

CORPORATE APPLICATION FOR HEALTH INSURANCE AND CHANGE OF DETAILS

(Select which option by marking 'X' in one of the boxes below)

- Join HCF health fund – new to private health insurance (complete sections 1-8, excluding 7)
- Transfer to HCF health fund from another fund (complete sections 1-8)
- Add people to my membership (complete sections 1, 2 and 8)
- Change my level of cover, includes adding HCF Life Recover Cover product(s) (complete sections 1, 3 and 8)

HCF Membership No.

OFFICE USE ONLY

May 26
 Corp Source code

Deal code

Rate code

Sales Source code

1 A. YOUR PERSONAL DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

To be completed by the Policyholder – see section 8 for definition.

Title First name Middle initial

Surname Gender (Please mark 'X')
M F

Home address

Suburb State Postcode

Phone - home Phone - work Mobile

Postal address (if different from your home address)

Suburb State Postcode

Email @

Date of birth (DD MM YYYY) Date you wish your membership to commence (DD MM YYYY)

B. CHOOSE YOUR COVER REQUIREMENT (PLEASE MARK 'X')

- Single (go to Section 3)
 Couple/Family (go to Section 2)
 Single parent family (go to Section 2)
 Extended Family Cover (go to Section 2)
 Retain my existing products

2 OTHER PERSONS TO BE COVERED (USE ANOTHER FORM IF SPACE IS INSUFFICIENT)

Provide details of all people covered by the policy (do not include yourself). If you are unsure of who can be covered on your membership, refer to the **HCF Corporate Products Brochure**.

<p>First name <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (DD MM YYYY) <input type="text"/> Gender (Please mark 'X') M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship <input type="text"/></p>	<p>First name <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (DD MM YYYY) <input type="text"/> Gender (Please mark 'X') M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship <input type="text"/></p>
<p>First name <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (DD MM YYYY) <input type="text"/> Gender (Please mark 'X') M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship <input type="text"/></p>	<p>First name <input type="text"/></p> <p>Surname <input type="text"/></p> <p>Date of birth (DD MM YYYY) <input type="text"/> Gender (Please mark 'X') M <input type="checkbox"/> F <input type="checkbox"/></p> <p>Relationship <input type="text"/></p>

3 CORPORATE CARE PRODUCT CHOICES (PLEASE MARK 'X')

Office Use Only

Hospital cover options

<input type="checkbox"/> HCF Corporate Care Basic		\$750	<input type="checkbox"/>
<input type="checkbox"/> HCF Corporate Care Basic Plus	\$500		<input type="checkbox"/>
<input type="checkbox"/> HCF Corporate Care Bronze Plus	\$250	\$500	<input type="checkbox"/>
<input type="checkbox"/> HCF Corporate Care Silver Plus	\$250	\$500	<input type="checkbox"/>
<input type="checkbox"/> HCF Corporate Care Silver Plus Advanced	\$250	\$500	<input type="checkbox"/>
<input type="checkbox"/> HCF Corporate Care Gold (must be combined with extras)		\$750	<input type="checkbox"/>

Hospital excess options

Extras cover options

- | | |
|---|--|
| <input type="checkbox"/> HCF Corporate Classic Starter Extras | <input type="checkbox"/> HCF Corporate Classic Advanced Extras |
| <input type="checkbox"/> HCF Corporate Flexi Extras | <input type="checkbox"/> HCF Corporate Flexi Extras Advanced |
| <input type="checkbox"/> HCF Corporate Classic Everyday Extras | <input type="checkbox"/> HCF Corporate Classic Premium Extras |
| <input type="checkbox"/> HCF Corporate Select Extras (Choose 4 services below) | <input type="checkbox"/> HCF Corporate Select Extras Advanced (Choose 4 services below) |

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Optical | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Mental health services | <input type="checkbox"/> Dietitian |
| <input type="checkbox"/> General dental | <input type="checkbox"/> Physiotherapy & exercise physiology | <input type="checkbox"/> Remedial massage & myotherapy | <input type="checkbox"/> Speech pathology |
| <input type="checkbox"/> Major dental | <input type="checkbox"/> Chiropractic & osteopathy | <input type="checkbox"/> Podiatry (including orthotics) | <input type="checkbox"/> Health Management Programs |
| <input type="checkbox"/> Pharmacy & vaccines | <input type="checkbox"/> Acupuncture & Chinese herbal medicine | <input type="checkbox"/> Artificial aids | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> HCF-approved pregnancy services | <input type="checkbox"/> Orthoptic (eye) therapy | | |

