

WESTFUND APPLICATION / CHANGE DETAILS FORM

- Join** **Change Details** **Transfer from another fund** **Promotion**
New member complete all details. Change details, persons covered or cover. Complete all details and clearance certificate. Employer _____

Applicant/Member Details

Surname **Membership Number**

Title **Given Name/s** (First/Middle/Surname) **Male / Female** **Date of Birth** (Day/Month/Year)

Note - the applicant is the owner of the membership and all correspondence will be directed to this person.

Home Address

 P/Code

Postal address (tick if same as above)

 P/Code

Home Phone
Mobile
Work Phone

Membership Password (for security and identification access purposes)

Password needs to be a minimum of 6 characters including 1 numeral and 1 capital letter
Password hint if forgotten

Email Address

Preferred Method of Contact (Please choose one)
 Post **Telephone** **Email**

Do you wish to receive communication via email **Yes** **No**

Other persons to be covered

#	Full Name <small>(First/Middle/Surname)</small>	Date of Birth <small>(Day/Month/Year)</small>	Male/Female	Relationship
1.	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
2.	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
3.	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
4.	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>
5.	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>	<input style="width: 95%; height: 25px;" type="text"/>

(Attach a separate sheet if necessary for more dependants)

Cover Options

Please choose your level of cover: **Single** **Family**

Please indicate your choice of cover:

<input type="checkbox"/> Classic Platinum Extended <small>(Family Only)</small>	<input type="checkbox"/> Classic Extras
<input type="checkbox"/> Classic Platinum	<input type="checkbox"/> Value First
<input type="checkbox"/> Classic Gold Extended <small>(Family Only)</small>	<input type="checkbox"/> Value Saver Plus
<input type="checkbox"/> Classic Gold	<input type="checkbox"/> Value Saver
<input type="checkbox"/> Classic Silver	<input type="checkbox"/> Westfund Ambulance

NOTE - all children must be under 18 years of age, unless they meet the Student Dependant or Extended Dependant criteria. If you wish to cover any children who are full-time students or apprentices aged from 18 to 25 inclusive, you will need to complete a separate application to register them.

I would like my membership to commence:

Immediately when my application has been accepted
(an initial payment of one month's premiums is required upon application).

From
(nominate a date in the future) (Day/Month/Year)

Federal Government Rebate

Please complete this section to receive the federal government rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums apply. If you wish to stop receiving the Federal Government Rebate as a reduced premium, you must notify Westfund as soon as possible.

Are all the people on this policy listed on a Medicare card or entitled to a Medicare card? **Yes** **No**
If YES please complete your medicare details. If NO you cannot apply until you are eligible for a medicare card.

Your Medicare card number **VALID TO** /

Your full name exactly as it appears on your Medicare card

The information provided on this form will be used for the purposes of registering you for the Federal Government Rebate. Its collection is authorised by law, and information collected may be disclosed to the Department of Health and Ageing, the Health Insurance Commission and the Australian Tax Office.

Employers and trustees of organisations cannot claim the Federal Government Rebate on policies paid on behalf of employees.

Date Federal Government Rebate to commence:
* for change to existing memberships only
 (Day/Month/Year)

Office Use Only: Membership Number: Branch: Cover Type: Signed:

CLEARANCE CERTIFICATE REQUEST - EXISTING HEALTH FUND DETAILS

If you are transferring from or have been a member of another health fund, please complete the information below and Westfund will arrange to cancel your existing health fund membership for you. If you have a direct debit arrangement with your existing health fund, please remember to advise your existing health fund to cancel your deductions. Alternatively if you have a payroll arrangement, you should notify your paymaster to cease deductions.

Name of existing Fund

Membership Number **Date Joined** (Day/Month/Year)

Person/s requiring clearance

Date Paid to (Day/Month/Year) **Date of Cancellation** (Day/Month/Year)

PERSONAL DETAILS **Date of Birth**
Member's Full Name (First/Middle/Surname) (Day/Month/Year)

I / We receive the 30% 35% 40% **Federal Government Rebate.**
 I hereby authorise Westfund to terminate my membership with your organisation and / or obtain personal details in relation to my membership, as indicated above. Please urgently refund any contributions paid in advance to the undersigned.

