

MEMBERSHIP APPLICATION /CHANGE OF DETAILS FORM



- ☐ Application to join Mildura Health Fund
- ☐ Change level of cover
- ☐ Add/Remove person(s) from this membership
- ☐ Transfer to Mildura Health Fund- Complete Transfer Certificate Request

- ☐ Change of contact details
- ☐ Add Delegated Authority
- ☐ Add Direct Debit/Credit details- change payment option
- ☐ Register for Rebate/Change Rebate Tier
- ☐ Other

I would like my Application/Change of details to take effect from:

/ /

MEMBER'S DETAILS		
Title:	M / F / X	Membership Number:
First name:	Second name:	Last name:
Home Address:	Date of Birth:	
Postal Address:	Phone:	
Email Address:	Mobile:	
Medicare card no:	Expiry date:	

* By giving us your email address you are consenting to receive correspondence via email

Please tick your level of cover ☐ Single ☐ Single Parent ☐ Single Parent Plus ☐ Family ☐ Family Plus

OTHER PEOPLE ON YOUR MEMBERSHIP (family type policy)			
Title:	M / F / X	Relationship:	Date of Birth:
First name:	Second name:	Last name:	
Email Address:	Phone:		
Medicare card no:	Expiry date:		
Title:	M / F / X	Relationship:	Date of Birth:
First name:	Second name:	Last name:	
Email Address:	Phone:		
Medicare card no:	Expiry date:		
Title:	M / F / X	Relationship:	Date of Birth:
First name:	Second name:	Last name:	
Email Address:	Phone:		
Medicare card no:	Expiry date:		
Title:	M / F / X	Relationship:	Date of Birth:
First name:	Second name:	Last name:	
Email Address:	Phone:		
Medicare card no:	Expiry date:		
Title:	M / F / X	Relationship:	Date of Birth:
First name:	Second name:	Last name:	
Email Address:	Phone:		
Medicare card no:	Expiry date:		

HOSPITAL COVER		EXTRAS COVER	
Five Star Gold	Basic Plus Hospital	Combined Extras	Stand Alone Extras
<input type="checkbox"/> F2- \$250/\$500 Excess	<input type="checkbox"/> H1- Basic Plus	<input type="checkbox"/> E1- Five Star Extras	<input type="checkbox"/> A1- Mid Extras
<input type="checkbox"/> F3- \$500/\$1000 Excess	\$750/\$1500 Excess	<input type="checkbox"/> A1D- Mid Extras & Dental Cover	<input type="checkbox"/> A- Base Extras
<input type="checkbox"/> F4- \$750/\$1500 Excess		<input type="checkbox"/> AD- Base Extras & Dental Cover	<input type="checkbox"/> D- Dental Only Cover

TRANSFER CERTIFICATE REQUEST FORM

Member name:	Date of Birth:
Partner Name:	Date of Birth:
Name of existing health fund:	Member No:
Date of cancellation:	

DELEGATED AUTHORITY

For your convenience, you may wish to nominate someone else (not covered by this membership) to act on your behalf when dealing with Mildura Health Fund. An authorised person is able to make claims on your behalf and has access to your personal information.

Nominated Person:	Surname	Given Names	Relationship to Member
Title			

CONTRIBUTION / BENEFIT PAYMENTS

<input type="checkbox"/> Direct Debit	<input type="checkbox"/> Direct Credit (tick if you would like benefits credited into your account)
Name of Financial Institution	
Name of Account Holder/s	
BSB	Account Number

Please debit my Mildura Health Fund contributions from the above account on	Date:			
<input type="checkbox"/> Fortnightly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> 6 Monthly	<input type="checkbox"/> Yearly
Or Receive Account	<input type="checkbox"/> Quarterly	<input type="checkbox"/> 6 Monthly	<input type="checkbox"/> Yearly	

Payment of your premium by direct debit from a savings or cheque account attracts a 2.5% discount. Discount applied to premium prior to any LHC loading or rebate amounts being added. I request Mildura Health Fund (user ID. 18530) until further notice in writing to debit from my nominated bank account, any amounts payable under my selected cover details.

Signature:	Date:
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APPLICATION FOR THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

This section must be completed to receive the Australian Government Rebate on Private Health Insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply.

You need to notify Mildura Health Fund as soon as possible should you want to nominate a new income tier or stop receiving the Rebate.

Are you covered by this policy? ☐ Yes ☐ No

Are all people on the policy eligible for Medicare? ☐ Yes ☐ No

Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Rebate Tier: The Rebate you receive depends on your household income, the age of the oldest person on your membership, inflation (CPI) and average health fund industry increases. Refer to the Rebate table in our current brochure to determine your Rebate Tier. For more information about the Australian Government Rebate on Private Health Insurance, go to www.humanservices.gov.au/privatehealth

Rebate Tier: ☐ Base Tier ☐ Tier 1 ☐ Tier 2 ☐ Tier 3

Privacy Notice: Your information may be provided to the Australian Government Department of Human Services. The Department of Human Services uses this information for administering the Australian Government Rebate on private health insurance as a reduced premium. The collection of this information is permitted by the Privacy Act 1988. The Department of Human Services may disclose this information to other Commonwealth departments or agencies, anyone who you have agreed to have your information or other parties where the release is required or authorised by law (including for the purpose of research or conducting investigations). You can get more information about the way in which the Department of Human Services will manage your personal information, including its privacy policy, at humanservices.gov.au/privacy.

If your Medicare Card is a Reciprocal ☐ or Interim card ☐ Please tick appropriate box

DECLARATION

I agree to the collection and storage of private/sensitive information by Mildura Health Fund for private health insurance purposes, and accept the rules, Privacy Policy, and Disclosure Statement of Mildura Health Fund, and undertake to inform all persons of consent age covered by this policy of the above. I understand the conditions of membership, waiting periods and Pre-Existing Conditions (please refer to the Pre-Existing Conditions rule in the brochure). I also agree to become a member of Mildura Health Fund and to be bound by the constitution and rules of the Company.

I declare that the information I have provided in this form is complete and correct and understand that giving false or misleading information is a serious offence.

Signature:	Date:
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