CBHS
Health Cover for the CommBank Family

Please write in **BLOCK LETTERS**, use a **BLACK** pen and mark the appropriate circles with an **X** or download the free Adobe software to view and fill out this form.

Membership application

This is an application to:

- ○ **Join for the first time or return 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)

Section A: Your details

1. Member eligibility. Please complete either 1a or 1b

1a. If you have worked for, or provided services to, CBA Group (including Bankwest) or CBHS, select your relationship:

- ○ Current employee
- ○ Former employee
- ○ Contractor
  (including employees of a supplier providing goods or services)
- ○ CBA Group subsidiary employee
- ○ CBHS employee

Name of employer

Year commenced employment

1b. If you are a family member of a person described in 1a, complete this section.

- ○ Current/former partner
- ○ Sibling
- ○ Child (adult or dependant)
- ○ Parent
- ○ Grandchild
- ○ Parents-in-law
- ○ Sibling-in-law

2. How did you hear about CBHS?

- ○ I saw an ad on the internet
- ○ I saw a post or ad on social media
- ○ My work was promoting CBHS
- ○ I heard from a friend or family member
- ○ CBHS was at my work (e.g. event or staff)
- ○ I received an email or letter from CBHS
- ○ Face to face

Name:

3. Personal details

Title ○ Mr ○ Mrs ○ Miss ○ Ms ○ Dr

Surname

Given names

Also known as

Date of birth

Gender ○ Male ○ Female ○ Non-specified

4. Home address

Street number

Street name

Suburb/town

State/territory Postcode

5. Postal address

Same as above ○

Street number

Street name

Suburb/town

State/territory Postcode

6. Contact numbers and email

Home ph

Work ph

Mobile

Email

We will send you 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, get a benefit quote and check your benefit limits online anytime.

Section B: Payment details - Please complete one of the payment options below (7a, 7b or 7c)

How did you want to pay your contribution to CBHS?

○ **7a. Salary deduction** (CBA Group employees only)

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

X

Date

○ **7b. Direct debit f**rom 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 the 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*

X

Date

Signature – *Account holder 2 (If applicable)*

X

Date

○ **7c. Payment notice (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 payment notice for your nominated contribution period.

8. Benefits

CBHS pays claim benefits directly to your bank account.

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

○ Same as direct debit account in **Question 7b** > Go to **Question 9**

○ Other account (Please provide details below)

Bank name

Account name

BSB number

Account number

Section C: Your membership details

9. What type of cover do you require?

( ) Single ( ) Couple ( ) Family ( ) Sole parent

( ) Non-student dependant family* > Go to **Question 10b** ( ) Non-student dependant sole parent* > Go to **Question 10b**

Based on your answer to Question 9, complete either 10a or 10b below. You do not need to complete both.

10a. Complete this section if you selected Single, Couple, Sole parent or Family health cover in Question 9. Please read the product sheets available at cbhs.com.au for each cover prior to joining.

Packaged cover includes Hospital and Extras cover

( ) KickStart (Basic Plus)

Note: If you select a packaged cover, there is no need to select Hospital and Extras below.

Hospital only pays benefits towards admitted Hospital services

Starter Basic Plus Hospital	Value Bronze Plus Hospital	Everyday Silver Plus Hospital	Advanced Silver Plus Hospital	Complete Gold Hospital
( ) $750 excess per admission	( ) $500 excess per admission	( ) $500 excess per admission	( ) $500 excess per admission	( ) $0 excess
	( ) $750 excess per admission	( ) $750 excess per admission	( ) $750 excess per admission	( ) $100 co-payment per day
				( ) $500 excess per admission
				( ) $750 excess per admission

Extras only pays benefits towards Extras cover services

( ) Essential Extras ( ) Intermediate Extras ( ) Top Extras

Other cover

( ) Ambulance cover only

If you have already completed 10a, go ahead to Question 11.

10b. Complete this section only if you selected Non-student dependant cover in Question 9. Please read the Product Brochure before joining. It contains important information about waiting periods, exclusions, restrictions and benefit limits that may apply to your cover.

