Latrobe HEALTH SERVICES
EveryBody benefits from our health cover

Latrobe Membership No.

# Membership Application

## I apply to:

Join ☐ Transfer from another fund (Complete Clearance Certificate) ☐ Change my membership details ☐ Join a corporate ☐ MemberBenefits (Corporate plan name)

**My cover is to commence on** / /

## My details:

| Title | Name | Surname |
|---|---|---|

Residential Address

| | State | Postcode |
|---|---|---|

Postal Address (if different to residential)

| | State | Postcode |
|---|---|---|

| Home Phone | Other Phone |
|---|---|

| D.O.B. / / | Email |
|---|---|

## Other people to be covered by this membership:

| Title | Surname | First Name | Birth Date | Sex | Full-time students 18-24yrs, name of educational institution |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Are all the people listed on this application citizens or permanent residents of Australia with 100% Medicare entitlements (a green Medicare card)? ☐ Yes If not, please call us before completing this application

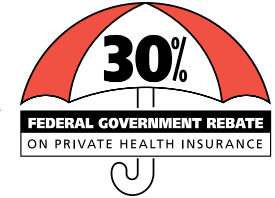
A Lifetime Health Cover penalty may apply for applicants over 31. Please refer to page 46.

## My chosen cover is: Insert code

| | Insert code | | |
|---|---|---|---|
| Hospital cover | | Hospital cover | $ |
| Extras cover | | Extras cover | $ |
| Ambulance Subscription | | Ambulance Subscription | $ |



# Federal Government 30% Rebate




Complete this application to receive the Federal Government 30% Rebate on private health insurance as a reduced premium.
If you do not complete this section, full membership premiums apply.

Are all the people on the policy listed on a green Medicare card and eligible to receive 100% Medicare entitlements?

☐ Yes ☐ No

Effective date for rebate to commence / /

You are entitled to a green Medicare card if you are:
An Australian citizen or, a holder of a permanent resident visa or, a New Zealand citizen

If Yes, please complete the remainder of this section.
If No, you cannot apply for the rebate until you obtain a Medicare card.

Medicare Card Number ☐☐☐☐ ☐☐☐☐☐ ☐ Valid to ☐☐ Month ☐☐☐☐ Year

Your name **exactly** as it appears on your Medicare Card

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

| Family Name | Given Name(s) | Birth Date | Sex | Dependant child |
|---|---|---|---|---|
| | | / / | | ☐ Y ☐ N |
| | | / / | | ☐ Y ☐ N |
| | | / / | | ☐ Y ☐ N |
| | | / / | | ☐ Y ☐ N |
| | | / / | | ☐ Y ☐ N |

| Signature | Date / / |
|---|---|

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

# Application Forms

Join over the phone or join online and avoid the paperwork!

✆1300 362 155 • latrobehealth.com.au

## Application checklist

1. Read and complete forms.
2. Lifetime Health Cover.
3. Federal Government 30% Rebate.
4. Are you transferring from another fund?
5. How do you want to pay your membership premiums?
6. Send the application section to:
   Latrobe Health Services, Reply Paid 41, MORWELL VIC 3840



# Member Feedback

Thank you for choosing Latrobe Health Services.

We pride ourselves in never losing sight of the fact that we are here to provide you with quality and affordable health cover, coupled with the highest possible level of ongoing service.

To remain at the forefront of these objectives, we invite you to participate in this member feedback questionnaire.

Your input and valuable time is much appreciated and we assure you that the information will be kept private in accordance with our Privacy Policy.

(PLEASE TICK)

**1. What prompted you to join Latrobe rather than any other fund?**

☐ Price ☐ Service ☐ Product ☐ Other........................................

Comment........................................................................

**2. What prompted you to contact us?**

☐ TV ☐ Radio ☐ Newspaper ☐ Letterbox Promo ☐ Corporate Promo ☐ Family Friend ☐ Yellow Pages

☐ Other........................................................................

**3. Did you find the brochure easy to follow?** ☐ Yes ☐ No

**4. Was your experience dealing with Latrobe**

| Excellent | Very Good | Good | Satisfactory |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**Comments**........................................................................