Signature **Date**

Note - the details of the above person must bear legal responsibility for the membership with the existing health fund.

(Day/Month/Year)

Lifetime Healthcover

Have you or another adult dependant listed on this application had private hospital health insurance cover since 1st July 2000?

You **Yes** **No** Other adult dependant **Yes** **No**

If yes. Please complete the Clearance Certificate request on the front of this form. A Westfund representative will forward the details to the relevant health fund.

Payment Methods

Choose your payment method and complete the relevant section

Direct Debit (Complete below) **Credit Card** (Complete below) **Direct Paying** **B-Pay** Biller Code - 726802 **Payroll Deduction** (Please complete Westfund Payroll Deduction Form)

Direct Debit Request

I / We request until further notice in writing to debit my / our account described in the schedule below any amounts Westfund (The User), (APCA User ID Number 002481) may debit or charge me / us through the direct debit system.

Bank Deduction Frequency

Weekly **Fortnightly** **Monthly** **Yearly**
Please note: Weekly and fortnightly deductions are made each Thursday. Please nominate specific deduction date if required: Ambulance Only

Financial Institution **Branch** **BSB** **Account Number**

Name/s of Account Holder **Signature of account holders**

X X
 X X **Date**
Please note: If joint account all signatures are required. (Day/Month/Year)

Credit Card Authority (MONTHLY DEBIT ONLY)

Visa Mastercard

Cardholders Name **Card Number**

Signature of Card Holder **Expiry Date**

X **Date** **Please note: Credit Cards are debited the last working day of every month.**
(Day/Month/Year)

Direct Credit of Benefits

I / We request until further notice in writing that payments of all Benefit refunds be credited to this Bank Account.

Direct Credit Details (tick if same as direct debit details)

Name/s of Account Holder **Financial Institution** **Branch**

BSB **Account Number**

Pre-existing Ailments & Conditions

Under the rules of Westfund, new applicants and those transferring from another fund are subject to the pre-existing ailments and conditions rule. A pre-existing ailment or condition is one that presents signs or symptoms which were considered to be in existence at any time during the 6 months preceding the day on which the member joins Westfund or upgrades level of Westfund cover. This may include signs and symptoms not previously diagnosed by a medical officer.

A 12 month waiting period applies (or balance if a waiting period is already being served). The question below is to be completed by all Applicants.

Have you, or any other person to be covered by this Membership had any ailments, conditions, signs or symptoms that have become present at any time during the past six (6) months for which you are receiving treatment or which you will require treatment? **Yes** **No**

Declaration

I wish to apply for the health cover chosen on the front of this application. I have read the terms and conditions for this health cover and have specifically noted:

- the pre-existing ailment and condition rule
- waiting periods
- my entitlements upon my transfer from another health fund (if applicable)

I understand that proof of identity including the age of myself and my dependents may be required. I understand that any claims made under this membership may be accepted under either the signature of myself or partner (where applicable) or a student or extended dependant aged 18-25 years who has been registered on the membership by separate application. I understand that Westfund may decide not to accept my application.

Where I have not understood any of the information in the terms and conditions, I have asked for and received assistance regarding these matters. I declare that this information, including information for the 30%, 35% and 40% Rebate if provided is correct. I understand that there are penalties for false or misleading information.

Westfund will keep you informed about new products and services from all of their companies, which Westfund considers of potential benefit to you and your family. However, if you do not wish us to communicate this information to you, please tick this box.

Signature

X **Date**
(Day/Month/Year)

Under the rules of Westfund Ltd, benefits are not payable and if paid may be recovered where false or inaccurate information is contained in the application or supplementary form.

Thank you for your Application to join Westfund. On acceptance of your Application, you will receive a Welcome Pack and a Westfund Membership Card.

Please return clearance certificate details to



PO Box 235, Railway Parade, Lithgow NSW 2790
 Phone: (02) 6353 1399 Fax: (02) 6352 3080