Latrobe Health Services Limited
ABN 94 137 187 010

Reply Paid 41, Morwell VIC 3840
Email: info@lhs.com.au
Website: latrobehealth.com.au

Member Service enquiries: 1300 362 144

Latrobe HEALTH SERVICES

our
EveryBody benefits from health cover

Please complete:

Clearance Certificate Request Form

Use this form to authorise Latrobe Health Services to obtain details of your existing health insurance membership on your behalf. Complete parts A to D and mail the form to Latrobe Health Services, Reply Paid 41, Morwell VIC 3840.

Part A My details

Full name

Date of birth

.... / .... / ....

Residential address

Postcode

Postal address (if different to above)

Postcode

Part B Details of all persons transferring

Full name

Date of birth

.... / .... / ....

Full name

Date of birth

.... / .... / ....

Full name

Date of birth

.... / .... / ....

Full name

Date of birth

.... / .... / ....

Full name

Date of birth

.... / .... / ....

Part C Previous health insurance details

Previous insurer membership number

Previous insurer name

This cancellation is effective from

.... / .... / ....

Note: If you pay via direct debit or payroll deduction, remember to cancel your payments with your existing health insurer or financial institution.

Part D Declaration

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 VIC 3840 within 14 days.
Any refund of premiums paid in advance should be sent to the postal address on the reverse side of this form.

Note: Spouse/partner signature is required if they are to be cancelled and a clearance issued.

Signature

Date signed

1 .... / .... / ....

Signature

Date signed

2 .... / .... / ....

Private Health Insurance Code of Conduct

MEMBERS OWN HEALTH FUND