

- 1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE**.
- **2.** Please complete all details that are relevant to you on all pages of this form.
- **3.** Read the declaration and sign all the relevant signature panels.

SECTION A: I'm applying to								
X Join as a new applicant	Add someone to my membership You, as the Policyholder, will need to fill in this form to add someone to your membership.							
Transfer from another health fund You'll also need to fill in the clearance certificate request - see 'Section F: Transferring from another health fund?'	Change my Level of Cover or other membership details							
SECTION B: Your details								
SECTION BY TOUR details								
Membership number (if relevant)  Surname	<b>Note:</b> The person named opposite is the Policyholder and has legal responsibility for the membership and for ensuring that premiums are kept up-to-date. Only the Policyholder is authorised to operate the membership and collect benefits on behalf of another insured person, unless they nominate an authorised person (see Section D). All correspondence will be directed to the Policyholder.							
First name	NSW/ACT residents only - important To ensure the correct amount of ambulance levy is paid for the state/ territory ambulance insurance plans, please complete the section below. If anyone on your membership holds one of the following concession cards: Health Benefits Card; Pensioner Health Benefits and Transport Concession							
Initial Title Date of birth  Date of birth  Date of birth  Male X Female	Card; Pharmaceutical Benefits Concession Card; Social Security Card; or Pensioner Concession Card issued by the Department of Veterans' Affairs (DVA), please provide the name of each concession card holder, the type of concession card and card expiry date (if relevant).							
	<b>IMPORTANT:</b> please inform us if the concession entitlements for any individuals on your membership change.							
SECTION C: Contact details								
Home address	Home phone number (including area code)							
	Mobile phone number							
Postcode								
Postal address (if different from home address)	Fax number							
	Email address							
Postcode								
From time to time, we may contact you (by phone, post, sms or email) to notify you about products, services, member updates and special offers that may be of interest to you. If you do not wish to receive this information please cross this box.	If you would like to receive notifications of your tax statement, standard information statements and other membership statements (as they become available) via email, please cross this box.							

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# SECTION D: Your partner and/or additional family member details

Due to space restrictions, we only have room to list four children. If you need to add more, please enclose a separate page with their details.

By providing the details of your partner/additional family members, you acknowledge that you have the consent of each person aged 17 or over to provide this information to us.

Surname	First name	Date o	of birt	:h		Gender (M/F)	Relationship

All children will be covered under this membership until the age of 21. Any full-time students can continue to be covered under this membership until age 25. **Note:** You can continue to cover any non full-time students (aged between 21-24 inclusive) if you purchase our Family Plus or Single Parent Plus membership option.

Total Tod carred tailed to cover	Child 1	Child 2	Child 3
Name of tertiary institution			
Expected date of completion			

### **Partner Authority**



If you wish to give your partner (as listed on this form) authority to operate this membership please cross this box. By authorising your partner you acknowledge that they will have the same rights and obligations as you, including access to health information, however they will not be able to cancel the policy or remove you from the policy. You also acknowledge that you remain responsible for your membership and for the actions of the authorised person, that authorisation is given at your own risk and that you will have no recourse against Bupa for any acts or omissions by the authorised person. This authority will remain in place until you contact us to revoke it. To authorise someone other than your partner, please contact us.

# **SECTION E: Your Cover requirements**

#### SECTION F: Transferring from another health fund? Please cross the appropriate box (if applicable): Clearance certificate request All Australian registered health funds are required to issue you with a I am/we are currently eligible for the following Federal Government clearance certificate when you cancel your health cover with them. If you Rebate on private health insurance: would like us to cancel your existing health fund cover for you and receive 30% 35% the clearance certificate on your behalf, please complete this section. If you have a direct debit arrangement with your existing health fund, please remember to personally advise them to cancel your deductions. If you or anyone on your membership are under 65 years of age and Your partner (if named) must sign this form if they are included on your believe the higher rebate applies to you then it is essential that we receive existing fund's health cover. a Savings Provision Clearance Certificate from your previous health fund. Name of existing health fund I authorise Bupa to terminate my health cover with your organisation (if still current) from the following date and obtain details about my health cover. Please issue a clearance certificate to Bupa. Please urgently refund any excess premiums owing to the undersigned. Please do not contact me Existing health fund cover/membership number further about this request. Cancellation date Your health cover details with existing health fund Signature of Policyholder Date Title First name Note: the signatory above must have legal responsibility for the health Date of birth cover at the 'existing fund'. Signature of partner Level of Cover The other health fund cover relates to: **Note:** this signature is required if your partner is covered on the health cover at the 'existing fund'. my my myself children partner parents **OFFICE USE ONLY** I confirm that I/we have held this cover for a minimum of 12 months from the date I/we request to join Bupa. Join date Member number

