CBHS HEALTH

Please write in **BLOCK LETTERS**, use a **BLACK** pen and mark the appropriate circles with an ✗.

CBHS Health Fund Limited ABN 87 087 648 717

MA

Membership Application

This is an application to:

- ◯ **Join for the first time or returning to CBHS** (Please complete sections **A, B, C, E, F, G** and **H**)
- ◯ **Transfer to CBHS from another health fund** (Please complete all sections **including section D - transfer certificate**)
- ◯ **Transfer from a parent's policy** (Please complete sections **A, B, C, E, F, G** and **H**)
- ◯ **Change other details*** Membership number:

Please specify:

*Most changes to existing memberships can be made by contacting us at **help@cbhs.com.au** or through the online **Member Centre**.

SECTION A: Your details

1. Membership eligibility

- ◯ Current employee
- ◯ Former employee
- ◯ CBA Group Contractor

Name of employer

Year commenced employment

- ◯ Family member of current/former CBA employee or contractor

Name of the relative:

How are you related to the above employee? I am their:

- ◯ Current/former partner
- ◯ Sibling
- ◯ Child (adult or dependant)
- ◯ Parent
- ◯ Grandchild

2. Where in the CBA Group do you or your family member work?

- ◯ Commonwealth Bank:
  - ◯ Retail, customer service branch
  - ◯ Business and private banking
  - ◯ Wealth management (CommInsure etc.)
  - ◯ Other:
  - ◯ CommSec
  - ◯ Enterprise services
- ◯ Bankwest
- ◯ Contractor/Consultant or Franchise employee for CBA Group
- ◯ Other:

Staff number (if known):

3. How did you hear about CBHS?

- ◯ Information or intranet at CBA
- ◯ Relationship representative
- ◯ Referral from friend or family

Name:

- ◯ Industry or ex-staff function or publication
- ◯ Internet search, advertisement or website
- ◯ Mail, email or telephone offer
- ◯ Other sign or advertisement (not at CBA or online)

4. Personal details

Title ◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Dr

Surname

Given names

Also known as

Date of birth / /

Gender ◯ Male ◯ Female

5. Home address

Street number

Street name

Suburb/Town

State/Territory Postcode

6. Postal address

◯ Same as above

Street number

Street name

Suburb/Town

State/Territory Postcode

7. Contact numbers and email

Home Ph ( )

Work Ph ( )

Mobile

Email

New members will receive a welcome email with details on how to register online for the CBHS Member Centre. The Member Centre allows you to make a claim, update details, obtain a benefit quote and check your benefit limits online anytime. If no email address is provided or if indicated below, critical information will be sent via post.

◯ Opt-out of online. Please send critical information via post.

SECTION B: Payment details

8. How will you pay your contribution to CBHS?

◯ **Salary deduction** Note: Salary deduction is only available to current full-time CBA Group staff.

I request that my employer deduct health contribution payments from my salary in accordance with the level of CBHS health cover I have chosen, and remit to CBHS Health Fund Limited and as specified by CBHS from time to time.

CBA/Bankwest employee no.

Signature

✗

Date / /

◯ **Direct Debit**

Direct Debit Request from a nominated bank account.

Please select the frequency of your debit:

Fortnightly ◯ CBA pay week ◯ Non-pay week

OR

Monthly ◯ 15th of month ◯ 21st of month

Which account should CBHS deduct your contributions from?

Bank name

Account name

Account type

BSB number –

Account number

I/We request CBHS Health Fund Limited (User ID 000 187) to arrange funds to be debited from my/our account through Bulk Electronic Clearing System in accordance with the terms described in the CBHS Direct Debit Request Service Agreement as detailed on the CBHS website ***cbhs.com.au****.*

Signature – *Account holder 1*

✗

Date / /

Signature – *Account holder 2 (If applicable)*

✗

Date / /

◯ **Invoice** - Invoice can be paid online using BPAY or BPoint.

How often will you pay your contributions?

◯ Quarterly (3 month period)

◯ Half-yearly (6 month period)

◯ Yearly (12 month period)

If you wish to pay via BPAY, you will be sent an invoice for your nominated contribution period.

9. Benefits

CBHS pays benefits for paid accounts directly to your bank account.

Please nominate an account to which CBHS should credit any benefits.

