

# Application Form

Buy online at [gmhba.com.au](http://gmhba.com.au)  
or return these forms with  
your payment to:  
GMHBA, Reply Paid 761,  
Geelong Vic 3220

Simply Great Value  
**HEALTH INSURANCE**



# Application Form

## 1. I wish to (please tick)

- Join GMHBA     Transfer from an existing GMHBA membership  
 Change my GMHBA cover

GMHBA member number (existing members only) \_\_\_\_\_

Cover or change of cover to commence from \_\_\_\_\_ / \_\_\_\_\_ /20

Cover does not commence until payment is received.

## 2. Type of cover

- Single     Family/Couple     Single Parents

## 3. My details

Title \_\_\_\_\_ Given names \_\_\_\_\_

Surname \_\_\_\_\_

Home address \_\_\_\_\_

Suburb/City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Postal address (if different) \_\_\_\_\_

Suburb/City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Date of birth \_\_\_\_\_ / \_\_\_\_\_ / Sex  Male  Female

Home phone \_\_\_\_\_ Day Phone \_\_\_\_\_

Mobile \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Preferred form of written communication  Email  Mail

## 4. Partner authority (optional for applicant to sign)

I authorise the person identified as my partner/spouse on this application form to make changes to this membership, including varying the level of cover.

Signed  \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ /20

## 5. Other people to be covered

- I confirm all people to be covered under my GMHBA membership are citizens or permanent residents of Australia who have full Medicare eligibility.

Note: Children under 21 are covered under family memberships. Children over 21 and under 25 are covered if they are single and undertaking a full-time apprenticeship, full-time traineeship or full-time study at eligible educational institutions (please list below).

(include surname if different to applicant)    Relationship    Date of birth    M/F

Given name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Educational institution \_\_\_\_\_

Given name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Educational institution \_\_\_\_\_

Given name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Educational institution \_\_\_\_\_

Given name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Educational institution \_\_\_\_\_

HOSPITAL	
<b>Premium Hospital</b>	
<b>Gold Plus Hospital</b>	
Level 0 nil excess	PGH0 <input type="checkbox"/>
Level 1 (\$250 maximum admission excess)	PGH1 <input type="checkbox"/>
Level 2 (\$500 maximum admission excess)	PGH2 <input type="checkbox"/>
<b>Silver Plus Hospital</b>	
Level 0 nil excess	PSH0 <input type="checkbox"/>
Level 1 excess (\$250 maximum admission excess)	PSH1 <input type="checkbox"/>
Level 2 excess (\$500 maximum admission excess)	PSH2 <input type="checkbox"/>
<b>Everyday Hospital</b>	
<b>Gold Hospital</b>	
Level 0 nil excess	GH0 <input type="checkbox"/>
Level 1 (\$250 maximum admission excess)	GH1 <input type="checkbox"/>
Level 2 (\$500 maximum admission excess)	GH2 <input type="checkbox"/>
<b>Silver Hospital Single Parents</b>	
\$100 maximum admission excess	SHSP <input type="checkbox"/>
<b>Silver Hospital</b>	
Level 0 nil excess	SH0 <input type="checkbox"/>
Level 1 excess (\$250 maximum admission excess)	SH1 <input type="checkbox"/>
Level 2 excess (\$500 maximum admission excess)	SH2 <input type="checkbox"/>
<b>Bronze Hospital</b>	
Level 0 nil excess	BH0 <input type="checkbox"/>
Level 1 excess (\$250 single and \$500 families/couples/single parents)	BH1 <input type="checkbox"/>
Level 2 excess (\$500 single and \$1,000 families/couples/single parents)	BH2 <input type="checkbox"/>
<b>PACKAGES</b>	
<b>Silver Everyday Package (Hospital and Extras)</b>	
Maximum excess (\$250 single and \$500 families/couples/single parents)	SHEPSAE <input type="checkbox"/>
<b>Silver Young Singles Package (Hospital and Extras)</b>	
\$250 maximum excess	SHYSZe <input type="checkbox"/>
<b>Bronze Young Singles Package (Hospital And Extras)</b>	
\$500 maximum excess	BHYSZp <input type="checkbox"/>
<b>EXTRAS</b>	
Platinum Extras	PE <input type="checkbox"/>
Gold Extras	GE <input type="checkbox"/>
Silver Standard Extras	SAE <input type="checkbox"/>
Bronze Extras	BE <input type="checkbox"/>

