ACA Health Application Form

1. I wish to...

☐ Join ACA Health ☐ Change details of existing membership #

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

If you are joining ACA Health, please confirm your eligibility to join:

☐ Current employee of SDA church company

☐ Past or transferring member/dependant — Membership Name — Number

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.

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
☐ Deluxe Hospital	☐ Complete Ancillary	☐ Single
☐ Private Hospital	☐ Ancillary Lite	☐ Family
☐ Basic Hospital		☐ Family + Dependant Extension

5. Payment Method

Please complete your details overleaf

☐ Bank Account *(direct debit)* ☐ Credit Card *(direct debit)* ☐ Payroll Deduction *(limited availability, see overleaf)*

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 — Date

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 ✕ — Date

Payment Options

1. Bank Account - Direct Debit

I / We request ACA Health Benefits Fund user ID 031606 to arrange for funds to be debited from my / our nominated account at the financial institution shown below according to the specified schedule. I agree that in the event of changes to premiums, transfer of product or arrears payment, I authorise ACA Health to alter the amount from the appropriate date in accordance with such changes.

Name of Financial Institution	Account Name
BSB ☐☐☐ - ☐☐☐	Account Number

Frequency:

☐ Monthly ☐ Quarterly

Premiums are deducted in advance on the 20th of the month, or the next working day

Signed ______ Date ______

2. Credit Card - Direct Debit

I / We request ACA Health Benefits Fund to charge my / our nominated credit card according to the specified schedule. I agree that in the event of changes to premiums, transfer of product or arrears payment, I authorise ACA Health to alter the amount from the appropriate date in accordance with such changes.

☐ Visa ☐ MasterCard

Account Name	Exp Date

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Account Number

Frequency:

☐ Monthly ☐ Quarterly

Premiums are deducted in advance on the 20th of the month, or the next working day

Signed ______ Date ______

3. Payroll Deduction

Currently only available to employees of:

Sydney Adventist Hospital, Sanitarium Health Food Co., Signs Publishing Co., South Australian Conference, Elizabeth Lodge ARV

I hereby give authority for payroll deductions for my appropriate premiums to be made as follows:

Payroll Officer	Signature	Date
Policy Holder	Signature	Date

ACA Health Benefits Fund

Call 1300 368 390

Phone: +61 2 9847 3390
Fax: +61 2 9847 3357
Email: acahbf.info@acahealth.com.au
Web: www.acahealth.com.au

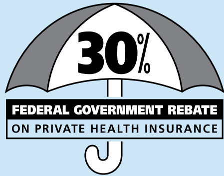
Postal Address:
Locked Bag 2014
Wahroonga NSW 2076

Office Address:
146 Fox Valley Rd
Wahroonga NSW 2076

ACA Health Benefits Fund is a restricted access, registered Health Fund operated by ACA Health Benefits Fund Limited.

Information in this brochure was correct at the time of printing. Changes may occur by Board of Management actions. The operation of the Fund is governed by the Fund Rules which can be read in the Policy Booklet in-conjunction with the relevant Product Benefit Guide/s for your membership.

...Because We Care



Application to Receive the Federal Government 30% Rebate as a Reduced Premium

- **Complete this registration form and lodge it with your health fund to receive the Federal Government 30% Rebate as a reduced premium.**
- **This application must be completed in black pen using block letters.**
- **All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium.**
- **If at any stage you wish to stop receiving the Federal Government 30% Rebate as a reduced premium, you must notify your health fund as soon as possible.**

Name of private health fund issuing the policy to which this application relates? ______

Membership number ______

Are you covered by this policy? Yes ☐ No ☐ → **Employers and trustees of organisations cannot claim the Federal Government 30% Rebate on policies paid on behalf of employees.**

Date premium reduction to commence ☐☐ / ☐☐ / ☐☐

Your Medicare card details Number ☐☐☐☐☐☐☐☐☐☐ Valid to ☐☐ / ☐☐☐☐

Your full name as it appears on your Medicare card ______

Your current postal address ______ Postcode

Your residential address (If same as above please write "as above") ______ Postcode

Your day time phone number (should we need to contact you) ( ) work ( ) home

Your date of birth / / Your sex Male ☐ Female ☐

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Details of all people covered by the policy (do not include yourself)

Family name	Given names	Date of birth	Sex	Dependant child
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐
			M ☐ F ☐	Y ☐ N ☐

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card? Yes ☐ No ☐

You are entitled to a Medicare card if:

- you are a person who lives in Australia; and
- you are an Australian citizen; or
- a holder of a permanent resident visa; or
- a New Zealand citizen; or, in some cases an applicant for a permanent resident visa.

Any inquiries about Medicare eligiblity can be made at any Medicare office or by phoning 132 011 for the cost of a local call.

Declaration

I declare that the information I have provided is correct. I understand that there are penalties for giving false or misleading information.

Signature

Date / /

Note:
- **Please check all sections of the form are complete and you have signed and dated the form.**
- **The completed form should be submitted to your private health insurance fund.**

The information provided on this form will be used for the purposes of registering you for the Federal Government 30% Rebate. Its collection is authorised by law, and information collected may be disclosed to the Department of Health and Aged Care, the Health Insurance Commission, and the Australian Taxation Office.