benefits Fund Limited trading as 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 _____

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 member 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 member wishes to defer any payment or alter any of the details referred to in the Schedule, the member 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. Members may obtain details of the direct debit 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 member should check with their financial institution at which the account is held. 7. The member 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 Authority, the member 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 members 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 Authority. 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 member may be charged a fee for each unpaid item. 12. Members 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 member's account and debit payments confidential.