## 6. Transferring from another health fund

Health fund \_\_\_\_\_

Cover name \_\_\_\_\_

Membership number \_\_\_\_\_

Date joined \_\_\_\_\_ / \_\_\_\_\_ /20    Date paid to \_\_\_\_\_ / \_\_\_\_\_ /20

If you're transferring from another health fund, please attach a transfer certificate to your application form. Or, you can complete the attached Transfer Certificate Request form if you want GMHBA to terminate your membership and request a transfer certificate on your behalf.

## 7. Direct credit of claims benefits

- Please direct credit my benefits on paid accounts into the bank/building society/credit union account nominated below.

BSB number    -

Account number

Name(s) the account is held in \_\_\_\_\_

Bank Name \_\_\_\_\_

Branch \_\_\_\_\_

(If you're unsure of the BSB number, please contact the bank where the account is held)

## 8. Method of payment

- Direct debit from my bank/building society/credit union (please complete Direct Debit Request form)

- Automatic payment from credit card (please complete Credit Card Authorisation form)

- Cash, cheque, BPay or BillPay each  Monthly  Quarterly  Half-yearly  Yearly

- Payroll deduction: Employer \_\_\_\_\_

(Call us on 1300 4 GMHBA (46422) to find out if this facility is available to you.)

## 9. Privacy

**Please read the following.** Personal information provided by you on this form will be used to deliver the health insurance products and services you request. Failure to provide all of the required information may prevent us from completing your request. The information we collect from you is confidential. We may disclose this information to Government authorities and third parties who are contracted to the fund to provide services. These contracts ensure that third parties keep your information secure and confidential. You are entitled to access any of your personal information and to make corrections if needed. You can do this in writing or over the phone. I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates and I confirm that I have the authority to act on behalf of the persons named on this application form.

## 10. Declaration (applicant to sign)

The signing of this application and the payment of any premium shall constitute an acceptance of the above privacy declaration and conditions laid down by the regulations in force at this time or as may be amended from time to time. I understand : proof of identity including age may be required to confirm the details of persons listed on this application, the rulings regarding pre-existing conditions/illnesses, waiting periods and the conditions of membership. I declare the above statements/information to be true and correct.

Signed  \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ /20

Please fill in forms to claim the Federal Government 30% Rebate on private health insurance and pay by Direct Debit.

## Application to receive the Federal Government Rebate

### Application to receive the Federal Government 30% Rebate on private health insurance as a reduced premium

- Complete this registration form and lodge it with GMHBA Limited to receive the Federal Government 30% Rebate on private health insurance as a reduced premium.
- This application must be completed in black pen using block letters.
- All the people listed on the policy must be eligible to claim Medicare for you to receive the Federal Government 30% Rebate on private health insurance as a reduced premium.
- If at any stage you wish to stop receiving the Federal Government 30% Rebate on private health insurance as a reduced premium, you must notify GMHBA Limited as soon as possible.
- If you do not complete this application, higher membership premiums will apply than those that appear in our rate inserts. Call us on 1300 4 GMHBA (46422) for more information.
- Employers and trustees of organisations cannot claim the Federal Government 30% Rebate on private health insurance policies paid on behalf of employees.

