

Application to join Doctors' Health Fund



The Doctors' Health Fund Pty Ltd

ABN 68 001 417 527 PO Box Q1749 Queen Victoria Building NSW 1230

freecall 1800 226 126 f. 02 9260 9958 w. www.doctorshealthfund.com.au e. join@doctorshealthfund.com.au

I am an Australian citizen or permanent resident ☐ Yes ☐ No

If not, unfortunately you are not eligible to join Doctors' Health Fund.

I qualify for membership of Doctors' Health Fund in the following category: Please tick appropriate box

- ☐ Medical Practitioner
- ☐ Health Practitioner (please circle one): medical radiation | optometry | dental | occupational therapy | physiotherapy | psychology
- ☐ an employee of a Medical Practitioner or a Health Practitioner
- ☐ a person studying to become a Medical or Health Practitioner at an Australian university, medical school or other educational institution
- ☐ an overseas trained doctor registered for the AMC exams
- ☐ an officer or employee of the federal, or a state, Australian Medical Association
- ☐ an officer or employee of an associated or subsidiary organisation of the federal, or a state, Australian Medical Association
- ☐ an officer or employee of any federal or state association of registered medical practitioners
- ☐ an officer or employee (including contractors) of Avant Insurance Limited
- ☐ The spouse, partner, child, grandchild, parent, sibling, former spouse or partner, niece, nephew, or the partner of an adult child or sibling of a person in the above categories

Are you a member of: Avant ☐ Yes ☐ No Avant Member ID:

Are you a member of: AMA ☐ Yes ☐ No Which state chapter? Optometry Australia ☐ Yes ☐ No

Personal details: Please write clearly

Date of Birth	<input type="text" value="DD/MM/YYYY"/>	Gender	<input type="text" value="Male/Female"/>
Title	<input type="text"/>	Surname	<input type="text"/>
	<input type="text"/>	Given Names	<input type="text"/>
Phone: Mobile	<input type="text"/>	Work	<input type="text"/>
	<input type="text"/>	Home	<input type="text"/>
Residential address	<input type="text" value="Not a Post Office Box address"/>		
Suburb	<input type="text"/>	State	<input type="text"/>
	<input type="text"/>	Postcode	<input type="text"/>
Postal address (if different from above)	<input type="text"/>		
Suburb	<input type="text"/>	State	<input type="text"/>
	<input type="text"/>	Postcode	<input type="text"/>
Email	<input type="text"/>		

Dependants: Provide details of all people covered by the policy (do not include yourself)

	Spouse/Partner	Dependant 1	Dependant 2	Dependant 3
Title	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Surname	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Given names	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date of birth	<input type="text" value="DD/MM/YYYY"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text" value="DD/MM/YYYY"/>
Gender	<input type="text" value="Male/Female"/>	<input type="text" value="Male/Female"/>	<input type="text" value="Male/Female"/>	<input type="text" value="Male/Female"/>
Relationship to you	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Student dependant cover where the student dependant is 21 years or over

Name of school/ college/university	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please tick those dependants who need a Fund card for electronic claiming of extras services

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Additional authoriser for this policy

I hereby authorise The Doctors' Health Fund Pty Ltd to give

Full name of authorised person

access to my membership. This will enable them to make enquiries and changes to the policy with the exception of cancelling the policy.

Your cover requirements

Please read the product information in our brochure or on our website carefully, and retain a copy of the "Welcome to the Fund" brochure you will receive upon joining.

HOSPITAL COVER

Cover options

- ☐ Top Cover Gold (no excess options available)
☐ Prime Choice Gold ☐ NIL ☐ \$500 excess ☐ \$750 excess
☐ Smart Starter Bronze Plus ☐ \$500 excess ☐ \$750 excess

EXTRAS COVER

Cover options

- ☐ Total Extras ☐ Essential Extras ☐ Starter Extras (Only with Smart Starter Bronze Plus Hospital Cover)

I would like my membership to commence

- ☐ From the date I sign this application ☐ From this date in the future

DD/MM/YYYY

Transferring from another health fund?

We can help you ensure continuity of benefits from another fund. Simply complete the details below, and Doctors' Health Fund will arrange to cancel your existing membership and obtain a transfer or clearance certificate from your current fund. A waiting period may apply to benefits not covered by your previous fund membership. Please see our 'Welcome to the Fund' brochure or our website for details.

Current Fund Name

Membership No.

I wish to cancel effective from

DD/MM/YYYY

I authorise Doctors' Health Fund to release the details of my membership including any personal information which is needed to provide a transfer certificate to Doctors' Health Fund within 14 days as specified in The Private Health Insurance Act 2007 section 99-1 and Private Health Insurance (Complying Product) Rules and amendments.

Member Signature

X

Date

DD/MM/YYYY

If you wish to add your partner to your Doctors' Health Fund cover:

Was your partner on a different policy ☐ Yes ☐ No

If Yes, please provide their Current Fund Name

and Membership Number

Payment frequency

I wish to make my payments: ☐ Yearly (2.5% discount) ☐ Half-yearly ☐ Quarterly ☐ Monthly (monthly payment only available by direct debit, see option 1 below.)

Payment options: Please select from option 1 or 2**OPTION 1 - by direct debit**

Automatic payments are deducted from your credit card or nominated account on the date your contribution is due.

