MEMBERSHIP APPLICATION

UPDATED APRIL 2019

CHECKLIST

- Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**
- Please complete all details that are relevant to you on all pages of this form
- Read the declaration and sign all the relevant signature panels
- Mail your completed application form to **UniHealth, GPO Box 9812, Sydney NSW 2001** or email to **info@unihealthinsurance.com.au**.

Phone **1300 367 906**
Overseas **+61 2 8346 2187**

Web **unihealthinsurance.com.au**
Email **info@unihealthinsurance.com.au**

Teachers Federation Health Ltd
ABN 86 097 030 414. A Registered Private Health Insurer. Trading as UniHealth.

I would like my membership to commence:

◯ Upon receipt of application by UniHealth

◯ Nominate a date in the future D D / M M / Y Y Y Y Promotional code:

A. YOUR DETAILS

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr Other

First name

Surname

Date of birth D D / M M / Y Y Y Y Gender ◯ Female ◯ Male

B. CONTACT DETAILS

Home phone Mobile

Email

Home address

Address

Suburb/town State Postcode

Postal address

◯ As above or please complete details if different to home address:

Address

Suburb/town State Postcode

I authorise communication from UniHealth, including information required by law such as tax statements, via email to the address supplied.

◯ Yes ◯ No

C. ELIGIBILITY

UniHealth operates for the higher education community and their families. To join UniHealth, you must satisfy certain eligibility criteria. Eligibility criteria can be found at unihealthinsurance.com.au or by calling 1300 367 906. Please note that UniHealth may contact you in the future to verify your eligibility such as requiring details of your union membership.

◯ Current Union Member – Please specify which Union

◯ Former Union Member

◯ Family Member of an eligible member

D. YOUR PARTNER AND/OR ADDITIONAL FAMILY MEMBER DETAILS

Provide details of all people covered by the policy (do not include yourself). If you need to add more than 5 people to be covered under your policy, please enclose a separate page with the details of the additional person(s). By providing the details of your partner/additional family members, you acknowledge that you have the consent of each person aged 17 or over to provide this information to us. If any family members are student dependants please ensure you complete the relevant details below as well as under the Student Dependant section.

FIRST NAME	SURNAME	DATE OF BIRTH	GENDER M/F	RELATIONSHIP

Partner Authority: I authorise my partner to be a point of contact on behalf of this policy. ◯ Yes ◯ No

All children will be covered under this membership until their 21st birthday or until their 25th birthday if they are full–time students/trainees/apprentices who are not married or in a de facto relationship. Please provide student details in table below. **Note:** If you have children aged between 21 and 25 who are no longer studying full–time, then the extended family cover will apply (see section E).

Student Dependants:

NAME OF CHILD	NAME OF UNIVERSITY/COLLEGE/EMPLOYER

E. YOUR COVER

◯ Single ◯ Couple ◯ Family ◯ Single Parent ◯ Extended Family ◯ Extended Family (single parent)

Hospital Cover

- ◯ Top Hospital (Gold)
- ◯ Top Hospital 300 (Gold)
- ◯ Top Hospital 500 (Gold)
- ◯ Mid Hospital 300 (Basic Plus)
- ◯ Mid Hospital 500 (Basic Plus)
- ◯ Mid Classic 300 (Silver Plus)
- ◯ Mid Classic 500 (Silver Plus)
- ◯ Basic Hospital (Basic Plus)

Extras Cover

- ◯ Top Extras
- ◯ Essential Extras
- ◯ Emergency Ambulance only

Combined Cover

- ◯ StarterPak (Basic Plus)

F. PAYMENT DETAILS – DIRECT DEBIT

I/we request, until notice in writing, that monies due to UniHealth be drawn under the Direct Debiting System from my/our account, as per details listed below.

BSB number ☐☐☐ – ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Account Holder Name/s

Payment frequency ◯ Fortnightly ◯ Monthly ◯ Quarterly ◯ Half yearly ◯ Yearly

Preferred deduction date D D / M M / Y Y Y Y

Your initial Direct Debit may differ from the standard contribution if your membership start date and the first Direct Debit date are not the same.

Benefit payment

Would you like benefits paid into the above account? ◯ Yes ◯ No – please fill out alternative account details below.

BSB number ☐☐☐ – ☐☐☐ Account number ☐☐☐☐☐☐☐☐☐

Account Holder Name/s

G. APPLICATION TO RECEIVE THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE AS A REDUCED PREMIUM

Please complete this section to receive the Australian Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums apply. 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 https://www.humanservices.gov.au/customer/services/medicare/medicare-card for more information. If you do not complete this section, full premiums apply.

If you select the wrong tier, this may have implications with respect to your annual tax return (and you may be required to repay the rebate, or some part of it).

1. Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

◯ **Yes** Please complete the remainder of this section.

◯ **No** You cannot apply for the Rebate until you obtain a Medicare card.

2. Are you covered by the policy?

◯ **Yes**

◯ **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.

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Expiry date *D D / M M / Y Y Y Y

**Inclusion of day in date is only applicable for those holding an interim or reciprocal Medicare card.*

Name on card (exactly as it appears) _____

I'd like to nominate the rebate tier below to be applied to my membership (Please mark one selection only)

		APPLICABLE REBATE %			INCOME THRESHOLDS	
Income Tier	*Tick*	Under 65 years	65–69 years	70+ years	Single	Couples/Family
Base Tier	◯	25.059%	29.236%	33.413%	Up to $90,000	Up to $180,000
Tier 1	◯	16.706%	20.883%	25.059%	$90,001 to $105,000	$180,001 to $210,000
Tier 2	◯	8.352%	12.529%	16.706%	$105,001 to $140,000	$210,001 to $280,000
Tier 3	◯	0%	0%	0%	More than $140,000	More than $280,000

Note: Single parents and couples (including de facto couples) are subject to family tiers as is defined by the ATO. For families with children, the thresholds are increased by $1,500 for each child after the first.

