



STUDENT DEPENDANT DECLARATION

Locked Bag 2014
148 Fox Valley Rd
Wahroonga
NSW 2076
Phone 02 9847 3390
or 1300 368 390
Fax 02 9847 3357
Web www.acahealth.com.au

Member No. _____

I, _____ declare that _____ is eligible to remain under my membership with ACAHBF under the terms and conditions of ACAHBF Rule 1, Definition of a Dependant, (c) Student Dependant.

Yes, _____ **is:**

- A full time student at _____ (School/College/University)
- Under 25 years of age. (They must join in their own right on their 25th birthday)
- Not expected to earn an income above \$10,000 gross per annum
- Unmarried
- Expected to complete Full Time Study ____/____ (Month/Year)

OR

No, _____ **is no longer eligible and I understand will be terminated from my membership.**

Here are the contact details for him/her so the Fund can forward further information on how to continue Private Health Insurance with the Fund in the future.

Address:
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Contact Number:

Signature _____ Date _____

Please return to the ACA Health Benefits Fund at your earliest convenience.