Latrobe Membership Number

Membership Application

I apply to:

Join ☐ | Transfer to Latrobe from another fund (Complete Clearance Certificate) ☐ | Change my level of cover or other membership details ☐ | Join a corporate health plan

(Corporate plan name)

My details:

Title | Surname | First Name

Address

Postcode

Contact phone numbers | Home | Other

Date of birth / /

Other people to be covered by this membership:

Surname	First Name	Birth Date	Sex	Student Dependants Details for full-time students under 25yrs, name of educational institution

Application to start from (date) / /

Hospital Table (insert table code)

Extras Table (insert table code)

Ambulance Subscription Yes/No

☐ I want my partner to have equal authority to enquire about or make changes to my membership

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

Please continue overleaf

My preferred payment method is:

Option 1 Direct Debit ☐ (Complete Direct Debit Authority)

Option 2 Renewal Accounts ☐ (Accounts are only sent monthly, quarterly, half yearly or yearly, but you may also choose weekly or fornightly payment periods)

Preferred payment period:

Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly ☐

“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 same consents.

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 and benefit limitations.

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.

Signature ____________________ Date ___ / ___ / ___

OFFICE USE ONLY					
Adult 1: ID	Clearance	YES/NO	LHC Cert	YES/NO	Agent
Adult 2: ID	Clearance	YES/NO	LHC Cert	YES/NO	Location
Confirmation Letter Sent					

Lifetime Health Cover Proof Of Age

Under Lifetime Health Cover legislation, premiums for hospital insurance for people over 30 years are based on age. If you are not transferring to Latrobe from another fund please attach a copy of one of the following documents for each adult on your membership:

- Passport.
- Driver's License.
- Birth Certificate.

If you do not have copies of these documents, please read and sign the declaration below and attach it to your application form. Your membership contributions will be calculated using applicable Lifetime Health Cover loadings unless you provide proof of age or complete this declaration.

DECLARATION

I declare that the ages stated for all adults appearing on my Latrobe membership application are correct.

Signature: ____________________ Date: / /

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 your membership eligible for a current Medicare card? Yes ☐ No ☐

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

____

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.

Clearance Request Certificate

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

Personal Details (please print)

(Insert name) I ____________________

(Insert address) of ____________________

____

State ____________________ Postcode ____________________

hereby authorise Latrobe Health Services to cancel my membership with your Fund

Previous fund ____________________

Previous fund membership number ____________________

and obtain the following details about my membership

- Lifetime Health Cover certified age of entry

- Clearance Certificate

- Claims History listing for the last 12 months

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

This cancellation is effective from ______ / ______ / ______

Signature ____________________

Date ______ / ______ / ______

OFFICE USE ONLY

LHS No. | | | | | | | | |

Direct Debit Request

I/we

of Address

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

To commence on / /

Direct Debit Request 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.*

Membership Signature

Date / /

Second account signatory (if required)

Date / /

Direct Debit Payment Details Schedule

Name of financial institution

Branch number (BSB) —

Address of financial institution

Account name

Account number

Payment frequency ◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Quarterly ◯ 1/2 Yearly ◯ Yearly

Credit Card Payment Details Schedule

Type of credit card ◯ Bankcard ◯ Mastercard ◯ Visa

Payment type ◯ Single payment ◯ Automatic payment

Payment period ◯ Monthly ◯ Quarterly ◯ 1/2 Yearly ◯ Yearly

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. Your signature on this document includes consent to the use of your personal information for business purposes. Visit our website at www.latrobehealth.com.au to read Latrobe's privacy policy or phone Latrobe on 1300 362 155 for a copy to be sent to you, or collect a copy at any Latrobe branch or agent during business hours.

Your Direct Debit Request Service Agreement

1. Latrobe Health Services (Latrobe) will debit only the BSB/Account nominated in this direct debit request.

2. Latrobe will give a minimum 14 days written notice to you should it propose to vary the arrangements of the direct debit request.

3. You may ask Latrobe to defer or alter the payment amount, due date or payment frequency by phoning 1300 362 144, or visiting any Latrobe branch. However, if you wish to change the drawing account details, you may be asked to complete a new direct debit request form.

4. Latrobe will assist you in the event of any disputed payment amount, and will endeavour to resolve the matter within the industry agreed time frames. You may visit any branch of your financial institution and complete a *Direct Debit System Claim Request* form to initiate this process.

5. Some financial institution accounts do not facilitate direct debits and you must check with your financial institution to ensure the account you have nominated in the schedule enables direct debiting.

6. The debit drawing will be made on the agreed due date nominated in the schedule. When the due date is a weekend, or a state or national public holiday, Latrobe will initiate the debit drawing on the next open business date. You may direct processing date inquiries to your financial institution.

7. You are responsible for ensuring that sufficient cleared funds are available at all due dates of the debit drawing. If your financial institution returns an unpaid debit due to insufficient funds, Latrobe will apply an *Outward Dishon our Fee* to your account.

8. If you wish to cancel this direct debit request you must notify Latrobe in writing not less than 7 days before the next scheduled debit drawing. This request may also be directed to your financial institution.

9. All requests for payment cancellation or changes, enquiries or disputes should be made directly to Latrobe.

10. Latrobe agrees to keep confidential all records and account details of this direct debit request unless authorised to release such information relating to a dispute or similar event where you have provided prior consent to do so.