◯ Same as direct debit account in **Question 8** > Go to **Question 10**

◯ Other account (Please provide details below)

Bank name

Account name

Account type

BSB number – Account number

SECTION C: Your membership details

10. What type of cover do you require?

○ Single ○ Couple ○ Family ○ Single Parent Family

○ Non-Student Dependant Family* > Go to **Question 11b** ○ Non-Student Dependant Single Parent Family* > Go to **Question 11b**

11a. Please select your health cover options for single, couple, single parent of family health cover.

Please read the product sheets available for each cover prior to joining.

PACKAGE COVER Includes Hospital and Extras cover.

○ **FlexiSaver (Basic Plus)** ○ **KickStart (Basic Plus)** ○ **StepUp (Bronze Plus)** ○ **Prestige (Gold)**

HOSPITAL ONLY Pays benefits towards admitted hospital services

Basic Plus Hospital
- ○ $0 excess
- ○ $500 excess per admission
- ○ $750 excess per admission

Limited Hospital (Bronze Plus)
- ○ $0 co-payment per day
- ○ $70 co-payment per day
- ○ $100 co-payment per day

Active Hospital (Silver Plus)
- ○ $100 co-payment per day

Comprehensive Hospital (Gold)
- ○ $0 co-payment per day
- ○ $70 co-payment per day
- ○ $100 co-payment per day
- ○ $750 excess per admission

EXTRAS ONLY Pays benefits towards extras cover services

○ **Essential Extras** ○ **Intermediate Extras** ○ **Top Extras**

OTHER COVER

○ **Ambulance cover only** ○ **Overseas Visitors Cover** (457 or 485 Visas only)

If you have already completed 11a, please proceed to Question 11c

11b. Please select your Non-Student Dependant Cover.

Please read the product sheets available for each cover prior to joining.

PACKAGE COVER Includes Hospital and Extras cover.

○ **Prestige (Gold)**

HOSPITAL ONLY Pays benefits towards admitted hospital services

Limited Hospital (Bronze Plus)
- ○ $0 co-payment per day
- ○ $70 co-payment per day
- ○ $100 co-payment per day

Comprehensive Hospital (Gold)
- ○ $0 co-payment per day
- ○ $70 co-payment per day
- ○ $100 co-payment per day
- ○ $750 excess per admission

EXTRAS ONLY Pays benefits towards extras cover services

○ **Intermediate Extras** ○ **Top Extras**

† This cover is available as **Single** and **Couple only**. All other covers are available as: **Single**, **Couple**, **Family** or **Single Parent Family.**

*** What is Non-Student Dependant Cover?**

Non-Student Dependant cover allows you to have your children on your policy who are:

- between the ages of 18 to 25 and do not have a spouse
- not a full-time student at a school, college, or university or undertaking an apprenticeship

(Note: Choosing Non-Student Dependant cover will incur an additional cost to your premium)

11c. Please provide details of ALL other family members to be covered if applicable.

If more space is required, please attach a separate sheet.

Given name	Middle Initial	Surname	Relationship	Gender	Date of birth
			Partner		/ /
			Child		/ /
			Child		/ /
			Child		/ /

Partner authority

Do you authorise your partner, as named above, to operate this membership? ○ Yes ○ No

Is your partner a current or former employee of the CBA Group? ○ Yes ○ No

12. Please provide details of any dependants named above who are 18–24 years old, full-time students without a live-in partner:

If more space is required, please attach a separate sheet.

Student's name

Institution name

Student's name

Institution name

13. Please provide details of any dependants named above who are 18–24 years old, non-student without a live-in partner:

Note: By keeping your non-student dependant on your cover you will incur an additional cost to your premium.

If more space is required, please attach a separate sheet.

Full name of first non-student dependant:

Full name of second non-student dependant:

14. When would you like your membership to commence?

- ○ As soon as your application is received *Note: An adjusting payment may be required to cover days preceding your first deduction*
- ○ From the date of the first direct debit or salary deduction after your application is received
- ○ From this date in the future / /

SECTION D: Transfer certificate

Transfer Certificate

CBHS Health Fund Limited
ABN 87 087 648 717

If you or your partner are transferring from another registered Health Fund, CBHS will cancel your existing health fund membership for you. Waiting periods are waived only if you transfer to an equivalent level of cover and have served all waiting periods with your existing fund. Benefits cannot be paid until your previous fund forwards a transfer certificate to CBHS.