Date to which health cover is paid:

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If not, date joined:

SECTION G: Paying your premium		

SECTION H: Application to rece	ivo the E	odoral (	Covorna	ont.	Dobato	26.2	roduco.	d pr	o maiu ma					
Please complete this section to receive the Federal Government Rebate on You private health insurance as a reduced premium. If you do not complete this section, full premiums apply.														
Are all the people on your membership eligit for a current Medicare card?	Your	Your name exactly as it appears on your Medicare card												
Yes.  Please complete the remainder of this s	ection.													
No. You cannot apply for the rebate unt a card from Medicare.	il you obtain		Valid	Valid to										
2. Are you covered by this membership?														
X Yes.			Some	Some of the information provided on this form will be used for the purpos										
No. Employers and trustees of organisate the Federal Government Rebate on menof employees.			insur be d	of registering you for the Federal Government Rebate on private healt insurance. Its collection is authorised by law, and information collected wibe disclosed to the Department of Health and Ageing, Medicare and th Australian Taxation Office.										
SECTION I: Your Lifetime Health	Cover d	etails												
Do you have a Certified Age of Entry (CAE) of 30 at time of joining?	X Yes	X No	then cove	your C r after t	ertified Aga his date the	e of Er en you	ntry (CAE) r CAE will k	will be be calc	y following y 2 30. If you culated base	take c d on t	out hospita he age yo			
2. If you answered 'No' to question 1, what is your current CAE?			If you	ı are tra	ansferring f	rom ar	other healt	h fund		nplete	'Section I			
3. Does your partner have a CAE of 30 at time of joining?	X Yes	X No	have	If you are transferring from another health fund, please complete 'Sect on this form, or provide a copy of your clearance certificate if you al have one. If you don't, we may need to add the appropriate loading fo age to your premiums.										
4. If you answered 'No' to question 3, what is your partner's current CAE?														
SECTION J: Looking after your	nealth													
We are committed to helping our members to I who hold Hospital Cover at no additional cost.	ead healthier				-	-				s to m	nembers			
Arthritis	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Asthma	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Back Pain	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Chronic Obstructive Pulmonary Disease	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Congestive Heart Failure	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Coronary Artery Disease and Angina	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Depression	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Diabetes	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Osteoporosis	X You		Partner		Child 1		Child 2		Child 3		Child 4			
Note: We may use your personal (including health) information to design, implement and offer a range of other health management programs and to identify customers who may be suitable candidates for such programs. From time to time, we may contact you to offer you the opportunity to participate in a program. Your participation is always voluntary and you will have the opportunity to opt out.														

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## Applicant, please read then sign this declaration

#### **Privacy Statement**

Your privacy is important to Bupa. This statement summarises how we handle your personal information. For further information about our information handling practices, please refer to our *Information Handling Policy*, available at bupa.com.au.

We will only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information about you from health service providers in order to process or verify any claim. We may disclose your personal information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting or our behalf. The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 17 or over may complete a *"Keeping it confidential"* form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information. We reserve the right to charge a fee for collating such information. If you or any insured person does not consent to the way we handle personal information, or does not provide us with the information we require, we may be unable to provide you with our products and services. We may use your personal (including health) information to offer you health management programs and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

#### **Direct Debit Service Agreement**

This agreement outlines the responsibilities of Bupa Australia Pty Ltd ("we", "us", "our") and you. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we will deduct the previous period's payment together with the current amount due. If you pay premiums at three, six, and twelve month intervals, then should your financial institution dishonour a drawing, we will draw the payment on the nominated day of the following month. If two or more drawings are returned unpaid by your financial institution, we will also stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or allows us to do so). We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

### Transferring from another fund

I am transferring from another private health insurer and hereby authorise Bupa Australia Pty Ltd to cancel my previous membership with that other insurer and obtain information about my previous policy on my behalf from other private health insurers as applicable.

## **Terms and Conditions**

I accept to be bound by the Fund Rules of Bupa Australia Pty Ltd (available on our website, or by calling us), as amended from time to time. I acknowledge that I have read the brochure in full and understand the terms and conditions of my cover, including those relating to pre-existing conditions, waiting periods, restricted benefit periods or any exclusions that apply to my cover. I declare that the information I have provided is true and correct. I have read and consent to, and have made the other people on this policy aware of, the collection, use and disclosure of my personal information as set out in this Privacy Statement and in the Information Handling Policy (available on our website, or by contacting us). I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates.

Signature of Policyholder	Date					Partner's signature	Date						

Just before you send	
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	Document name
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