MEMBERSHIP APPLICATION /CHANGE OF DETAILS FORM

Mildura HEALTH Fund

- ☐ Application to join Mildura Health Fund
- ☐ Change level of cover
- ☐ Add/Remove person(s) from this membership
- ☐ Transfer to Mildura Health Fund- Complete Transfer Certificate Request
- ☐ Change of contact details
- ☐ Add Delegated Authority
- ☐ Add Direct Debit/Credit details- change payment option
- ☐ Register for Rebate/Change Rebate Tier
- ☐ Other

I would like my Application/Change of details to take effect from: ☐☐ / ☐☐ / ☐☐☐☐

MEMBER'S DETAILS		
Title:	**M / F / X**	**Membership Number:**
First name:	**Second name:**	**Last name:**
Home Address:		**Date of Birth:**
Postal Address:		**Phone:**
Email Address:		**Mobile:**
Medicare card no:		**Expiry date:**

* By giving us your email address you are consenting to receive correspondence via email

Please tick your level of cover ☐ Single ☐ Single Parent ☐ Single Parent Plus ☐ Family ☐ Family Plus

OTHER PEOPLE ON YOUR MEMBERSHIP (family type policy)			
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**
Title:	**M / F / X**	**Relationship:**	**Date of Birth:**
First name:		**Second name:**	**Last name:**
Email Address:			**Phone:**
Medicare card no:			**Expiry date:**

HOSPITAL COVER		EXTRAS COVER	
Five Star Gold	**Basic Plus Hospital**	**Combined Extras**	**Stand Alone Extras**
☐ F2- $250/$500 Excess	☐ H1- Basic Plus $750/$1500 Excess	☐ E1- Five Star Extras	☐ A1- Mid Extras
☐ F3- $500/$1000 Excess		☐ A1D- Mid Extras & Dental Cover	☐ A- Base Extras
☐ F4- $750/$1500 Excess		☐ AD- Base Extras & Dental Cover	☐ D- Dental Only Cover

This space is for office use only:

Mildura Health Fund
ABN 13 078 202 089 / ACN 078 202 089
79 Deakin Ave Mildura Vic 3500
PO Box 5046 Mildura Vic 3502
T 03 5023 0269
F 03 5023 7732
E mhf@mildurahealthfund.com.au
www.mildurahealthfund.com.au

TRANSFER CERTIFICATE REQUEST FORM

Member name:	**Date of Birth:**
Partner Name:	**Date of Birth:**
Name of existing health fund:	**Member No:**
Date of cancellation:	
Have you been with this Health Fund for more than 12 months? If no, please supply your previous health fund name and membership number:	

DELEGATED AUTHORITY

For your convenience, you may wish to nominate someone else (not covered by this membership) to act on your behalf when dealing with Mildura Health Fund. An authorised person is able to make claims on your behalf and has access to your personal information.

Nominated Person:	**Surname**	**Given Names**	**Relationship to Member**
Title			
Phone		**Email**	

DIRECT DEBIT REQUEST (DDR)

☐ **Direct Debit** **(Note: This account will also be used for any refunds or benefits payable to you)**

Name of Financial Institution

Name of Account Holder/s

BSB | | | | | | | **Account Number**

Please debit my Mildura Health Fund contributions from the above account on **Date:**

☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ 6 Monthly ☐ Yearly

Or Receive Account ☐ Quarterly ☐ 6 Monthly ☐ Yearly

I Request and authorise Mildura Health Fund (18530), until further notice to arrange, through its own financial institution, a debit to your nominated account any amount payable under my selected Mildura Health Fund cover.

This debit will be made through the Bulk Electronic Clearing System (BECS) from your account held at the financial institution you have nominated and will be subject to the terms and conditions of the Direct Debit Request Service Agreement'.

Acknowledgment: By signing and/or providing us with a valid instruction in respect to your Direct Debit Request, you have understood and agreed to the terms and conditions governing the debit arrangements between you and Mildura Health Fund as set out in this Request and in your Direct Debit Request Service Agreement

Account Signature:	**Date:**

APPLICATION FOR THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

This section must be completed to receive the Australian Government Rebate on Private Health Insurance as a reduced premium.

If you do not complete this section, full rate membership fees will apply.

You need to notify Mildura Health Fund as soon as possible should you want to nominate a new income tier or stop receiving the Rebate.

Are you covered by this policy? ☐ Yes ☐ No

Are all people on the policy eligible for Medicare? ☐ Yes ☐ No

Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

Rebate Tier: The Rebate you receive depends on your household income, the age of the oldest person on your membership, inflation (CPI) and average health fund industry increases. Refer to the Rebate table in our current brochure to determine your Rebate Tier. For more information about the Australian Government Rebate on Private Health Insurance, go to www.humanservices.gov.au/privatehealth

Rebate Tier: ☐ **Base Tier** ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 3**

Privacy Notice: Your information may be provided to the Australian Government Department of Human Services. The Department of Human Services uses this information for administering the Australian Government Rebate on private health insurance as a reduced premium. The collection of this information is permitted by the Privacy Act 1988. The Department of Human Services may disclose this information to other Commonwealth departments or agencies, anyone who you have agreed to have your information or other parties where the release is required or authorised by law (including for the purpose of research or conducting investigations).
You can get more information about the way in which the Department of Human Services will manage your personal information, including its privacy policy, at humanservices.gov.au/privacy.

If your Medicare Card is a Reciprocal ☐ **or Interim card** ☐ Please tick appropriate box

DECLARATION

I agree to the collection and storage of private/sensitive information by Mildura Health Fund for private health insurance purposes, and accept the rules, Privacy Policy, and Disclosure Statement of Mildura Health Fund, and undertake to inform all persons of consent age covered by this policy of the above. I understand the conditions of membership, waiting periods and Pre-Existing Conditions (please refer to the Pre-Existing Conditions rule in the brochure). I also agree to become a member of Mildura Health Fund and to be bound by the constitution and rules of the Company.

I declare that the information I have provided in this form is complete and correct and understand that giving false or misleading information is a serious offence.

Signature:	**Date:**