Name of private health fund issuing the policy to which this application relates:

**GMHBA**

Are you covered by this policy?  Yes  No

**Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?**  Yes  No

You are entitled to a Medicare card if you are a person who lives in Australia; you are an Australian citizen; a holder of a permanent resident visa; a New Zealand citizen, or, in some cases an applicant for a permanent resident visa. Any inquiries about Medicare eligibility can be made at any Medicare office or by phoning 132 011 for the cost of a local call.

Your full name exactly as it appears on your Medicare card:

Medicare number                      Valid to / /20

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 may be disclosed to the Department of Health and Ageing, the Health Insurance Commission, and the Australian Taxation Office.

### Declaration

I declare that the information I have provided is correct including details of dates of birth on this application form. I understand that there are penalties for giving false or misleading information.

Signed  \_\_\_\_\_ Date / /20

### Please include this registration form with your application

If you need to know more about the Federal Government 30% Rebate on private health insurance and reduced premiums through your health fund, contact the Department of Health and Ageing or visit [www.health.gov.au](http://www.health.gov.au)

## Direct Debit Request



GMHBA Limited ABN 98 004 417 092  
60-68 Moorabool Street PO Box 761, GEELONG VIC 3220  
Tel: 1300 4 GMHBA (46422) Fax: (03) 5221 4582  
Email: [service@gmhba.com.au](mailto:service@gmhba.com.au) Website: [gmhba.com.au](http://gmhba.com.au)



Date / /20

GMHBA Member number \_\_\_\_\_

Member name \_\_\_\_\_

Home address \_\_\_\_\_

Suburb/City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

Name(s) \_\_\_\_\_

I/we authorise and request GMHBA Limited User ID No. 015617 to arrange for funds to be debited from my/our account at the financial institution identified below and as prescribed below through the Bulk Electronic Clearing System (BECS) and to apply these funds in payment of the member's premium up to the next direct debit date, including any arrears of premium. This authorisation is to remain in force in accordance with the terms described in the Direct Debit Request Service Agreement.

### Bank/Financial Institution

Bank name \_\_\_\_\_

Bank address \_\_\_\_\_

Account name \_\_\_\_\_

BSB number    -

Account number

Frequency  Fortnightly  Monthly  Quarterly  
 Half-yearly  Yearly

Excluding the 29th, 30th & 31st of any month, the first direct debit is to take place on

/ /20

I/We have read and accept the terms of the Direct Debit Request Service Agreement as may be amended from time to time by GMHBA and authorise the following:

1. GMHBA to verify the details of the above mentioned account with my/our financial institution
2. My/Our financial institution to release information allowing GMHBA to verify the above mentioned account details.

Signature(s) (of account holder/s) \_\_\_\_\_

Signed  \_\_\_\_\_ Date / /20

Signed  \_\_\_\_\_ Date / /20

## Transfer Certificate Request



GMHBA Limited ABN 98 004 417 092  
60-68 Moorabool Street PO Box 761, GEELONG VIC 3220  
Tel: 1300 4 GMHBA (46422) Fax: (03) 5221 4582  
Email: [service@gmhba.com.au](mailto:service@gmhba.com.au) Website: [gmhba.com.au](http://gmhba.com.au)

Please complete this form if you want GMHBA to terminate your membership with another health fund and request a transfer certificate and claims history on your behalf. This form must be signed by the member who has legal responsibility for membership of your previous fund.

Health fund \_\_\_\_\_

Membership number \_\_\_\_\_

Member Name \_\_\_\_\_

Home address \_\_\_\_\_

Suburb/City \_\_\_\_\_ Postcode \_\_\_\_\_

I authorise GMHBA to cancel my  Hospital only  Extras only

Combined cover with your fund from:

Date / /20

Signed  \_\_\_\_\_ Date / /20

Please refund my premiums paid in advance of the cancellation date and send a transfer certificate and claims history for all people covered under my membership to GMHBA.

Remember! Continuity of a member's/partner's certified age at entry (CAE) is possible when transferring from another Australian registered health fund under Lifetime Health Cover.

