Teachers Federation Health Ltd ABN 86 097 030 414 trading as Teachers Health Fund
A Registered Private Health Insurer GPO Box 9812, Sydney NSW 2001

Phone 1300 728 188 **Mobile callers** 02 8346 2111 **Fax** 1300 728 388
Email info@teachershealth.com.au **Website** teachershealth.com.au

1. Complete all details that are relevant to your application on all pages of this two page application form.
2. Read the declaration and sign all the signature panels, as required.
3. Mail your completed application form to: Teachers Health Fund, GPO Box 9812, Sydney NSW 2001.

If you have any questions or require assistance, our membership consultants are available on 1300 728 188 and will be pleased to help.

Membership Application

I am applying to:

- ○ Join Teachers Health Fund
- ○ Transfer to Teachers Health Fund — If you are transferring from another fund you will need to complete the Clearance Certificate Request on the back of this form
- ○ Change other details — Please specify _____ Teachers Health Fund No. _____

I would like my membership to commence:

- ○ Upon receipt of application by Teachers Health Fund
- ○ Nominate a date in the future / /

A. YOUR DETAILS

1. Personal details

Title Mr ○ Mrs ○ Miss ○ Ms ○ Dr ○

Surname

Given names

Date of Birth / / Male ○ Female ○

2. Home address

Address

Suburb / town State Postcode

3. Postal address

○ As Above

Please complete details if different to home address

Address

Suburb / town State Postcode

4. Contact numbers

Home Work

Mobile Fax

Email

5. Membership eligibility

Category 1: Education Community

- ○ Current Teaching or Academic Staff
- ○ Former Teaching or Academic Staff
- ○ Current Administration/Support Staff
- ○ Former Administration/Support Staff

Please indicate which Union you belong / belonged to:

- ○ AEU
- ○ ASU
- ○ FSU
- ○ IEU NSW/ACT
- ○ IEUTAS
- ○ IEUWA
- ○ IEUSA
- ○ NSW Teachers Federation
- ○ NTEU
- ○ PSA
- ○ SSTUWA
- ○ VIEU
- OTHER (please specify)

Union Membership

Union Membership No.

Date membership ceased / /

(Must be provided if no longer a member)

Category 2: Family Relationship

Immediate family member of a Teachers Health Fund member

- Current/former partner
- Parent
- Adult / dependant child
- Sibling
- Grandchild

Full name of Teachers Health Fund member

Teachers Health Fund member number

B. YOUR MEMBERSHIP DETAILS

6. WHAT TYPE OF COVER DO YOU REQUIRE?

- Single
- Single Parent
- Extended Family (Single Parent)
- Couple / Family
- Extended Family

Partner details

- Spouse
- Partner/ Defacto

Surname

Given names

Date of Birth / /

- Male
- Female

Partner Authority: Do you authorise your partner, as named above, to operate this membership

- **Yes**
- **No**

Dependant 1

Surname

Given names

Date of Birth / /

- Male
- Female

Dependant 2

Surname

Given names

Date of Birth / /

- Male
- Female

Dependant 3

Surname

Given names

Date of Birth / /

- Male
- Female

Dependant 4

Surname

Given names

Date of Birth / /

- Male
- Female

- Additional dependants (please provide details on a separate sheet and submit with your application)

7. Student dependant declaration

If you have a dependant who is single, between 21 and 25 years of age, and a full time student / trainee / apprentice, they can be covered on your policy. Please complete this section if it applies to you

Surname

Given names

Date of Birth / /

- Male
- Female

Name of University / college / employer

8. Choose your level of cover

Select one Hospital and/or one Extras cover, OR select one packaged cover option.