Hospital only pays benefits towards admitted Hospital services

Starter Basic Plus Hospital	Value Bronze Plus Hospital	Everyday Silver Plus Hospital	Advanced Silver Plus Hospital	Complete Gold Hospital
( ) $750 excess per admission	( ) $500 excess per admission	( ) $500 excess per admission	( ) $500 excess per admission	( ) $0 excess
	( ) $750 excess per admission	( ) $750 excess per admission	( ) $750 excess per admission	( ) $100 co-payment per day
				( ) $500 excess per admission
				( ) $750 excess per admission

Extras only pays benefits towards Extras cover services

( ) Essential Extras ( ) Intermediate Extras ( ) Top Extras

* 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 18-30 and do not have a partner
- 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).

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

Given name	Middle initial	Surname	Relationship	Gender	Date of birth	Status of schooling *(e.g. non-student or full time student)*
			Partner			
			Child			
			Child			
			Child			
			Child			
			Child			
			Child			
			Child			
			Child			

Partner authority

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

12. When would you like your membership to commence?

From this date in the future

CBHS

Transfer Certificate request form

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. We can't pay benefits 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 request form. Download additional forms from **cbhs.com.au/forms**

Previous 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 benefit payments and Lifetime Health Cover status. If applicable, any refund of contributions paid in advance of the date that my CBHS cover commences should be sent to the recorded address.

Please provide information to CBHS about:

◯ Myself ◯ My partner ◯ My dependants

Signature

X

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

13. Would you like to participate in the Australian Government Rebate on private health insurance by reducing your premium?

Yes No > go to Question 14

Introduction

- Pages 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.
For Medicare eligibility questions, go to a Services Australia service centre or call 132 011.
If you are unsure whether you are eligible for Medicare, go to servicesaustralia.gov.au/medicare 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 Ref no.

Green Medicare cards require expiry date in MM/YYYY format. Blue and 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 select your income tier:

	○ Base Tier	○ Tier 1	○ Tier 2	○ Tier 3
Singles	$105,000 or less	$105,001 to $123,000	$123,001 to $164,000	$164,001 or more
Family/ Couples	$210,000 or less	$210,001 to $246,000	$246,001 to $328,000	$328,001 or more

Single parents and couples (including de facto couples) are subject to family tiers. For families with children, the income thresholds are increased by $1,500 for each child after the first.

Privacy notice

Your personal information is protected by law (including the Privacy Act 1988) and is collected by Services Australia 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 servicesaustralia.gov.au/your-right-to-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)

14. 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 request form 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 loading

15. 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 request form** 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.

   Where you provide personal information about another individual, you confirm that you are authorised to do so and have informed them of this Privacy Collection Notice.
7. I consent and am authorised by each person listed in this application form to consent, to the collection, use and disclosure of personal information and sensitive information (including health information) for the purposes described 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 six 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 cbhs.com.au or by calling 1300 654 123.

Privacy Collection Notice

1. CBHS collects your personal and sensitive information (including health information) for the purpose of providing, administering, and marketing our products and services. This could include providing 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 sensitive information may be collected from you directly when you contact us by telephone, email, website chat or regular mail, or open and start to complete (or complete) a form on our website, or indirectly, for example, from authorised sources/ third parties (such as Health Service Provider) and by way of cookies when you visit the CBHS website.
3. By providing your personal and sensitive 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. If you do not provide or authorise the provision of Personal or Sensitive Information we request, we may be unable to provide you with some or all of our products and services or the products and services of our partners.
5. CBHS may disclose your personal and sensitive information to entities such as hospitals and health medical services and 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.
6. 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 by logging into the Member Centre at members.cbhs.com.au or via the CBHS app).
7. For full details on CBHS' Privacy Policy, please refer to the full Privacy Policy available at cbhs.com.au/privacy-policy. For any enquiries relating to CBHS' Privacy Policy, please contact CBHS' Privacy Officer on privacy@cbhs.com.au

Signature

✗

Date

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

Email: help@cbhs.com.au

V07 06/26