A: ☐ Credit card deductions from my ☐ Visa ☐ Mastercard * Due to compliance reasons we will call you in order to verify your credit card details.

B: ☐ Direct Debit from my bank/building society/credit union

Name of Financial Institution

Name(s) of account holder(s)

BSB No

Account No

Preferred day of month for automatic deduction

I/We request The Doctors' Health Fund Pty Ltd (ID No 324455) to arrange a debit from the credit card or account nominated above in accordance with the terms and conditions of the Direct Debit Request Service Agreement in the Fund's product brochure and on the Fund's website.

Account Holder(s) signature(s)

X

DD/MM/YYYY

X

DD/MM/YYYY

OPTION 2 - by invoice

☐ I would like Doctors' Health Fund to send me an invoice for each contribution payment. I will pay my contributions by credit card, BPay, cheque or money order made payable to The Doctors' Health Fund Pty Ltd.

Claim payments: Faster payment, direct to your account

☐ I would like Doctors' Health Fund to directly credit into my bank account the benefits payable to me when I make a claim for a doctor or healthcare providers account. Please note that direct credit is not available to credit card accounts.

Account Name

Not a Credit Card Account

BSB No

Account No

Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

If you do not complete this section, full contribution payments will apply.

Your name as it appears on your Medicare card	Medicare card no.	Expiry date

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card? **Yes**

- All people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium. If you are unsure whether you are eligible for Medicare, go to www.humanservices.gov.au/customer/services/medicare/medicare-card for more information.
- For more information about the Australian Government Rebate on Private Health Insurance, go to www.privatehealth.gov.au
- Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling **132 011**.

Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

- If you select the wrong rebate tier, this may have implications on your annual tax return. If you have any questions call us on **1800 226 126**.

Age of oldest person to be on your Doctors' Health Fund cover:

Tier	Tick	Under 65 years	65-69 years	70+ years	Single (Annual income pre-tax)	Couples, families, single-parent (Combined annual income pre-tax)
Base	<input type="checkbox"/>	25.059%	29.236%	33.413%	\$90,000 or less	\$180,000 or less
Tier 1	<input type="checkbox"/>	16.706%	20.883%	25.059%	\$90,001 to \$105,000	\$180,001 to \$210,000
Tier 2	<input type="checkbox"/>	8.352%	12.529%	16.706%	\$105,001 to \$140,000	\$210,001 to \$280,000
Tier 3	<input type="checkbox"/>	0%	0%	0%	\$140,000 +	\$280,001 +

Are you covered by the policy? Yes ☐ No ☐

(If 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.

Date premium reduction to commence:

If at any stage you wish to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your health fund as soon as possible.

Private Health Insurance rebate effective from 1 April 2018 to 31 March 2019.

Lifetime Health Cover: If you are over 30 years old this may apply to you

Lifetime Health Cover is a government initiative designed to encourage people to take out and maintain hospital insurance. Those who delay will pay a 2% loading on top of their contribution payments for every year they are aged over 30 when they first take out hospital cover. Any LHC loading that you pay for ten (10) continuous years will be removed from your hospital cover premium as long as you retain your hospital cover.

Have you or your partner turned 31 since 1 July 2000? ☐ Yes ☐ No

(If you ticked yes, LHC may apply)

Have you had private health insurance hospital cover since you turned 31? ☐ Yes ☐ No

(If you ticked no, LHC may apply)

Did you or your partner acquire full Medicare cover status for the first time more than 12 months ago? ☐ Yes ☐ No

(If you ticked no, we require your Medicare eligibility letter/s for confirmation. If you ticked yes, LHC may apply)

Did you have private health insurance hospital cover within 12 months of acquiring full Medicare status? ☐ Yes ☐ No

(If you ticked yes, we require your Medicare eligibility letter/s for confirmation. If you ticked no, LHC may apply)

How did you first hear about Doctors' Health Fund? (Pick one answer)

☐ Colleague ☐ Family ☐ Event/Conference/Seminar ☐ Internet advertising or search advertising
☐ Direct mail ☐ Employee of Avant ☐ OA/AMA Promotion ☐ Advertising
☐ Avant ☐ Other

Declaration note**I declare that:**

- the information provided on this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

I agree to be bound by the rules of Doctors' Health Fund, which may change from time to time, including changes to rates and benefits. I

agree to Doctor's Health Fund using my personal information in accordance with its Privacy Policy and providing information and marketing material by phone, text message, mail or email.

Signature

X

Before you send us the application please check that you have signed all the signature boxes relevant to your application, including the declaration above.

Your privacy is important to us

Doctors' Health Fund is committed to meeting the requirements of the Commonwealth Privacy Act 1988, as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act) and the National Privacy Principles which form part of the Act. We only collect personal information we need to provide you with health insurance services. We share relevant personal information with other parties bound by the same privacy standards who are involved in your healthcare to provide you with health insurance services. We do not sell your personal information to anyone. For complete information about our privacy policy please visit www.doctorshealthfund.com.au

By entering into this agreement, you agree that Doctors' Health Fund's strategic partner, the Australian Health Service Alliance ("AHSa") may collect your personal information, including your health information ("your information") and use your information and/or disclose it to Doctors' Health Fund or your health service provider, for the purposes of providing health services to you and/or managing the funding of those services, or as required by law. AHSa's privacy policy, at www.ahsa.com.au/web/ahsa/privacy_policy provides its contact details and explains how you may access and correct your information, or make a complaint.