GUHealth

Adobe Health Plan for Overseas Visitors Application Form

Group No.: 88846
Effective date: 1 October 2016

For Non Residents of Australia

GU Health Membership No. (if you have one):

Cover commencement date or change of cover date: D D M M Y Y Y Y

I wish to (please indicate with an X): **Only complete the relevant sections**
Join GU Health (Sections: 1 – 9) **or** Change my GU Health Cover (Sections: 1, 4, 9) **or** Add dependant/s (Sections: 1, 3, 9)

Complete this Application form and return to GU Health by:

- FreePost to: GU Health, Reply Paid 2988, Melbourne VIC 8060 (no stamp required); **or**
- Email: corporate@guhealth.com.au

For assistance or for more information FreeCall 1800 633 819

Please print in black ink, using capital letters and mark check boxes with an X.

Section 1: Policyholder's details (the person in whose name membership is held)

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y

Home address:

State: Postcode:

Postal address (if different from home address):

State: Postcode:

Work telephone number: Home telephone number: Mobile number:

Email address:

Employee number: Country of permanent residency:

Section 2: Australian Government Rebate on Private Health Insurance

(Please complete only if you are eligible for Medicare through a Reciprocal Health Care Agreement (RHCA) with Australia). See Section 4 for list of RHCA countries.

Complete this section to apply for the Australian Government Rebate on Private Health Insurance.

Are all of the people to be covered by this membership eligible for a current RHCA Medicare card? Yes No

If **YES**, please complete the remainder of this section. If **NO**, you cannot apply for the Australian Government Rebate until all persons to be covered on the membership have RHCA Medicare entitlements. Visit medicareaustralia.com.au for further details.

Medicare card number: Valid to: D D M M Y Y Y Y

Policyholder's name and initial (exactly as they appear on your Medicare card):

Unless you select a rebate tier that better reflects your entitlements, the rebate will be applied to your membership at Base Tier. **Refer to your member booklet for details and visit the Australian Taxation Office website to calculate your rebate tier or for more information at ato.gov.au.**

Select applicable box to indicate your rebate tier (this is optional), otherwise your rebate entitlement will be reconciled as part of your tax return. Tier 1 Tier 2 Tier 3

If at any stage you wish to stop claiming the rebate as a reduced premium, or you wish to amend your rebate tier, you must notify GU Health.

Information in this form may be disclosed to the Department of Health, the Department of Human Services and the Australian Tax Office or as authorised or required by law.

Policyholder's signature: Date signed: D D M M Y Y Y Y

Section 3: About your dependant/s (Photocopy this section if more dependant/s)

Spouse/Partner

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y Country of permanent residency:

Dependant children

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

A student dependant is a child of the policyholder, who is between the ages of 21 and 25, without a partner, and who is a fulltime student at an approved Australian school, college or university.

Dependant/s

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y

If student dependant - name of Australian school/college/university: Course start and end dates: / / / / Student number:

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y

If student dependant - name of Australian school/college/university: Course start and end dates: / / / / Student number:

Title: Surname: Sex: M F

Given name: Date of birth: D D M M Y Y Y Y

If student dependant - name of Australian school/college/university: Course start and end dates: / / / / Student number:

Section 4: Health plan option

Please indicate with an X in the appropriate box.

☐ **For members from RHCA Countries** (all countries listed below)
Belgium, Finland, Italy, Malta, The Netherlands, New Zealand, Norway, The Republic of Ireland, Slovenia, Sweden and United Kingdom.

☐ **For members from Non RHCA* Countries** (all countries **not** listed below)
Non-RHCA countries include all countries not in this list: Belgium, Finland, Italy, Malta, The Netherlands, New Zealand, Norway, The Republic of Ireland, Slovenia, Sweden and United Kingdom.

*** Members covered under non-RHCA plans will not receive a Tax Statement and are not eligible to apply for the Australian Government Rebate through GU Health.**

☐ Single ☐ Family

X Your Plan: Optimum Plus Hospital with Medical & Added Value Benefits

Section 5: Direct credit of claims (FastBack)

Would you like to save time and effort when you claim?

Now you can take advantage of the GU Health FastBack claims system, to get your money back even faster! FastBack claims mean we can directly deposit any claim reimbursement into your nominated Australian financial institution account. Just complete the authority below and we'll set it up for you.

Authority for FastBack claims

I request GU Health, until further notice, to credit the following Australian account with any amount which may be payable by GU Health in respect of a claim on my membership.

Bank details

Name of financial institution at which your account is held:

Branch address:

State: Postcode:

Name of account to be credited:

BSB number: Account number:

Section 6: Transfer Certificate request (Complete this form only if you are transferring from another Australian health fund and GU Health will cancel your existing health fund membership for you. Please note you must personally advise your bank to cancel your deduction if you have a direct debit arrangement with your existing health fund.)

GU Health will contact your previous Australian health fund to cancel your membership and request a Transfer Certificate. If GU Health does not receive your Transfer Certificate, waiting periods served with your previous fund cannot be recognised.

If any person nominated on your GU Health membership is transferring from another Australian health fund (or separate policy) please make a copy of this section and complete separately.

Title: Surname:

Given name: Middle initial: Date of birth: D D M M Y Y Y Y

Name of existing health fund: Membership number:

Home address:

State: Postcode:

I authorise GU Health to terminate my membership with my existing Australian health fund and obtain details concerning: (please mark)

☐ Myself ☐ My partner ☐ My dependant(s)

Cancellation effective from: D D M M Y Y Y Y

I further request my previous Australian health fund to forward a Transfer Certificate directly to GU Health GPO Box 2988 Melbourne Vic 8060, or via corporate@guhealth.com.au

Previous policyholder's signature: Date signed: D D M M Y Y Y Y

Transfers from an overseas registered insurer:

If you are transferring from an overseas health insurer, you may apply for continuity of cover. Continuity of benefits will only be granted if your 'cover commencement date' with GU Health is within two (2) months of your 'date paid to' with your previous fund. You must also provide the following information to GU Health for assessment of continuity:

- A certificate from your previous insurer detailing your period of insurance, the date paid to, the level of cover and other members covered by the plan.
- Policy wording for your previous level of cover (in English).

Please note: GU Health reserves the right to assess each application for transfer from an overseas insurer on a case by case basis.

Section 7: 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?

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.)

Section 8: Privacy statement

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 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. GU Health may need to contact practitioners to enable us to efficiently answer enquiries to process transactions.

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 **(Only sign this section if adding a third party)**

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.

Full name: Relationship to policyholder:

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

Policyholder's signature: Nominated individual's signature:

Date signed: D D M M Y Y Y Y Date signed: D D M M Y Y Y Y

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

Section 9: Declaration (must be signed)

I am authorising GU Health to create a membership based on the information provided in this form.

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 acknowledge that I have read and understood the membership booklet along with the Terms and Conditions listed therein. 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: Date signed: 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.

☐ Have you correctly provided your financial institution account details?