rt health FUND (MEMBERS OWN HEALTH FUND)

Please make sure you've answered each question and signed the form before sending it to us.

Complete this form to *change* your cover

Main member's details (this is the person in whose name the membership is held)

rt membership number

Given names

Family name

Date of birth (dd/mm/yy)

Daytime telephone number

Email address

What date would you like this change to take effect?

(dd/mm/yy)

What change would you like to make?

- ☐ Change my health cover – complete section 1
- ☐ Change the people covered – complete section 2

Section 1: change your cover

Choose your hospital cover:	Choose your hospital cover excess:	Choose your extras cover:
☐ Premium Hospital	☐ no excess ☐ $250 excess ☐ $500 excess	☐ Premium Extras
☐ Smart Hospital	☐ $250 excess ☐ $500 excess	☐ Smart Extras
☐ Step Up Hospital	☐ $250 excess ☐ $500 excess	☐ Value Extras
☐ First Start Hospital	☐ $250 excess ☐ $500 excess	
☐ Public Hospital		
☐ Ambulance only		

Section 2: change the people you have covered

Tick the type of membership you would like to have:

☐ Family ☐ Sole-parent family ☐ Couple ☐ Single

☐ Family extension (only available with Premium Hospital with or without extras)

Would you like to change the people covered by your membership?

☐ Add someone ☐ Remove someone ☐ Change someone's details

If you are changing someone's name please provide a copy of either a marriage certificate or a change of name certificate.

Your partner / spouse

☐ Add ☐ Remove ☐ Change details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss (other) ☐

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy) ☐☐/☐☐/☐☐

Would you like to give your partner / spouse authority to make changes to the membership and sign claim forms? ☐ Yes ☐ No

If you tick 'yes', the only thing your partner / spouse will not be able to do is to suspend or cancel the membership, that can only be done by the main member.

Your children (dependants)

☐ Add ☐ Remove ☐ Change details

The natural, adopted or foster children of either adult named on the membership can be covered under a family or sole-parent family membership up until the age of 21.

Children aged between 21 and 25 who are not married or living in a de facto relationship, and who are full-time students (at an approved Australian school, college or university) can be covered under a family or sole-parent family membership at no additional cost. Please note, part-time students and apprentices are not eligible for cover as student dependants.

Children aged between 21 and 25 who are not full-time students can be covered under a family or sole-parent family membership for a small additional fee, provided you choose our Premium Hospital cover product.

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy) ☐☐/☐☐/☐☐

☐ Under the age of 21 ☐ Student between 21 and 25 ☐ Non-student between 21 and 25

Name of school, college or university (for students aged between 21 and 25)

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy) ☐☐/☐☐/☐☐

☐ Under the age of 21 ☐ Student between 21 and 25 ☐ Non-student between 21 and 25

Name of school, college or university (for students aged between 21 and 25)

If you have more than ~~two~~ dependent children, please attach details on a separate sheet.

Government programs

Lifetime Health Cover

Only answer this question if you are adding a partner / spouse and he / she is is over the age of 31.
Has he / she held continuous private hospital cover since July 2000?

☐ Yes ☐ No

If no, what is his / her Lifetime Health Cover Loading ☐☐ % ☐ Don't know

Australian Government Rebate on Private Health Insurance

Only answer this question if you want to claim or change the way you currently claim the Australian Government Rebate on Private Health Insurance.

Which rebate tier are you eligible for? ☐ No Tier ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ I no longer want to claim the rebate

What date would you like this change to become effective?

☐☐/☐☐/☐☐

For more information about the current income tier thresholds, please visit www.ato.gov.au.

Please note, if you claim a higher level of rebate than you are entitled to, you may have a tax debt when you next lodge your income tax return, but there is no tax penalty. Similarly, if you receive a lower level of rebate than you are entitled to, you may receive a tax credit.

If at any stage you wish to stop receiving the rebate as a reduced contribution, you must notify rt health fund. Employers and trustees of organisations cannot claim the rebate on memberships paid on behalf of employees.

Medicare eligibility

All the people covered by this membership must be eligible to claim Medicare. You are entitled to a Medicare card if you are a person who lives in Australia, and you are:

– an Australian citizen, or
– a holder of a permanent resident visa, or
– an NZ citizen, or,
– in some cases, an applicant for a permanent resident visa.

What colour is your Medicare card? ☐ Green ☐ Blue ☐ Yellow

Your full name exactly as it appears on your Medicare card

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Your Medicare card number

☐☐☐☐☐☐☐☐☐☐

Valid to (mm/yy)

☐☐/☐☐

Privacy notice

Some of the information provided on this form will be used for the purposes of registering you for the Federal Government Rebate on Private Health Insurance. Its collection is authorised by the Private Health Insurance Act 2007 and Private Health Insurance Incentives Act 1998, and information collected will be disclosed to the Department of Health and Ageing, Medicare Australia and the Australian Taxation Office.

Declaration and signature

- I declare the information I have provided is correct and accurate. I understand that there are penalties for giving false or misleading information.
- I declare that I am authorised to act on behalf of my partner / spouse and any dependants, and provide their personal information for all purposes associated with rt health fund assessing this application and administering any issued policy. I will inform my partner / spouse and any dependants of the existence of the rt health fund privacy policy.
- I authorise my previous health fund, any medical practitioner, hospital, or health service provider to release to rt health fund all information regarding me, my partner / spouse or my dependants to confirm my membership and our benefit entitlements, as well as to assess any claims made by me.
- I agree to become a member of rt health fund if this application is accepted and be bound by its Constitution, rules and policies.

Main member please sign here

✗

Today's date / /

rt health FUND (MEMBERS OWN HEALTH FUND)

Complete this form if you are adding someone who is *transferring* from another health fund

This form authorises rt health fund to cancel your membership with your current fund and obtain a transfer certificate which provides information about your membership. If you, your partner / spouse or anyone currently has separate health cover, we require a transfer form for each of you (download additional forms from www.rthealthfund.com.au). If you have a direct debit arrangement with your current fund, please contact them directly to cancel the debits.

Your details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss (other) _____

Given names

Family name

Date of birth (dd/mm/yy) ☐☐/☐☐/☐☐

Current health fund details

Name of health fund _____

Membership number _____

Name of the person your membership is held in (if not in your own name)

Given names | Family name | Date of birth (dd/mm/yy) ☐☐/☐☐/☐☐

Names of other people transferring (in addition to you)

Given names	Family name	Date of birth (dd/mm/yy)
		☐☐/☐☐/☐☐
		☐☐/☐☐/☐☐
		☐☐/☐☐/☐☐
		☐☐/☐☐/☐☐

Cover being transferred

☐ Hospital cover only ☐ Extras cover only ☐ Hospital and extras cover

Cancellation date

What date would you like this cover to be cancelled from? (dd/mm/yy) ☐☐/☐☐/☐☐

Authorisation

I / We authorise rt health fund to terminate my / our membership from the date specified and to obtain from your organisation details relating to my / our membership, and details of any claims made in the previous 12 months. I understand that rt health fund will not be able to finalise my membership application or process claim payments until you have provided a transfer certificate.

Current health fund's main member please sign here

✗ Today's date / /

Partner / spouse (if covered by current health fund) please sign here

✗ Today's date / /