HOSPITAL COVER

- Top Hospital
- Private Hospital Saver 300
- Private Hospital Saver 500
- Public Hospital

EXTRAS COVER

- Top Extras
- Essential Extras
- Emergency Ambulance

PACKAGED COVER

- Top Hospital + Top Extras
- CoreElect 300
- CoreElect 500
- StarterPak

9. Payment Method

How would you like to pay your contributions to Teachers Health Fund?

office use only

○ **Direct Debit from a nominated bank account (savings or cheque accounts only)**

Please select your payment frequency

○ Fortnightly ○ Monthly ○ Quarterly ○ Half yearly ○ Yearly

Commencing / / (Date must be in the future)

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

Financial Institution

Account Name

BSB No – Account No

Signature(s) of Account holders

○ **Salary Deduction**

Standing order to deduct monies from salary for Teachers Health Fund.

In some circumstances salary deduction is not available. Please contact Teachers Health Fund on **1300 728 188** to discuss the availability of this payment option.

Name of deducting authority (e.g Department of Education)

Surname

Given names

Payroll / Serial Number

Place of employment

Signature

10. Teachers Health Fund pay benefits for paid accounts directly to your bank account.

Please nominate an account that Teachers Health Fund should credit any benefits to.

○ Same as Direct Debit account in question 9

○ Other account

Financial Institution

Account Name

BSB No – Account No

C. FEDERAL GOVERNMENT REBATE REGISTRATION

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 contribution rates apply.

11. Would you like to receive the Federal Government Rebate on your private health insurance as a reduced contribution?

○ No – go to question 13 ○ Yes

12. Are all people on your membership eligible for a current Medicare card?

○ No – you cannot apply for the rebate unless all people on your membership are eligible for a Medicare card. Go to question 13.

○ Yes – please fill in your Medicare details:

Card Number

Valid to /

Name exactly as it appears on your Medicare Card

D. LIFETIME HEALTH COVER

13. **Are you under 31 years of age?** ○ Yes ○ No

Is your partner (if applicable) under the age of 31? ○ Yes ○ No

14. **Have you held Hospital cover at any time since 1 July 2000?** ○ Yes ○ No

Has your partner (if applicable) held Hospital cover at any time since 1 July 2000? ○ Yes ○ No

If you or your partner have held Hospital cover at any time since 1 July 2000, you will need to provide a Clearance Certificate to avoid paying any loadings. Please attach your Clearance Certificate or complete the Clearance Certificate request (below).

E. DECLARATION

15. **Please read and then sign this declaration.**

I agree that Teachers Federation Health Ltd. (trading as Teachers Health Fund) can use the address, telephone and email details supplied by me to keep me informed of future products and services, until such time as I advise Teachers Health Fund otherwise. I agree to be bound by Teachers Health Fund Rules. I declare that the information provided in this form is true and correct. I agree to Teachers Health Fund using the information provided in this form to provide health insurance services, health care services including dental and eye care services and general insurance services, where applicable. At times this may involve disclosing information to people or bodies who have involvement with the provision of services or to verify the accuracy of information provided to us. These people or bodies may include service providers, joint venture partners, government agencies, education unions and organisations that have a contract for the provision of services to Teachers Health Fund. You may request access to your personal information and are entitled to make corrections if necessary.

Signature

Print Name

Date / /

Clearance Certificate Request

If you or your partner are transferring from another registered health fund, Teachers Health Fund will cancel your existing health fund membership for you. Waiting periods are waived only if you transfer to an equivalent level of cover and have served all waiting periods with your existing fund. Benefits cannot be paid until your previous fund forwards a certificate of clearance to Teachers Health Fund.

If you and your partner are transferring from separate memberships, you will each need to complete a Clearance Certificate Request. Contact Teachers Health Fund for another form or download from **teachershealth.com.au**

Existing Fund Details

Fund Name Membership Number

Member's Details ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr

Surname

Given Names

Date of Birth / /

I hereby authorise Teachers Health Fund to terminate my membership from / / with your organisation (if still current) and / or obtain details about my membership.

Please provide information to Teachers Health Fund about ○ myself ○ my partner ○ my dependants

Signature

Date / /