Latrobe HEALTH SERVICES

EveryBody benefits from our health cover

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

Membership Application

Please complete both sides and mail to Latrobe Health Services, Reply Paid 41, Morwell VIC 3840

My details

Latrobe membership number ☐☐☐☐☐☐☐☐

My cover to commence on / /

Important: Waiting periods, default and limited benefits, restricted benefits, co-payment and excesses may apply.

I apply to: ☐ Join ☐ Transfer from another insurer ☐ Change my membership details ☐ Join a corporate

Title | Name | Surname

Email | Gender ☐ M ☐ F | Date of Birth / /

Daytime phone number | Other phone number

Residential address | Postcode

Postal address (if different to above) | Postcode

Details of other people covered by this membership

Full name | Date of birth / /

Gender ☐ M ☐ F | If a full-time student aged 18-24 years, name of educational institution

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Private Health Insurance Code of Conduct

Latrobe Health Services proudly supports and complies with the Private Health Insurance Code of Conduct

MEMBERS OWN HEALTH FUND

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My payment details

Preferred payment method ☐ By account[1] ☐ By direct debit[2]

[1] Reminder accounts are not sent if you choose weekly or fortnightly payment options.
[2] Please provide the relevant direct debit details below. Reminders are sent if you choose half yearly or yearly payment options.

Preferred payment period ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half yearly ☐ Yearly

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

Direct debit to commence on / /

Name of financial institution

Branch number (BSB) ☐☐☐-☐☐☐

Account holder

Account number

Please note: Due to credit card security compliance, we are unable to collect credit card details on application forms. Options to pay via direct debit with VISA or MasterCard are:

- Go to **latrobehealth.com.au** and complete your application online
- Phone **1300 362 144**; our Member Service Centre can complete your application over the phone
- Our Member Service Centre can contact you.

Daytime contact number:

My cover details

My chosen hospital cover is:

Hospital cover cost $

My chosen extras cover is:

Extras cover cost $

My chosen Ambulance subscription is:

Ambulance subscription cost $

Previous health insurance details for clearance certificate request

Previous insurer membership number

Previous insurer name

This cancellation is effective from / /

Does this apply to all persons? ☐ Yes ☐ No

Member declaration

I declare and acknowledge that:

1. I am aware 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.
2. 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.
3. I understand that waiting periods, default and limited benefits, restricted benefits, co-payment and excesses may apply to the cover I have selected.
4. I accept and agree to be bound by Latrobe Health Services' Rules 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.
5. 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 form.

Signature

Date signed / /

AGENT NAME AND NUMBER:

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