

SA Application Form

Police Health Limited ABN 86 135 221 519
A registered, not for profit, restricted access private health insurer

Post:
Police Health
PO Box 6111
ADELAIDE SA 5000

Adelaide local phone 8112 7000 Other areas 1800 603 603



Application / Variation reason <input type="checkbox"/> New member <input type="checkbox"/> Change of cover <input type="checkbox"/> Add/delete dependents <input type="checkbox"/> Payment changes Please complete both sides of this form as required					
Application Details					
					Police Health Membership No. <input type="text"/>
Mr/Mrs/Miss/Ms _____		Surname _____		Given Names _____	
				Date of Birth / /	
Home Address _____				Postcode _____	
Postal Address _____				Postcode _____	
Phone (Hm) _____		(Wk) _____		(Mob) _____	
Email _____					
Family members to be included on your cover Please attach details of further dependents if necessary. In addition For full time students 21 and over please complete the student dependent form overleaf.	First Name and Middle Name	Surname	Relationship	Date of Birth	Sex M/F
Health Cover Required <input type="checkbox"/> Top Hospital only <input type="checkbox"/> SureCover Extras only* <input type="checkbox"/> FAMILY <input type="checkbox"/> SINGLE <input type="checkbox"/> Platinum Health - our combination of Top Hospital plus SureCover Extras* <input type="checkbox"/> Platinum Plus - an extension of Platinum Health to cover your growing family* (See Police Health brochure for further details) <input type="checkbox"/> SINGLE PARENT FAMILY *Information is provided to National Pharmacies for provision of their membership benefits					
Declaration Do you, or any person on this membership, have a pre existing illness, injury or medical condition? <input type="checkbox"/> No <input type="checkbox"/> Yes - please provide details of names and conditions _____ _____					
I declare that: <ul style="list-style-type: none"> The statements in this application are true and complete and agree to be bound by the rules of the fund. I acknowledge that this application form and the Health Fund brochure do not contain all the Rules of Police Health and I understand the pre existing condition rule and waiting periods Police Health has made me aware of the Privacy Statement and its availability to me, and I have made, or will make, other people on the application aware of the statement's availability. I acknowledge, where practicable, information is provided with the consent of the individual to whom it relates and I confirm I have the authority to act on behalf of other persons named in this Application Form. I (and on behalf of the other persons) consent to the use and disclosure of my (or our) personal information, including health information, in accordance with the Privacy Statement, and note that personal information about a person insured on the health insurance policy may be disclosed to other people insured under the same health insurance policy. I (and on behalf of the other persons) authorise Police Health to collect and authorise any third party to supply from time to time full and complete details of all or any information necessary to the assessment of any claim or any operation of the health insurance policy. 					
Signature _____ Date / /					

Application for Federal Government 30% rebate on private health insurance

Please complete and sign this section if you wish to receive the Federal Government 30% rebate as a reduced premium.

All persons on your membership must be eligible for Medicare for you to receive the rebate.

Your Medicare card No. _____

Your name as it appears on your Medicare card _____

Signature _____ Date / /

Payment options

- Direct Debit - fortnightly only (complete authority below)
- Payroll - fortnightly only (complete authority below)
- Renewal Notice
- Quarterly Half Yearly Yearly
- Police Superannuation Fund

Direct Debit Request

Please complete your account details and sign for Direct Debit deductions

Financial Institution _____ BSB No. _____

Account No. _____ Name account held in _____

I request and authorise Police Health, user ID 049196, to arrange, through its own financial institution, a debit to my nominated account any amount Police Health has deemed payable by myself. This debit or charge will be made through the Bulk Electronic Clearing System (BECS) from my account held at the financial institution nominated above and will be subject to the terms and conditions of the Direct Debit Service Agreement (available on our website).

Signature _____

Date / /

Authority to deduct from SAPOL Pay

I _____
 Title _____ Surname _____ Initials _____
 request until further notice in writing from me, to deduct from my salary as long as I remain a member of Police Health the amount as notified by Police Health from time to time.

Payroll No. _____

Signature _____ Date / /

Authority to cease existing health insurance deductions from SAPOL Pay

I _____
 Title _____ Surname _____ Initials _____
 authorise Payroll to immediately cease deductions from my South Aust Police Dept

salary for _____ Fund name _____ Payroll No. _____

Signature _____ Date / /

Transferring from another fund

Previous cover Hospital Extras Combined

Previous fund name _____ Membership No. _____ Date joined / / Date paid to / /

Lifetime health cover certified age of entry held with previous fund Member _____ Partner _____

Membership in name of _____ Please cancel my cover from / / and forward to Police Health a letter of clearance specifying details relating to my membership with your fund.

List of persons covered on membership _____

Member signature _____ Date / /

Partner signature _____ Date / /

Eligibility Declaration (New members only)

As Police Health is a restricted access private health insurer, eligibility is largely restricted to police and their family. You may either be eligible through your 'police employment' or through your relationship to such a person. Once you have established this eligibility, you can choose a single policy for yourself or a family policy to cover yourself and your dependents.

You must be able to select at least one of the following criteria to be eligible to be a policy holder with Police Health:

- | I am | I am a relative of | Eligible persons |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a person who is currently employed by a State, Territory or Federal police department/service or association/union.
Name of police dept/service or assoc/union _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | a past employee of a State, Territory or Federal police department/service or association/union who worked for them at anytime since 1 January 2001. Name of police dept/service or assoc/union _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | a person who was an employee of South Australia Police before 1 January 2001. |
| <input type="checkbox"/> | <input type="checkbox"/> | a person who was covered by a Police Health policy at anytime before 12 October 2007.
Name of that policy holder _____ or membership number (if known) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | a person who is an employee of Police Health or an approved contractor. Name of approved contractor _____ |

As a relative of person above please select your relationship with them:

Partner Former partner Name of person I am related to _____

Dependent Child Adult Child and their Police Health member number (if applicable) _____

Adult Child's Partner Adult Child's child Signature _____ Date / /

Student Dependent declaration

Application to register an unmarried student dependent from 21 years of age and under 25 years of age who are a full-time student.

Name(s) of student dependent(s)	School, college or university being attended on a full time basis	Date commenced as full-time adult student

Is each dependent listed a full-time student? Yes No

Is each student listed unmarried? Yes No

Comment/details (where applicable) _____

I undertake to inform Police Health **immediately** of any change in the circumstances of any of the above-named dependants.

Members signature _____

Date / /

This declaration is for the current calendar year only. A new application to register student dependants must be lodged by the 1st of March each year.
 *Children who are married or in a defacto relationship are not covered.