

Change of details form

Please complete all questions, tick boxes and sign where appropriate. Leaving a question blank may delay the processing of this form.

SECTION 1: CURRENT DETAILS *(use block letters)*

Health policy number

Surname

Given name(s)

Initial

Title

Residential address

Postcode

Postal address

Postcode

Email address *if you would like us to keep you up-to-date with Fund news and services via email, fill in your email address below.*

Home phone number

SECTION 2: DETAILS OF CHANGES REQUIRED

Change/s required from

PART A: CHANGE NAME DETAILS

Surname

Given name(s)

Initial

Title

PART B: CHANGE OF ADDRESS, PHONE NUMBER OR EMAIL

Residential address

Postcode

Postal address *(if same as residential address, write 'as above')*

Postcode

Email address

Home phone number

Work phone number

Mobile phone number

PART C: CHANGE TO EASY CLAIM AUTHORITY

Receive your benefit payments on paid claims the easy way by having them deposited directly into your nominated bank account

Add Delete Change

Name of Financial Institution

Bank Building Society Credit Union

Branch location

Name of account holder to be credited

BSB number

Account number

Credit Unions only

Direct credit is not available on credit card accounts.

PART D: CHANGE TO EASY PAY *(Direct Debit Payments)*

The Fund's direct debit allows you to have your premiums deducted directly from your bank account. Please complete a Direct Debit Request form that can be obtained by calling 133 234.

PART E: CANCEL MY POLICY

I *(Policy holder's name)*

wish to cancel my policy effective

Policy holder's signature

X

Reason for cancelling cover

PART F: FEDERAL GOVERNMENT REBATE

Please complete details below: Add Delete

Are all people on your policy eligible for a current Medicare card? Yes No

If **Yes**, please complete the remainder of this section.

If **No**, you cannot apply for the rebate until you obtain a card from Medicare.

Are you covered by this membership? Yes No

If No, employers and trustees of organisations cannot claim the Federal Government Rebate on policies on behalf of employees.

Date premium reduction to commence

Your Medicare card no.

Your name exactly as it appears on your Medicare card

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

SECTION 3: DECLARATION

I **declare** that information provided on this form is true, correct and complete and I will notify the Fund of any changes. I **agree** to be bound by the rules of the Fund.

If the Easy Claim Authority has been completed: I authorise the Fund to credit my account as detailed in this Authority (the Fund should immediately be notified of any changes to particulars). I accept that the Fund reserves the right at any time to terminate or suspend the Easy Claim payment system and to pay by cheque or in any other manner which the Fund may determine from time to time.

Policy holder's signature

X

