

ACA Health

Membership Changes Form



Call 1300 368 390
Fax 02 9847 3357

Locked Bag 2014
Wahroonga NSW 2076

www.acahealth.com.au
Email acahbf.info@acahealth.com.au

1. I wish to...

Change details of existing membership #

Please change my membership & pay the appropriate contributions from / /

2. Policy Holder's Details

Title	Surname	Given names
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Suburb	State	Postcode	/ / Date of Birth	M / F Gender
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Home Phone	Work Phone
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Mobile Phone	E-mail Address
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3. Details of others to be covered under your family policy

Relation to member	Surname	Given names	Date of birth	Gender

Please attach a further listing if space is insufficient.

Please make my partner an Authorised Benefit Recipient on the policy. I understand this allows them to claim benefits directly and to make changes on the membership

4. Select your cover

Please tick one hospital and/or one General Treatments cover.

NB: *Dependant Extension must be taken in conjunction with a combined Ancillary and Deluxe or Private Hospital Cover. It cannot be taken with Basic Hospital. Please see www.acahealth.com.au or call us for more info.*

Hospital Cover	General Treatments Cover	Membership Type
<input type="checkbox"/> Deluxe Hospital	<input type="checkbox"/> Complete Ancillary	<input type="checkbox"/> Single
<input type="checkbox"/> Private Hospital	<input type="checkbox"/> Ancillary Lite	<input type="checkbox"/> Family
<input type="checkbox"/> Basic Hospital		<input type="checkbox"/> Family + Dependant Extension

5. Payment Method

If you wish to make changes to your payments, please complete the Change Payment Details Form

<input type="checkbox"/> Bank Account (direct debit)	<input type="checkbox"/> Credit Card (direct debit)	<input type="checkbox"/> Payroll Deduction (limited availability, contact us)
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6. Transferring from another Health Fund?

If yes, please provide your clearance certificate and complete the following:

Name of previous Fund	Membership #
Cover type	/ / Date Joined
	/ / Date Paid To

7. Pre-Existing Ailments

Do you, or any person on this membership have any illness or condition which may require hospitalisation, medical or major dental treatment? Y / N

If Yes, please provide details

Name	Condition / ailment

8. Proof of Age

With the introduction of the Government incentives such as Lifetime Health Cover and the Federal Government Rebate, all new members must provide a proof of age by way of a copy of a birth certificate, current drivers license or passport.

Office Use: Proof of Age Sighted

<input type="text"/>	Date	<input type="text"/>
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9. Declaration

I declare all details provided to be true and correct and agree to be bound by the rules of ACA Health Benefits Fund. I understand the Pre-existing Ailment Rule and Waiting Periods (including pregnancy related services). I declare students aged between 21 and 25 on this membership are attending an approved full-time course.

Policy Holder or authorised person's signature

X

<input type="text"/>	Date	<input type="text"/>
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