HCF Life Recover Cover

- Cash Back Cover
 Kids' Accident Cover*
 Income Protect Insurance
 Personal Accident Insurance
 Critical Illness Cover

Applicant name

First name	Surname
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Gender (Please mark 'X')

M F

Benefit amount

\$

Occupation

Height

cm

Weight

kg

Smoking status

Yes No

* Name/s of children to be covered by Kids' Accident Cover (use another form if space is insufficient)

First name	Surname
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

First name	Surname
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

4 APPLICATION TO RECEIVE THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE AS A REDUCED PREMIUM

All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium. If you're unsure whether you're eligible for Medicare, go to servicessaustralia.gov.au/medicare-card for more information.

Are all people on the policy eligible for Medicare? (Please mark 'X') Yes No

Questions about Medicare eligibility can be made at any Services Australia Service Centre or by calling **132 011**. **Note:** Call charges apply - calls from mobile phones may be charged at a higher rate. For more information about the Australian Government Rebate on Private Health Insurance, go to privatehealth.gov.au

Are you covered by the policy? (Please mark 'X') Yes No

(If 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.

Please complete the relevant details below:

Your Medicare card number	Medicare card valid to (DD MM YYYY)	Gender (Please mark 'X')	Date of birth (DD MM YYYY)
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	M <input type="checkbox"/> F <input type="checkbox"/>	<input style="width: 100%;" type="text"/>

Your full name as it appears on your Medicare card

First name	Surname
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Nominate your rebate tier below. If at any stage you wish to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible. **Note:** you may incur additional tax payments if you nominate the incorrect rebate tier.

Age	Base Tier	Tier 1	Tier 2	Tier 3	Date premium reduction to commence (DD MM YYYY)
Under 65 years	24.118% <input type="checkbox"/>	16.079% <input type="checkbox"/>	8.038% <input type="checkbox"/>	0.000% <input type="checkbox"/>	<input type="text"/>
65-69	28.139% <input type="checkbox"/>	20.098% <input type="checkbox"/>	12.058% <input type="checkbox"/>	0.000% <input type="checkbox"/>	
70 years+	32.158% <input type="checkbox"/>	24.118% <input type="checkbox"/>	16.079% <input type="checkbox"/>	0.000% <input type="checkbox"/>	

Privacy notice

Your information may be provided to Services Australia. Services Australia 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. Services Australia 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 Services Australia will manage your personal information, including its privacy policy, at servicesaustralia.gov.au/privacy

5 REIMBURSING OF CLAIMS

To have your claims paid directly into your bank account, please complete the following:

Account name

BSB Number Account No

6 PAYMENT METHOD (PLEASE MARK 'X')

There are a number of easy ways to pay your premiums. Please choose from one of the options below to pay your premiums automatically.

Credit card payments (see Section 6a) <input type="checkbox"/>	Group payroll deduction (please complete Section 6c) <input type="checkbox"/>
Ezipay direct debit (please complete Section 6b) <input type="checkbox"/>	N/A – fully subsidised by company (go to Section 7) <input type="checkbox"/>

A. CREDIT CARD PAYMENTS

To protect your privacy we can't accept credit card details through printed forms or emails. To make payments using a credit card:

- Log in to online member services hcf.com.au/members
- Visit your local branch hcf.com.au/branches
- Call us **13 13 34**

B. EZIPAY DIRECT DEBIT REQUEST

I authorise The Hospitals Contribution Fund of Australia Limited User ID Number 245164 to arrange for funds to be debited from the account set out below through the Bulk Electronic Clearing System (BECS). I agree to be bound by the terms described in the HCF Direct Debit Customer Service Agreement and this authorisation is to remain in force in accordance with these terms.

Debit frequency (PLEASE MARK 'X')

Weekly Fortnightly Monthly* Quarterly* Half yearly* Yearly*

(DD MM YYYY)

Please debit on the day* of the month. First debit* to occur on

(*Please nominate a day and note that the 28,29,30 and 31 dates are only available for weekly and fortnightly debits.)

