

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

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
<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

Please complete your payment details overleaf

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 #

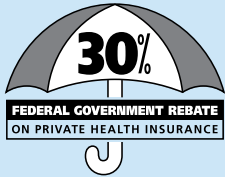
Cover type / / Date Joined / / Date Paid To

9. Declaration & Signature

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

- I have attached 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 X Date



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

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

Family name	Given names	Date of birth	Sex	Dependant child
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
			M <input type="checkbox"/> F <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

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 eligibility 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.