Latrobe HEALTH SERVICES
EveryBody benefits from our health cover

Membership Application

Latrobe Membership No.

My cover to commence on / /

I apply to:
Join ☐ Transfer from another insurer (Complete Clearance Certificate) ☐ Change my membership details ☐ Join a corporate ☐
(Please contact Latrobe for further details)

My details: (please use block letters)

TITLE	NAME	SURNAME	D.O.B. D D / M M / Y Y Y Y

RESIDENTIAL ADDRESS	CITY	STATE	POSTCODE
POSTAL ADDRESS (if different to residential)	CITY	STATE	POSTCODE

PHONE	OTHER PHONE	EMAIL

Other people to be covered by this membership:

TITLE	NAME	SURNAME	D.O.B. D D / M M / Y Y Y Y	SEX	FULL-TIME STUDENTS 18-24YRS, NAME OF EDUCATIONAL INSTITUTION

Preferred payment method (Please tick)

By Account ☐ By Direct Debit ☐

Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half Yearly ☐ Yearly ☐

Accounts are not sent if you choose weekly or fortnightly payment options.
Please provide the relevant Direct Debit details below. Reminders are sent if you choose half yearly or yearly payment options.

Direct debit request

I/We authorise Latrobe Health Services (User ID Number 002319) to debit funds from my financial institution account as detailed in The Schedule below. The payment is for health insurance premiums identified by:

To commence on / /

Direct Debit Payment Details

NAME OF FINANCIAL INSTITUTION

Branch number (BSB) ☐☐☐ - ☐☐☐

ACCOUNT HOLDER

ACCOUNT NUMBER

Credit Card Payment Details

Type of credit card ◯ Mastercard ◯ Visa

Payment type ◯ Single payment ◯ Automatic payment

Credit card number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiry date /

CARDHOLDER NAME

CARDHOLDER SIGNATURE

My chosen cover is:

	Insert code		
Hospital cover		Hospital cover	$
Extras cover		Extras cover	$
Ambulance Subscription		Ambulance Subscription	$

Are all the people listed on this application citizens or permanent residents of Australia with 100% Medicare entitlements (a green Medicare card)? ☐ Yes
If not, please contact us before completing this application

Policy Holder Declaration

I declare and acknowledge that:

1. I have read and understand the important information in this booklet.
2. I have read Latrobe's Privacy Statement (Page 49) and understand that I may request a copy of the *Privacy Policy* at any time. I consent to the use and disclosure of my personal information in the manner described therein. Where this application contains the personal information about other people, I confirm that I have obtained their consent.
3. I authorise Latrobe to obtain from or disclose to any hospital, medical or other health service provider all information relevant to the assessment of any claim for benefits and I have obtained the same authorities from any other people covered by this application.
4. I have read and understand the extent and conditions of the cover for which I am applying, including the conditions regarding waiting periods and pre-existing conditions.
5. I accept and agree to be bound by Latrobe Health Services' rules of and understand that I can make arrangements to view a copy of these rules. I will inform any other people covered by this application about the existence of these rules and that they are similarly bound.
6. I declare that the ages stated for all adults appearing on my Latrobe membership application are correct. I understand that there are penalties for giving false or misleading information.

Other people to have access to this membership:

For Family or Couples - Please note you and your partner both have equal authority to this membership. If this is unsuitable, please call Latrobe.

☐ I want another person to have this authority. Please send me a Third Party Authority application

SIGNATURE

DATE D D / M M / Y Y Y Y

Federal Government 30% Rebate

Complete this application to receive the Federal Government 30% Rebate on private health insurance as a reduced rate. If you do not complete this section, full membership rates apply.

Are all the people on the policy listed on a green Medicare card and eligible to receive 100% Medicare entitlements?

☐ Yes ☐ No

You are entitled to a green Medicare card if you are:
An Australian citizen or, a holder of a permanent resident visa or, a New Zealand citizen

If Yes, please complete the remainder of this section.
If No, please contact us before completing this application

Effective date for rebate to commence ☐☐/☐☐/☐☐☐☐

Medicare Card Number ☐☐☐☐ ☐☐☐☐☐ ☐

Valid to ☐☐ Month ☐☐☐☐ Year

Your name **exactly** as it appears on your Medicare Card

Details of all people covered by the policy *(do not include yourself)*

Family Name	Given Name(s)	Birth Date	Sex	Dependant child
		/ /		☐ Y ☐ N
		/ /		☐ Y ☐ N
		/ /		☐ Y ☐ N
		/ /		☐ Y ☐ N
		/ /		☐ Y ☐ N

SIGNATURE DATE D D / M M / Y Y Y Y

Some of the information provided on this form will be used for the purposes of registering you for the Federal Government 30% Rebate on private health insurance. Its collection is authorised by law and information collected will be disclosed to the Department of Health & Aged Care, the Health Insurance Commission and the Australian Taxation Office.

Agent name & number

Clearance Certificate Request

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Use this form to authorise Latrobe Health Services to obtain details of your existing health insurance membership on your behalf.

NAME

ADDRESS

CITY | STATE | POSTCODE

PREVIOUS INSURER

List all other persons transferring

NAME	SURNAME	D.O.B. (DD/MM/YYYY)
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y
		D D / M M / Y Y Y Y

PREVIOUS INSURER MEMBERSHIP NUMBER

COVER NAME

DATE JOINED D D / M M / Y Y Y Y

DATE PAID TO D D / M M / Y Y Y Y

This cancellation is effective from D D / M M / Y Y Y Y

I hereby authorise Latrobe Health Services to terminate my membership with your organisation and obtain a Clearance Certificate. Please forward a copy of the Clearance Certificate to PO Box 41 Morwell 3840

If applicable, any refund of contributions paid in advance should be sent to the above policy holder.

Signatures - Spouse/partner signature is required if they are to be cancelled and a clearance issued

1. DATE D D / M M / Y Y Y Y

2. DATE D D / M M / Y Y Y Y

Note: if you pay via Direct Debit or Payroll deduction, remember to cancel your payments for your existing health insurer.