



### Section 3: Corporate Health plan options

Please indicate with an X in the appropriate box.

- Single       Family
- Option 1: Premier Hospital (\$250 Single / \$500 Family Excess) – AP7
- Option 2: Premier Hospital (\$250 Single / \$500 Family Excess) and Value Benefits – APD
- Option 3: Premier Hospital (\$250 Single / \$500 Family Excess) and Economy Benefits – APE
- Option 4: Pricepoint Hospital (\$250 Single / \$500 Family Excess) – AP9

### Section 4: Other people to be covered

**Spouse/Partner** (use another form if space is insufficient)

Title:  Surname:  Sex:  M  F

Given name:  Date of birth:  Country of permanent residency:

#### Dependant children

Children can be covered under a Family membership up to the age of 21 years; student dependants can be covered up to the age of 25 years.

<b>Dependant 1</b> Surname:	Given name:	Date of birth:	Sex:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
If student dependant - name of Australian school/college/university:	Course start and end dates:	Student number:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Dependant 2</b> Surname:	Given name:	Date of birth:	Sex:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
If student dependant - name of Australian school/college/university:	Course start and end dates:	Student number:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
<b>Dependant 3</b> Surname:	Given name:	Date of birth:	Sex:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F
If student dependant - name of Australian school/college/university:	Course start and end dates:	Student number:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	



**Section 5: Previous fund details**

**NOTE: Lifetime Health Cover**

Under the Federal Government’s Lifetime Health Cover initiative, you have until the 30th of June following your 31st birthday to take out hospital cover for the first time without incurring a Lifetime Health Cover loading.

If you are transferring from another Australian registered health fund we can request a Transfer Certificate on your behalf which provides the necessary information about your Lifetime Health Cover status. Please complete this section: ‘Authority to transfer existing insurance’ so that GU Health can obtain a Transfer Certificate.

**Authority to transfer existing insurance** (if required)

Please complete the details below to authorise GU Health to obtain a Transfer Certificate from your existing Australian health fund. You must contact your existing health fund to terminate your policy with them.

GU Health will attempt to contact your previous fund on your behalf to obtain a Transfer Certificate. If GU Health does not receive your Transfer Certificate within 90 days, any applicable loading will be applied to your membership from the date you joined. Lifetime Health Cover status and waiting periods served with your previous fund cannot be recognised without receipt of a Transfer Certificate.

If you have more than one dependant that is transferring from another Australian health fund (or separate policy) please make a copy of this section and complete separately.

Yes, I authorise you to provide the information sought and any further information arising out of my membership of your fund to GU Health.

Title:	Surname:	Given name(s):
<input type="text"/>	<input type="text"/>	<input type="text"/>

Fund:	Date cover ceases:
<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"/>

Membership number:	Name/type of cover:
<input type="text"/>	<input type="text"/>

Signature:	Date:
<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"/>

**Spouse details:** (if transferring from a separate policy)

Title:	Surname:	Given name(s):
<input type="text"/>	<input type="text"/>	<input type="text"/>

Fund:	Date cover ceases:
<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"/>

Membership number:	Name/type of cover:
<input type="text"/>	<input type="text"/>

Signature:	Date:
<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"/>







**Section 8: Pre-existing conditions**

Do any of the people on this membership suffer from a pre-existing condition for which they are receiving treatment or will require treatment?  
Please Note: A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time during the six months before the day on which you joined or upgraded to a higher level of hospital cover.

Yes  No

If YES, please provide person's name and details of condition. (Please provide separate sheet if insufficient space.)

[Empty text input area for providing details of condition]

**Section 9: Privacy statement (must be signed)**

GU Health is committed to meeting the requirements of the Privacy Act 1988. GU Health will assist all health fund members to access, update and/or correct personal information held by GU Health. Personal information will be protected by security measures, and will be used by GU Health for regulatory reporting and for the provision of eligibility information for service providers/agents/brokers and hospitals as well as to provide, and assist in the development of, member services which may include use by its related agencies, but will not be used for any other purpose, such as the sale or disclosure to an unrelated third party, without the member's approval. Also, GU Health may need to inform your employer of hospital claims made under your policy where your employer has agreed to pay, on your behalf, any hospital excess under your policy. In these circumstances, GU Health will not disclose the reasons for hospitalisation or the medical treatment received, rather only the fact that a hospitalisation has occurred for excess billing purposes.

If you do not wish to receive information on other GU Health products and services please indicate with an X.

**Spousal/Partner authority**

Your Spouse/Partner, if listed on the membership, will have access to membership information and may make changes to the policy with the exception of cancelling the policy. If your partner (or another third party) is not on the membership and you would like to allow access please complete the section 'Third party policy access authority'.

