

## 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.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
I apply to:				
<input type="checkbox"/> Join	<input type="checkbox"/> Transfer from another insurer	<input type="checkbox"/> Change my membership details	<input type="checkbox"/> Join a corporate	
Title	Name	Surname		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Email		Gender	Date of Birth	
<input type="text"/>		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	
Daytime phone number		Other phone number		
<input type="text"/>		<input type="text"/>		
Residential address				Postcode
<input type="text"/>				<input type="text"/>
Postal address (if different to above)				Postcode
<input type="text"/>				<input type="text"/>

### Details of other people covered by this membership

Full name		Date of birth	
<input type="text"/>		<input type="text"/>	
Gender	If a full-time student aged 21-31 years, name of educational institution		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>		
Full name		Date of birth	
<input type="text"/>		<input type="text"/>	
Gender	If a full-time student aged 21-31 years, name of educational institution		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>		
Full name		Date of birth	
<input type="text"/>		<input type="text"/>	
Gender	If a full-time student aged 21-31 years, name of educational institution		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>		
Full name		Date of birth	
<input type="text"/>		<input type="text"/>	
Gender	If a full-time student aged 21-31 years, name of educational institution		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>		
Full name		Date of birth	
<input type="text"/>		<input type="text"/>	
Gender	If a full-time student aged 21-31 years, name of educational institution		
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>		

## My payment details

Preferred payment method  By account<sup>1</sup>  By direct debit<sup>2</sup>

<sup>1</sup> Reminder accounts are not sent if you choose weekly or fortnightly payment options.  
<sup>2</sup> 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

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.

Account number

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:



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