ACA Health
Membership Changes Form

Call 1300 368 390
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Wahroonga NSW 2076

Email info@acahealth.com.au
www.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

Mailing address

Suburb | State | Postcode | / / Date of Birth | M / F Gender

Home Phone | Work Phone

Mobile Phone | E-mail Address

Mother's maiden name (to protect your privacy)

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.

Dependant Extension must be taken in conjunction with a General Treatments **and Deluxe or Private Hospital Cover. It cannot be taken with Basic Hospital. Children aged 21-25 who are not studying full time can stay on your family policy with a 30% loading.*

Hospital Cover	General Treatments Cover	Membership Type
☐ Deluxe Hospital	☐ Complete Ancillary	☐ Single
☐ Private Hospital	☐ Ancillary Lite	☐ Family
☐ Basic Hospital		☐ Family + Dependant Extension*

5. Payment Method

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

6. Claiming Benefits by Direct Credit

I request ACA Health Benefits Fund to arrange for benefits claimed to be credited to my nominated account at the financial institution shown below. I agree that if the nominated bank account changes, the Fund must be notified in writing; where incorrect payment details have been provided I am responsible for all costs associated with the recovery of the payment. If I am unwilling to pay the cost to recover the amounts paid by the fund in satisfaction of the claim, the benefit entitlement is considered extinguished by the health fund.

*Note: Benefit payments can only be made to **bank accounts**, not credit cards.*

Name of Financial Institution | Account Name

☐☐☐ - ☐☐☐ BSB | Account Number

7. 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

9. Declaration & Signature

To complete your application, please check the following details and sign below:

☐ I have atttached proof of age (driver's license, birth certificate or passport) for all adults on my policy.

☐ I declare students aged 21 to 25 on this membership are studying full-time, OR a 30% loading will be charged to my membership according to the Dependant Extension rules.

☐ I understand all hospital admissions within the first 12mths of joining or upgrading my cover are subject to the Pre-existing Ailment confirmation process, as determined by the Medical Advisor of the Fund.

☐ I understand the Waiting Periods (including pregnancy related services).

☐ I declare all details provided to be true and correct and agree to be bound by the rules of ACA Health.

Policy Holder or authorised person's signature ✕ Date