

Membership details

New member Change to existing membership Membership no. (if known) _____

Your details

Title _____ Family name _____ Given names _____ Male Female Date of birth ____ / ____ / ____

Residential address _____ Postcode _____

Postal address (if different to above) _____ Postcode _____

Home Ph. () _____ Work Ph. () _____ Mobile Ph. _____ Email _____

Identification type (please choose one and supply number)

Passport Driver's Licence Medicare card Birth certificate Identification Number _____

I have current private health insurance Name of current fund _____ Member No. _____

Paid until ____ / ____ / ____ In the past I have had private health insurance My Certified Entry Age is: _____

Your partner's details

Title _____ Family name _____ Given names _____ Male Female Date of birth ____ / ____ / ____

Identification type (please choose one and supply number)

Passport Driver's Licence Medicare card Birth certificate Identification Number _____

I have current private health insurance Name of current fund _____ Member No. _____

Paid until ____ / ____ / ____ In the past I have had private health insurance My Certified Entry Age is: _____

Dependants (please list the family members you would like to provide cover for):

Family name	Given names	Date of birth	Sex

I would like to choose one of the following covers:

Hospital Cover Options

- Corporate Overseas Cover Level 1
- Corporate Overseas Cover Level 2
- Reciprocal Health Care Agreement Cover

Extras Cover Options

- Premier Extras
- General Extras
- Your Choice Extras (list your 4 choices below)
- 1. _____ 2. _____
- 3. _____ 4. _____
- Standard Extras
- Basic Extras
- General Dental

Membership required

Single Single Parent (available on hospital cover) Family Family Plus Please commence my cover on: ____ / ____ / ____

Declaration

Do you or any person on this membership have an existing illness, injury or medical ailment?

If yes, please provide details _____

I am transferring from another fund (Please present current membership record)

Name of fund _____ Level of cover _____ Membership No. _____

Date joined: ____ / ____ / ____ Date paid until: ____ / ____ / ____

I accept the rules of HBA/Mutual Community and I understand the conditions regarding the pre-existing rule, Waiting Periods, exclusions and Restricted Benefits. I hereby declare that the information provided is true and correct. I have read and understood, and have made the other people on this application aware of, the information in the Privacy Disclosure Statement (overleaf). I acknowledge that, where practicable, information is provided with consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the person named on this application form. I understand that if my employer pays premiums on my behalf, it is my responsibility to ensure that premiums are paid, for example during periods of unpaid absence or if my employment ceases. I hereby authorise HBA/Mutual Community to obtain details of any previous membership on my behalf from other health funds as applicable.

Signature _____ Date ____ / ____ / ____

Payment. Important: Ask our staff which payment method applies before completing this section.

Initial Payment

I understand that I will need to make an initial payment for one month to cover me until my first payroll deduction.

I have enclosed a cheque I have completed the credit card section below

I have completed the payment from bank account section below

Initial payment by credit card

Credit card payment can only be arranged for the 7th, 14th, 21st or 28th day of the month (or the closest business day – SA and NT only) or the 7th, 15th, 21st or 28th day of the month (or the closest business day – all other states).

Please debit my Bankcard Mastercard Visa

I understand that my cover will commence from the start date selected and I will make an initial one month payment to cover me whilst my payroll deductions are being set up. I also understand that these may commence at any time during this period to ensure that my membership is paid in advance, which will assist with the processing of any claims that I may submit. I hereby authorise my employer to deduct my health insurance premiums from my salary/wages.

Cardholder's name _____ Credit card no (16 digits) _____ Expiry date ____ / ____ / ____

Signature _____ Expiry date ____ / ____ / ____ Membership no (if known) _____

Initial payment from my bank account

I authorise HBA/Mutual Community to deduct a single payment from my specified account as follows.

Account holder's name _____ BSB (6 digits) _____ Account number _____

Signature _____ Date ____ / ____ / ____

Payroll Deduction

Fortnightly Monthly Start date ____ / ____ / ____

I understand HBA/Mutual Community will deduct an initial payment after receiving this application form that will cover me until my nominated start date. I will monitor my account and ensure the correct payment has been deducted. Please read the Direct Debit Customer Service Agreement below.

Employer's name _____ Employee number _____ The amount of \$ _____ per fortnight/month (please circle)

Department or office name _____ Employer's address _____

Direct Debit Request

1. Direct debit from my financial institution account (statement account only)

I authorise HBA to deduct from my specified account as follows (please tick and complete as applicable. Allow 14 days for processing).

Monthly Start my deductions on ____ / ____ / ____ I understand HBA will deduct an initial payment after receiving this application form that will cover me until my nominated start date. I will monitor my account and ensure the correct payments are being deducted.

1 a. Form of request for debiting account by the Direct Debit System

To the manager

Name of institution _____ Branch _____ Date ____ / ____ / ____

Institution address _____ Postcode _____

I, family name _____ Given names _____

of address _____ Postcode _____

request that you, until further notice, in writing, debit from the account detailed below, any amount which BUPA Australia Health Pty Ltd ABN 50 003 098 655 trading as HBA/Mutual Community may debit or charge me through the Direct Debit System. I understand and acknowledge that:

1. The financial institution may, in its absolute discretion, determine the priority of payment by it or any monies in accordance with this request or any authority, or mandate.
2. The financial institution may, in its absolute discretion, at any time by giving notice in writing to me, terminate this request as to future debits.
3. In the event of changes to my rates/cover I authorise HBA/Mutual Community to alter the amount of deductions without prior notice.

1 b. Please complete your account details and sign

Account name _____ BSB (6 digits) _____ Account number _____

Signature _____ Date ____ / ____ / ____

2. Direct Debit my credit card

Direct Debit payments from your credit card can only be arranged in SA and NT for the 7th, 14th, 21st or 28th day of every month (or closest business day). In all other states, payment can only be arranged for the 7th, 15th, 21st or 28th day of every month (or closest business day).

Please debit my Bankcard Mastercard Visa For single payment only for _____ (months). Please debit my credit card on the following day every month:

7th 14th 21st 28th (SA and NT only). Or 7th 15th 21st 28th (all other states).

I understand that HBA/Mutual Community will deduct an initial payment after receiving this application form that will cover me until my nominated start date. I will monitor my account and ensure the correct payments are being deducted. Please read the Direct Debit Customer Service Agreement.

Cardholder's name _____ Credit card no. (16 digits) _____ Expiry date ____ / ____ / ____

Signature _____ Date ____ / ____ / ____