If you and your partner are transferring from separate memberships, you will each need to complete a Transfer Certificate. Download additional forms from **cbhs.com.au**

Existing fund details

Fund name

Membership number

Date CBHS cover will commence

/ /

Member's details

Title ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr

Surname

Given names

Date of birth / /

I hereby authorise CBHS Health Fund Limited to terminate my membership with your organisation (if still current) and/or obtain details about my membership, including my eligibility for a 35% or 40% Rebate under the increased Private Health Insurance Rebate. If applicable, any refund of contributions paid in advance of the date my CBHS cover commences should be sent to the recorded address.

Please provide information to CBHS about:

○ Myself ○ My partner ○ My dependants

Signature

✗

Date / /

** The person signing this form must have legal responsibility for the "other fund" membership.*

SECTION E: Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

15. Would you like to participate in the Australian Government Rebate on Private Health Insurance by reducing your premium?

◯ Yes ◯ No > go to **Question 16**

Introduction

- Page 6 and 7 may be provided to the Australian Government for the purpose of applying to receive or change the Australian Government Rebate on Private Health Insurance as a reduced premium
- All the people listed on the policy must be eligible to claim Medicare for you to receive the rebate as a reduced premium.
- Policy holders must nominate the income tier to which they believe they are entitled.
- If a policy holder claims an income tier above their actual entitlement, a recovery of monies will occur through the Australian Taxation Office (ATO) as a tax debt.
- If a policy holder claims an income tier below their actual entitlement, a refund will occur through the ATO as a tax credit.
- If at any stage you wish to stop receiving or wish to nominate a new income tier for the Australian Government Rebate on Private Health Insurance as a reduced premium, you must notify your health fund as soon as possible.

For more information

For more information about the Australian Government Rebate on Private Health Insurance, go to privatehealth.gov.au. Questions about Medicare eligibility can be made at any Human Services' Service Centre or by calling 132 011.
Note: Call charges apply – calls from mobile phones may be charged at a higher rate.
If you are unsure whether you are eligible for Medicare, go to www.humanservices.gov.au/customer/services/medicare/medicare-card for more information.

Claimant's details

Name of private health fund

C B H S

Health fund membership number (if new member leave blank)

Are you covered by the policy?

◯ No Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

◯ Yes Date premium reduction to commence

/ /

Medicare card number

– –

Expiry D D / M M / Y Y Y Y Ref no.

Green Medicare cards require expiry date in MM/YYYY format.
Blue & Yellow Medicare cards require expiry date in DD/MM/YYYY format.

Surname (Full name as it appears on your Medicare card)

Given name(s) (Full name as it appears on your Medicare card)

Permanent address

Street

Suburb/Town

State/Territory Postcode

Postal address (same as above ◯)

Street

Suburb/Town

State/Territory Postcode

Daytime phone ( )

Date of birth / /

Gender ◯ Male ◯ Female

Details of people covered by the policy

Provide details of all people covered by the policy
(do not include yourself)

Person 1

Surname

Given name(s)

Date of birth / /

Gender ◯ Male ◯ Female

Dependant child ◯ No ◯ Yes

Person 2

Surname

Given name(s)

Date of birth / /

Gender ◯ Male ◯ Female

Dependant child ◯ No ◯ Yes

Person 3

Surname

Given name(s)

Date of birth / /

Gender ◯ Male ◯ Female

Dependant child ◯ No ◯ Yes

Person 4

Surname

Given name(s)

Date of birth / /

Gender ◯ Male ◉ Female

Dependant child ◯ No ◯ Yes

SECTION E cont.: Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

Details of people covered by the policy (continued)

Person 5

Surname

Given name(s)

Date of birth / /

Gender ○ Male ○ Female

Dependant child ○ No ○ Yes

If there are more people covered by the policy, attach a separate sheet with details.

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card?

○ Yes ○ No

Please selected your income tier:

	○ Base Tier	○ Tier 1	○ Tier 2	○ Tier 3
Singles	$90 000 or less	$90 001 to $105 000	$105 001 to $140 000	$140 001 or more
Family/ Couples	$180 000 or less	$180 001 to $210 000	$210 001 to $280 000	$280 001 or more

Privacy notice

Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including their privacy policy, at **www.humanservices.gov.au/privacy**

Claimant's declaration

I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

☐ Please check this box to indicate you have read and understood the declaration.

