Change of cover form

ahm Health Insurance

1 Your details

USE BLACK PEN ONLY AND PRINT IN UPPERCASE

Membership number | Title | First names

Surname

Residential street address

Suburb | State | Postcode

Postal address – if this is the same as your residential address please write 'As above'

Suburb | State | Postcode

Date of birth (D D M M Y Y) | Gender (X) (M F) | Phone | Mobile phone

Email

Sign me up to receive email updates from ahm [X]

2 Medicare eligibility

Are all persons to be covered by this policy listed on your:

[X] **GREEN** Unrestricted Medicare card?

[X] **BLUE** Interim Medicare card?

[X] **YELLOW** Reciprocal Medicare card?

[X] **NO** Medicare card?

Please state the expiry date of your Medicare card if you hold one (D D M M Y Y)

If you hold a YELLOW, BLUE or NO Medicare card, some of the benefits outlined under our covers may not apply to you. We strongly recommend that you only purchase these covers in conjunction with an Overseas Visitors Health Cover which is more suitable to your needs. Please contact ahm for further information.

3 Change of cover

Complete this section if you're changing your cover.

Place a (X) in the box next to the level of cover you need and the type of cover you require.

LEVEL OF COVER

- [X] Single
- [X] Single parent
- [X] Couple/Family

EXTRAS COVER ONLY

- [X] Basic Extras
- [X] Lifestyle Extras
- [X] Family Extras
- [X] Super Extras

HOSPITAL COVER ONLY

- [X] Basic Hospital
- [X] Essential Hospital Level 5
- [X] Family Hospital Level 5
- [X] Top Hospital
- [X] Top Hospital Level 5
- [X] Top Hospital Level 8

HOSPITAL & EXTRAS COMBINED

Please make sure you select a cover from both the **EXTRAS COVER** column and the **HOSPITAL COVER** column.

4 Adding someone to your cover

Complete this section to add a spouse/partner or dependant up to the age of 21 to your cover. If you don't have enough space, please attach a separate sheet with the extra information.

1 Title | First name

Surname (if different to policy holder)

Date of birth (D D M M Y Y) | Relationship to policy holder

2 Title | First name

Surname (if different to policy holder)

Date of birth (D D M M Y Y) | Relationship to policy holder

5 Student dependant declaration

If you have a dependant student who is single, between 21 and 25 years of age, and a full time student, they can be covered on your policy. Please complete this section if this applies to you.

Do you have children who are 18-25 years, single and not studying full-time? They may be eligible to be on your cover for an additional premium with our +18 cover. Call us to discuss.

Student's full name

Educational institution where they are studying | Student ID number | Date study commenced (D D M M Y Y)

Locked Bag 1006, Matraville NSW 2036 Phone: 134 246 Fax: 1300 329 246
Email: info@ahm.com.au Web: www.ahm.com.au

6 Are you changing the way you pay for your cover?

If yes, you can choose direct debit from your bank account or credit card. If not, you don't need to complete this section.

X **Bank account –** complete Sections A, C and D X **Credit card –** complete Sections B, C and D

Section A – Your full name

Name of your financial institution | Address of your financial institution

Name of account holder | BSB number | Bank account number

Section B – Type of card

X MasterCard X Visa

Credit card number | Expiry date M M Y Y

Name on card

Section C – Choice of payment frequency

X Weekly X Fortnightly X Monthly X Quarterly X Half yearly X Yearly

If you've chosen weekly or fortnightly, please choose a day of the week you'd like ahm to draw your premiums: X Mon X Tue X Wed X Thur X Fri

If you've chosen monthly, quarterly, half yearly or yearly, please choose a date from the 1st to the 28th on which you'd like ahm to draw your premium each time it's due: D D

Section D – I authorise Australian Health Management Group Pty Limited to charge my health insurance premiums to my bank account/credit card. In the event of changes to premiums, levels of cover or arrears of payments to my policy, I authorise Australian Health Management Group Pty Limited to alter the amount from the appropriate date in accordance with such changes. A copy of our Direct Debit Service Agreement will be sent to you upon receipt of these details. The first debit will cover your standard premium plus any adjustments necessary to bring your policy in line with your required debit date. For existing policy holders any change to debit dates may result in the next debit varying from the standard deduction.

Signed in accordance with account/credit card authority

SIGN HERE | Date D D M M Y Y

7 Account details for payment of benefits

If you'd like us to pay your claims directly into your account, please complete the details below. Once you do this, you can use our phone and internet claiming services. (Please note: We can't pay benefits into a credit card account)

Name of your financial institution | Address of your financial institution

Name of account holder | BSB number | Bank account number

8 Medical research fund

Please complete this section if you'd like to help Australian researchers develop new treatment and cures. I would like to dontate the following amount to medical research. X 50 cents per week X $1.00 per week X $2.00 per week

9 Declaration

You are applying for a private health insurance policy with Australian Health Management Group Pty Limited ABN 96 003 683 298 (ahm) under the Health Benefits Fund operated by ahm and agree to be bound by the Rules of the Fund. You declare that all of the statements made in this application are true and complete and understand ahm may refuse payment of benefits, and that Lifetime Health Cover loading may be affected, if any statements are false in any respect. ahm reserves the right to vary its premiums, its private health insurance products or benefits payable, subject to the *Private Health Insurance Act 2007* and Rules. If you have paid premiums in advance, you will not be exempt from such changes. You consent to ahm collecting, using and disclosing personal information in accordance with the ahm Privacy Policy. You warrant that each named beneficiary has also given that consent. This includes consent to collect any personal information about a named beneficiary from you, any other named beneficiary, medical practitioner or previous health insurer. You completely indemnify ahm, its officers, employees and agents for any losses, damages or expenses that arise from any allegation by any named beneficiary that ahm's conduct, in acting in accordance with the ahm Privacy Policy, is without consent or otherwise amounts to an interference with their privacy.

By signing this I have read, and agree to, the above declaration

SIGN HERE | Date D D M M Y Y

Your privacy Australian Health Management Group Pty Limited (ahm) is subject to the *Privacy Act 1988* and complies with the principles for handling your personal information. ahm's privacy policy can be viewed on the ahm web site **www.ahm.com.au** or you can call us on **134 246** to have a copy of the policy posted or emailed to you.