Membership Application

We're here for you

▶▶ This is an application to:

Join Westfund ☐

Transfer to Westfund from another fund ☐ You will also need to complete the *Transfer Certificate Request* on Page 3.

Your details

1. Westfund Membership Number *(if relevant)*

2. Personal details

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given names

Also known as

Date of birth / / Male ☐ Female ☐

3. Home address

State Postcode

4. Postal address (if the same as Home address, write 'as above')

State Postcode

5. Contact numbers

Home ( )

Work ( )

Mobile

Fax ( )

E-mail Address

Do you wish to receive fund communication via email? No ☐ Yes ☐

Your membership details

6. What type of cover do you require?

Single ☐ ▶ Go to Question 7

Couple / Family ☐ ▶ Give details of ALL other family members to be covered. If you need more space, please attach a separate sheet.

PARTNER

Surname

Given names

Date of Birth / / Male ☐ Female ☐

Partner Authority - do you authorise your partner, as named above, to operate this membership? No ☐ Yes ☐

DEPENDANT 1

Surname

Given names

Date of Birth / / Male ☐ Female ☐

If this dependant is a student aged between 18-25 please complete:

Student ID

Institution

DEPENDANT 2

Surname

Given names

Date of Birth / / Male ☐ Female ☐

If this dependant is a student aged between 18–25 please complete:

Student ID

Institution

DEPENDANT 3

Surname

Given names

Date of Birth / / Male ☐ Female ☐

If this dependant is a student aged between 18–25 please complete:

Student ID

Institution

DEPENDANT 4

Surname

Given names

Date of Birth / / Male ☐ Female ☐

If this dependant is a student aged between 18–25 please complete:

Student ID

Institution

7. Please select your health cover options

PLATINUM EXTENDED		Family ☐
PLATINUM	Single ☐	Family ☐
GOLD EXTENDED		Family ☐
GOLD	Single ☐	Family ☐
GOLD 500	Single ☐	Family ☐
PLATINUM HOSPITAL	Single ☐	Family ☐
PLATINUM HOSPITAL 500	Single ☐	Family ☐
SILVER	Single ☐	Family ☐
GOLD EXTRAS	Single ☐	Family ☐
VALUE FIRST	Single ☐	Family ☐
VALUE EXTRAS	Single ☐	Family ☐
AMBULANCE	Single ☐	Family ☐

8. When would you like your membership to commence?

☐ As soon as your application is received (Note: An adjusting payment may be required to cover days preceding your first deduction)

☐ From the date of the first direct debit or salary deduction after your application is received

☐ From this date in the future / /

Australian Government Rebate on Private Health Insurance

If you do not complete this section, the full premium rate will apply.

9. Would you like to receive the Australian Government Rebate on Private Health Insurance as a reduced premium?

Note: Employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance policies paid on behalf of employees.

No ☐ ▶ Go to Question 10

Yes ☐ ▶ Please complete our application to receive or change the Australian Government Rebate on Private Health Insurance as a reduced premium

Lifetime Health Cover

10. Are you or your partner *(if applicable)* under 31 years of age?

You Yes ☐ No ☐

Partner Yes ☐ No ☐

11. Have you or your partner *(if applicable)* held HOSPITAL cover at any time since 1 July 2000?

You Yes ☐ No ☐

Partner Yes ☐ No ☐

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?

No ☐ Yes ☐

Westfund Direct Debit

12. Bank Account Details

I/We request until further notice in writing to debit my account described in the schedule below the amounts Westfund (The User), (APCA User ID Number 002481) may debit or charge me/us through the direct debit system; in accordance with the terms described in the Westfund Direct Debit Service Agreement as detailed on the Westfund website: **http://www.westfund.com.au/members-area**

Branch

BSB —

Acc Number

Acc Name/s

X

X Date / /

Please note: If joint account all signatures are required

Frequency ☐ Weekly ☐ Fortnightly ☐ Monthly

Please note: Weekly and fortnightly deductions are made on a Thursday

13. Or Credit Card

VISA ☐ Mastercard ☐

C/C Number

Expiry Date /

Card Holder

X Date / /

Frequency ☐ Weekly ☐ Fortnightly ☐ Monthly

Please note: Weekly and fortnightly deductions are made on a Thursday

14. Or Direct Paying

By cheque, BPay or Cash ☐

How often will you pay your contributions?

Monthly ☐ 3 Month period (quarterly) ☐

6 Month period (half-yearly) ☐ 12 Month period (yearly) ☐

If sending a cheque with your application, please contact Westfund for an accurate quote

15. Westfund pays benefits for paid accounts directly to your bank account. Please nominate the account Westfund should credit any benefits to:

Same as direct debit account in Question 12 ☐

Other Account ☐ ▶ Provide details

Branch

BSB —

Acc Number

Acc Name/s

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

X

X Date / /

Please note: If joint account all signatures are required

Privacy Collection Statement

The information provided on this form and your membership details generated by Westfund, will be used to provide you with health insurance services (including for benefit payment, entitlements and audit purposes), administer your membership and communicate with you. To enable us to do these things, we may disclose this information to people or bodies who provide services to Westfund. Where you receive treatment from a Hospital or Provider contracted to Westfund, we may provide them with your cover details to enable them to fulfill their obligations to you under the contract.

You may request access to your information and ask that it be corrected by contacting us. If you do not provide us with the information sought, we may be unable to provide you with health insurance services.

Declaration

I wish to apply for the health cover chosen on 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 dependants 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 Australian Government Rebate on Private Health Insurance if provided is correct. I understand that there are penalties for false or misleading information.

Westfund will keep me informed about new products and services from all of their companies, which Westfund considers of potential benefit.

However, if you do not wish Westfund to communicate this information to you, please tick this box. ☐

X	Date / /

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.

Transfer 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	
Member's full name	
Date of Birth	/ /
Date joined	/ /
Date paid to	/ /
Date of cancellation	/ /

Other persons requiring clearance	
Date of birth	/ /
	/ /
	/ /
	/ /

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.

X	Date / /

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