Claimant's Signature

✗

Date / /

SECTION F: Savings provision entitlement (Rebate Relates to Prior Policy)

16. Are you entitled to the savings provision entitlement under the Australian Government Rebate on Private Health Insurance due to previously being covered by a private health insurance policy which also covered a person over the age of 65 or 70 years?

○ Yes ○ No

If **YES**, please ensure that you fill out the Transfer Certificate in **Section D** of this form (If you are terminating your cover with another private health insurer) or provide some other form of evidence about your earlier hospital cover.

You should refer to the information provided under **Question 15** relating to eligibility for the Australian Government Rebate on Private Health Insurance. This rebate is income-tested (including with respect to the savings provision entitlement relating to the age of persons on your prior cover). The savings provision entitlement is not available where a partner is being added to your policy.

SECTION G: Lifetime health cover

17. If you or your partner are over 30 years of age, you will need to provide evidence that you are exempt from any loading, otherwise loadings will apply to your selected hospital cover.

Are you AND your partner (if applicable) under 31 years of age?

○ No ○ Yes > Go to **Section H**

Have you or your partner (if applicable) held HOSPITAL cover at any time since 1 July 2000?

○ No ○ Yes > Complete this form and the **Transfer Certificate** in **Section D**

SECTION H: Declaration and Privacy Collection Notice

Declaration

By signing this form, I declare and acknowledge that:

1. The information provided in this form is true, complete and correct.
2. I have read and understood the information contained in the CBHS Product Brochure which includes important information about limits, pre-existing conditions, waiting periods (including 12 months for pre-existing conditions), inclusions, exclusions and restrictions which apply to my chosen level of cover.
3. I accept and agree to be bound by the CBHS Health Benefit Fund Rules which can be accessed on the CBHS website at www.cbhs.com.au or by calling 1300 654 123 and understand this may mean my contribution rates are increased or my benefit entitlements are changed.
4. I personally selected my tier for the purposes of the Australian Government Rebate on Private Health Insurance and understand the implications this choice may have with respect to my annual tax return.
5. I am the policy holder who is responsible for payment of the contribution rates and the receipt of all CBHS policy correspondence.
6. I have read and understood the Privacy Collection Notice below and the CBHS Privacy Policy which can be accessed on the CBHS website at www.cbhs.com.au or by calling 1300 654 123.
7. I consent, and am authorised by each person listed in this application form to consent, to the collection, use and disclosure of personal and health information for the purposes summarised in the Privacy Collection Notice and identified in the CBHS Privacy Policy.
8. This authority replaces all previous authorities and remains valid until written notification is given by either me or CBHS.

Termination within six months

1. If I receive any reduction or waiver on waiting periods and terminate my membership within 6 months of incurring an expense and receiving a benefit, CBHS reserves the right to recover any benefits received for artificial aids, health care appliances, oxygen and related apparatus, optical appliances, orthodontics or crowns or bridges. For more details, refer to the CBHS Health Benefit Fund Rules which can be accessed on the CBHS website at www.cbhs.com.au or by calling 1300 654 123.

Privacy Collection Notice

1. CBHS collects your personal and health information including sensitive information to provide you with its health insurance products and services, including for the payment of benefits and product development purposes, and to communicate with you in relation to specialised health programs and offers from CBHS.
2. Personal and health information may be collected from you directly when you tell us or complete a form, or indirectly, for example, by way of cookies when you visit the CBHS website.
3. By providing your personal and health information you consent to its collection, use and disclosure by, CBHS under the terms of this Privacy Collection Notice and the CBHS Privacy Policy which contains information about how you may access and seek to correct your personal and health information or complain about a breach of the Australian Privacy Principles, and how CBHS will deal with that complaint.
4. CBHS may disclose your personal and health information to entities such as hospitals and medical providers and personal information to third party service providers such as data storage and data handling providers. Such disclosure will only be made in a way which is consistent with the CBHS Privacy Policy.
5. CBHS may contact you (by phone, email, SMS or post) and use and disclose your personal information for direct marketing purposes, unless you opt out (which you can do at any time in accordance with the CBHS Privacy Policy).

Signature

✗

Date / /

Clear Form

For office use only

CBHS Representative:
Promo Code:
Source:

Send this application and any additional information to:

By post:	Locked Bag 5014, Parramatta, NSW, 2124
Member Care:	1300 654 123
Fax:	02 9843 7676
Email:	help@cbhs.com.au