Please do not contact me further about this request.

## Credit Card Authorisation

GMHBA Limited ABN 98 004 417 092  
60-68 Moorabool Street PO Box 761, GEELONG VIC 3220  
Tel: 1300 4 GMHBA (46422) Fax: (03) 5221 4582  
Email: service@gmhba.com.au Website: gmhba.com.au

Date \_\_\_\_ / \_\_\_\_ /20 \_\_\_\_

GMHBA Member number \_\_\_\_\_

Member name \_\_\_\_\_

Home address \_\_\_\_\_

Suburb/City \_\_\_\_\_ State \_\_\_\_\_ Postcode \_\_\_\_\_

I hereby authorise GMHBA Limited to charge my credit card

on this occasion for the amount of \$ \_\_\_\_\_

automatically

Monthly  Quarterly  Half-yearly  Yearly

Until instructed by me in writing to cease deductions.

I understand that the first credit charge will occur on 01/ \_\_\_\_ /20 \_\_\_\_

(first working day of the month).

I also authorise GMHBA Limited to charge my credit card such amount as is required to pay the member's premium up to the next charge date. If the premium changes or payments are in arrears, I authorise GMHBA Limited to alter the amount from the appropriate date in accordance with such changes.

Alterations/cancellations to membership or account details must be received in writing, on the prescribed form/s at least 7 days before the next scheduled direct debit deduction date.

A refund of premiums cannot be issued within 14 days of the debit date. This allows sufficient time for the financial institution to advise GMHBA of any debit deduction dishonour.

After two consecutive dishonours GMHBA will remove the membership from the debit scheme.

### Type of credit card

Mastercard  Visa Card

Card number

□□□□ □□□□ □□□□ □□□□

Expiry date \_\_\_\_\_ /20 \_\_\_\_

Cardholder's name \_\_\_\_\_

Cardholder's signature ✕ \_\_\_\_\_

## Application Checklist:

- Application Form
- Application to receive the Federal Government Rebate on private health insurance as a reduced premium form
- Direct Debit or Credit Card Authorisation form
- Transfer Certificate Request form (if transferring from another health fund)

## Once we've processed your membership we'll:

- Send your welcome pack and membership card.
- Start your direct debits (if applicable.)
- For transferring members, send your Transfer Certificate Request to your previous health fund. Please send your transfer certificate and claims history to us as soon as you receive it from your previous health fund. Any premiums paid in advance will be refunded.

How did you hear about us? \_\_\_\_\_

\_\_\_\_\_

- From time to time, GMHBA contacts members (by phone, email, post) to notify of special offers, products, services. If you do not wish to receive this information please cross this box.

**Please keep the Member Guide with your other GMHBA documents**





**Health Insurance**

### **HEAD OFFICE**

60-68 Moorabool Street  
PO Box 761, GEELONG VIC 3220  
Ph: 1300 4 GMHBA (46422)  
Fax: (03) 5221 4582  
Email: [service@gmhba.com.au](mailto:service@gmhba.com.au)  
Website: [gmhba.com.au](http://gmhba.com.au)

### **BRANCHES**

**Geelong:** 60-68 Moorabool Street

**Belmont:** 178 High Street

**Norlane:** Bellpost Shopping Centre, Anakie Road

**Newcomb:** Bellarine Village, Queenscliff Road

**Ballarat:** 62 Bridge Mall

**Bendigo:** Shop 11a Fountain Court, Mitchell Street

**Colac:** 178 Murray Street

**Portland:** 112a Percy Street

**Warrnambool:** 114 Lava Street

**Hamilton:** 182 Gray Street

**Perth:** Suite 7, Atrium Building, 168 St Georges Terrace

## **1300 4 GMHBA**

(1300 4 46422)

## **[gmhba.com.au](http://gmhba.com.au)**

**Agent, organisation or referring  
member number:**