**Third party policy access authority**

This section is to be completed to give a spouse, partner or third party (who is not listed on the policy) access to the membership.

I hereby authorise GU Health to give the following person access to my GU Health cover.

Name/Relationship:

[Empty text input area for Name/Relationship]

As the owner of the Policy, I understand that I may revoke this authority at any time, in writing to GU Health.

Signature of policyholder:

Signature of nominated individual:

[Empty signature box for policyholder]

[Empty signature box for nominated individual]

Please Note: If a Power of Attorney already exists, please attach a certified copy to this Authority.

**Section 10: Declaration (must be signed)**

I declare all the information in this application form to be true and complete and I agree to be bound by the rules and by-laws of the organisation as registered and accept the applicable waiting periods. I confirm that where this form contains personal information about other persons, I have obtained all necessary consents to disclose that information to GU Health, and have the authority to act on those persons' behalf. I authorise all such persons to make claims on this policy.

Policyholder's Signature:

[Empty signature box for policyholder]

Date:

[Date input fields: D D M M Y Y Y Y]

Members 16 years and over, who are not the policy holder, may request that access to their personal, health-related information be limited. If you wish for this Information to be kept confidential and not privy to other members of this membership please print your name and provide your signature in the box provided below.

**Proof of age:** Proof of age is required to validate your certified age of entry if not transferring from another fund. Please attach a copy of drivers license, birth certificate or passport for each person over the age of 16 to be covered.

Name:

[Empty name box]

Signature:

[Empty signature box]

Private:

[Date input fields: D D M M Y Y Y Y]

Name:

[Empty name box]

Signature:

[Empty signature box]

Private:

[Date input fields: D D M M Y Y Y Y]

Name:

[Empty name box]

Signature:

[Empty signature box]

Private:

[Date input fields: D D M M Y Y Y Y]

Name:

[Empty name box]

Signature:

[Empty signature box]

Private:

[Date input fields: D D M M Y Y Y Y]

## Checklist

Please note that failing to provide any of the information below will cause delay in the processing of your application.

- Has the policy holder signed the declaration?
- Is there a commencement date? Please refer to your Human Resources Department if you are on a subsidised plan and are unsure.
- Are all people listed on the application eligible for full Medicare entitlements? Please call GU Health if unsure.
- Are you claiming the Federal Government 30% Rebate? If so, have you advised us of your Medicare number?
- Have you correctly provided your financial institution account details?

## Direct Debit Request Service Agreement

Keep for your records

### Direct Debit Request Service Agreement

#### Our commitment to you

This document sets out your rights, our commitment to you and your responsibilities to us, together with where you should go for assistance in respect of your direct debit arrangement with Grand United Corporate Health (GU Health).

#### Initial terms of the arrangement

In terms of the Direct Debit Request (DDR) arrangement made between us and signed by you, we undertake to periodically debit your nominated account in accordance with your signed authority to direct debit.

#### Drawing arrangements

- If a drawing is due on a non-business day, it will be debited to your account on the next business day following the scheduled drawing date.
- We will give you at least 14 days notice when we intend to make changes to the initial terms of the arrangement.

#### Your rights

##### Changes to the arrangement

If you want to make changes to the drawing arrangement, please notify us in writing at least 4 business days prior to your next scheduled drawing date. These changes may include:

- deferring the drawing; or
- altering the schedule; or
- stopping an individual debit; or
- suspending the DDR; or
- cancelling the DDR completely.

#### Enquiries

If you have any enquiries they should be directed to GU Health, rather than to your financial institution.

All information relating to the DDR held by us will remain confidential except for information that may be provided to our financial institution to initiate the drawing to your nominated account, or information disclosed to a third party as required by law. Information may also be provided to Australian Unity Limited or any of its wholly-owned subsidiaries to enable this DDR to be effected.

#### Disputes

- If you believe that a drawing has been initiated incorrectly, you should raise the matter directly with GU Health.
- If you do not receive a satisfactory response from us to your dispute, contact your financial institution who will respond to you with an answer to your claims in accordance with their dispute resolution procedures.

Note: Your financial institution will ask you to contact us to resolve your disputed drawing prior to involving them.

#### Your commitment to us

It is your responsibility to ensure that:

- your nominated account can accept direct debits (your financial institution can confirm this); and
- that on the drawing date there is sufficient cleared funds in the nominated account; and
- that you advise us if the nominated account is transferred or closed.

If your drawing is returned or dishonoured by your financial institution, we will notify you in writing.

Any transaction fees payable by us in respect of the above may be passed on to you. Consecutive returns or dishonours may result in the direct debit facility being withdrawn.