..................................................................................

..................................................................................

# Member Declaration

I declare and acknowledge that:

1. I have read and understand the important information in this booklet.
2. I have read Latrobe's Privacy Statement and understand that I may request a copy of the Privacy Policy at any time. I consent to the use and disclosure of my personal information in the manner described therein. Where this application contains the personal information about other people, I confirm that I have obtained their consent.
3. I authorise Latrobe to obtain from or disclose to any hospital, medical or other health service provider all information relevant to the assessment of any claim for benefits and I have obtained the same authorities from any other people covered by this application.
4. I have read and understand the extent and conditions of the cover for which I am applying, including the conditions regarding waiting periods, pre-existing conditions.
5. I accept and agree to be bound by the fund rules of Latrobe Health Services and understand that I can make arrangements to view a copy of these rules. I will inform any other people covered by this application about the existence of these rules and that they are similarly bound.
6. **I declare that the ages stated for all adults appearing on my Latrobe membership application are correct. I understand that there are penalties for giving false or misleading information.**

Other people to have access to this membership:

For Family or Couples - Please note you and your partner both have equal authority to this membership. If this is unsuitable, please call Latrobe.

☐ I want another person to have this authority. Please send me a Third Party Authority application

| Signature | Date / / |
|---|---|

Please turn over and complete the payment information form on page f

| AGENT USE ONLY |
|---|
| |



# Clearance Certificate Request

Use this form to authorise Latrobe Health Services to obtain details of your existing health fund membership on your behalf.

| Name | | |
|---|---|---|
| Address | | |
| Suburb | State | Postcode |

| Previous fund |
|---|

List all other persons transferring

| First name | Surname | Date of birth (DD/MM/YYYY) |
|---|---|---|
| | | / / |
| | | / / |
| | | / / |
| | | / / |
| | | / / |

| Previous fund membership number | |
|---|---|
| Cover name | |
| Date joined / / | Date paid to / / |

I hereby authorise Latrobe Health Services to terminate my membership with your organisation.

This cancellation is effective from / /

Latrobe Health Services is authorised to obtain the following details about my membership - Lifetime Health Cover certified age of entry, Clearance Certificate and Claims History listing for the last 12 months.

If applicable, any refund of contributions paid in advance should be sent to the above address.

Signatures - Spouse/partner signature is required if they are to be cancelled and a clearance issued

| 1. | 2. | Date / / |
|---|---|---|

Note: if you pay via Direct Debit or Payroll deduction, remember to cancel your payments for your existing health fund.

Clearance Certificate Request
reverse side



# Preferred Payment Method

| | Weekly | Fortnightly | Monthly | Quarterly | Half Yearly | Yearly | |
|---|---|---|---|---|---|---|---|
| **Accounts** Please tick | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Accounts are not sent if you choose weekly or fortnightly payment options |
| **Direct Debit** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | Please provide the relevant Direct Debit details below. Reminders are sent if you choose half yearly or yearly payment options. |

## Direct Debit Request

I/We

of Address

State | Postcode

authorise Latrobe Health Services (User ID Number 002319) to debit funds from my financial institution account as detailed in The Schedule below. The payment is for health insurance premiums identified by:

Membership Number (If known) | To commence on / /

## Direct Debit Authorisation

I/We have read and understood the Service Agreement and acknowledge and agree to it. I/We request this arrangement remain in force in accordance with The Schedule described below and in compliance with the Service Agreement on page 49

First account signatory | Date / /

Second account signatory (if required) | Date / /

## Direct Debit Payment Details

Name of financial institution | Branch number (BSB) –

Address of financial institution

Account holder | Account number

## Credit Card Payment Details

Type of credit card: ○ Mastercard ○ Visa

Payment type: ○ Single payment ○ Automatic payment

Credit card number | Expiry date /

Cardholder name | Cardholder signature

Latrobe Health Services is committed to protecting your privacy and to the safe keeping of the confidential information you entrust to us. Visit latrobehealth.com.au to read or download our Privacy Policy, or phone for a copy, or visit any Latrobe branch.