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.

For more information about the Australian Government Rebate on Private Health Insurance, go to 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.

Date you wish Rebate to commence from D D / M M / Y Y Y Y

H. LIFETIME HEALTH COVER DETAILS

1. Are you or your partner under the age of 31? ◯ Yes ◯ No
2. Have you held continuous private hospital cover for the past 10 years (or since your 31st birthday) ? ◯ Yes ◯ No
3. Has your partner (if applicable) held continuous private hospital cover for the past 10 years (or since their 31st birthday)? ◯ Yes ◯ No

If yes, please ensure you complete section I – Transfer request below to ensure additional loadings are not applied.

I. TRANSFER REQUEST

If you or your partner are transferring from another registered health fund, UniHealth will cancel your existing health fund membership for you. Waiting periods already served are recognised if you transfer to an equivalent level of cover and have served all waiting periods with your existing fund. Waiting periods for services already covered are recognised if they are also covered by UniHealth. Benefits cannot be paid until your previous fund forwards a certificate of clearance to UniHealth and your membership has been paid to the date of service.

If you and your partner are transferring from separate memberships, you will each need to complete a request to transfer. Contact UniHealth for another form or visit **unihealthinsurance.com.au/cc.**

Existing fund details

Fund name _____ Level of cover _____

Member name _____

Membership number _____

Please cancel this membership on D D / M M / Y Y Y Y or on the day I commence with UniHealth.

I authorise UniHealth to:

Contact my previous health fund on my behalf ◯ Yes ◯ No

Cancel the membership for ◯ Myself ◯ All persons covered

_____ D D / M M / Y Y Y Y

Signature of existing primary member at transferring fund Date

J. DECLARATION

Please read and acknowledge the following:

◯ I declare that the information I have provided in this form is complete and correct. I understand that giving false or misleading information is a serious offence.

◯ I have authority to sign on behalf of all members on this policy (if relevant).

◯ I have read the Privacy Notice below and agree to the collection and use of my personal and sensitive information as outlined therein.

◯ I agree to be bound by the UniHealth Rules as amended from time to time, and understand that my contribution rates may increase and/or my benefit entitlements may change. An abridged version of the UniHealth Fund Rules can be found at unihealthinsurance.com.au or a copy is available on request by calling 1300 367 906.

◯ I understand that waiting periods may apply to my chosen level of cover (including 12 months for pre-existing conditions).

◯ I agree to receive marketing material from UniHealth.

_____ _____

Signature of new primary member at UniHealth Print Name

Date D D / M M / Y Y Y Y

K. HOW DID YOU HEAR ABOUT US?

◯ Word of mouth (Family)

◯ Word of mouth (Colleague)

◯ From my union

◯ UniHealth representative (Please specify name)

_____

◯ Online search

◯ Advertising

◯ Promotion (Please specify)

_____

◯ Other (Please specify)

_____

PRIVACY NOTICE

To arrange and manage your private health insurance, Teachers Federation Health Ltd ABN 86 097 030 414 trading as UniHealth (and its duly authorised representatives) collects personal information including sensitive information from its members and prospective members, those authorised by its members such as family members, and may in the course of its business collect some information from third parties such as hospitals, medical and ancillary providers, trade unions, employer organisations, aggregators and third party service providers. Information may be collected directly (for example, when an individual tells us or fills in a form) or indirectly (for example, by way of cookies when an individual visits the UniHealth website).

The purpose of collecting the information is so UniHealth can provide its products and services, specifically health insurance; dental, eyecare and other allied health services; healthy lifestyle programs; broader health cover services and general and life insurance products and services. UniHealth may also collect, use and disclose it to confirm eligibility to become a member, for product development, marketing, research, IT systems maintenance and development, recovery against third parties, fraud prevention and for other purposes with your consent or where authorised by law. If personal information is not collected from an individual, UniHealth may not be able to provide its products and services to that individual.

UniHealth usually discloses personal information it has collected to those entities, bodies or persons required in order to provide its products and services – for example, to unions to verify eligibility for membership, hospitals and medical providers for eligibility checks, to contracted providers of healthy lifestyle programs or broader health cover services, to financial institutions to pay health insurance claims, to government and regulatory bodies for compliance purposes, to third party service providers such as data storage, data handling providers and mailing houses who distribute UniHealth member communications and to fraud prevention agencies. UniHealth is not likely to disclose personal information to overseas recipients.

The UniHealth Privacy Policy contains information about how an individual may access and seek correction of their personal information held by UniHealth and about how to complain to UniHealth about a breach of the Australian Privacy Principles. An abridged version of the UniHealth Privacy Policy may be accessed at **unihealthinsurance.com.au** or request a copy by calling **1300 367 906**. Any enquiries and requests relating to the Privacy Act should be directed to the Privacy Officer telephone **1300 367 906** or **privacyofficer@unihealthinsurance.com.au**

Unless you opt out, UniHealth may contact a member by telephone, mail, electronic messages (including email), online and via other means with direct marketing material. If a member does not wish to receive such material, they can opt out at any time by calling **1300 367 906** or emailing **unsubscribe@unihealthinsurance.com.au**

When someone provides personal information about other individuals such as family members on their health insurance policy, UniHealth rely on that person having made them aware of the matters in this Privacy Notice and having obtained their consent on these matters.

MEMBERS OWN HEALTH FUND

WHAT NEXT? Once form is completed please send to **GPO Box 9812, Sydney NSW 2001** or **info@unihealthinsurance.com.au**

OFFICE USE ONLY

Member number