Details of account to be debited (all details must be supplied)

Name of financial institution <input type="text"/>	BSB No. <input type="text"/>	Account No. <input type="text"/>
Branch <input type="text"/>	Account holder name (first initial and surname) <input type="text"/>	

C. GROUP PAYROLL DEDUCTION AUTHORITY

Payroll deductions are available only when your employer has an arrangement with HCF.

Employer's name Payroll or employee ID

I hereby authorise my employer to deduct from my wages or salary. (Please mark 'X')

Weekly Fortnightly Monthly Quarterly Half yearly Yearly

Employee's details

Title First name Middle initial Membership No. (if already a member)

Surname Date marking the end of the first deduction pay period (DD MM YYYY)

Other contribution details

If you wish to pay for other HCF memberships please give their details below:

Membership No. <input type="text"/>	Surname <input type="text"/>	Health \$	<input type="text"/>
Membership No. <input type="text"/>	Surname <input type="text"/>	Cash Assist \$	<input type="text"/>
		Total \$	<input type="text"/>

7 INTERFUND TRANSFER (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

(Complete this section if you have held health insurance with an Australian registered health fund at any time since 1 July 2000).

This section must be completed by the owner of the previous fund policy. It permits us to take care of the transfer for you.

(Please mark 'X') I authorise HCF to terminate my membership with my existing health fund and I consent (and confirm I have the authority to do so on behalf of everyone else on that policy) to the disclosure to HCF of the cover details of everyone on that policy including the issue of a transfer certificate to HCF.

If you have a direct debit arrangement with your previous health fund please remember to personally advise your bank or your pay office (if you pay by payroll deduction) to cancel your deductions.

Title <input type="text"/>	First name <input type="text"/>	Middle initial <input type="text"/>
Surname <input type="text"/>	Date of birth (DD MM YYYY) <input type="text"/>	
Name of previous health fund <input type="text"/>	Membership No. <input type="text"/>	
Home address <input type="text"/>		
Suburb <input type="text"/>	State <input type="text"/>	Postcode <input type="text"/>
Cancellation effective from (DD MM YYYY) <input type="text"/>		
Signature of previous fund policyholder <input type="text"/>	Date (DD MM YYYY) <input type="text"/>	

8 DECLARATION

(Please read and sign. Before you apply, ask staff for a copy of the HCF Corporate Brochure, or download at hcf.com.au/corporatebrochure)

I acknowledge and agree that:

- By signing the below, you confirm that you have provided voluntary, positive, and clear consent to discuss Recover Cover products; and you wish to add the Recover Cover product(s) to your HCF membership and understand the premium will be added to your existing HCF payments. If you're paying by payroll deduction, HCF will notify your pay office. Your decision to apply for this cover is based on the material received and read and your understanding of that information, including the enclosed Combined Product Disclosure Statement (PDS), Policy Document and Financial Services Guide (FSG) dated 1 April 2021;
- I have the authority to act and give consent on behalf of other persons to be covered under the policy, to provide their information (including sensitive information) and to receive from HCF and HCF Life their information for the purposes of the policy;
- I am the policyholder who is responsible for payment of the contribution rates, the ongoing maintenance of the policy, and the receipt of all policy correspondence;
- I am bound by the Fund Rules of The Hospitals Contribution Fund of Australia Limited (available on the HCF website and from HCF branches); and
- You and anyone covered by the policy/policies agree to their information being collected by HCF and HCF Life deals in accordance with HCF's Privacy Policy (available on the HCF website and from HCF branches) which explains how we handle personal information we collect about you and anyone else covered by the policy/policies including how to make correction and access request and how to make and how we deal with complaints.

I confirm that I have read and understand:

- this declaration and the information relating to my product choice in the HCF Corporate Brochure (including any applicable exclusions and waiting periods) and members' privacy (including the HCF Privacy Policy and the Privacy Statement); and
- the Product Disclosure Statement and Financial Services Guide in the HCF Corporate Brochure for any Recover Cover options I have chosen.

I authorise payment by the method indicated on the form and have the authority to do so.

I agree that my insurance will commence once my application is accepted.

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

Signature <input type="text"/>	Date (DD MM YYYY) <input type="text"/>
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