



1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE**.
2. Please complete all details that are relevant to you on all pages of this form.
3. Read the declaration and sign all the relevant signature panels.
4. See Important Information [bupa.com.au/visitors-info](http://bupa.com.au/visitors-info) for all details relating to how you are covered.

### SECTION A: I'm applying to

- Join as a new applicant**
- Transfer from Bupa overseas**  
See Section I: Transferring from Bupa overseas.
- Transfer from another health fund or insurer**  
You'll also need to fill in the clearance certificate request - see 'Section H: Transferring from another health fund?'
- Add someone to my membership** You, as the Policyholder, will need to fill in this form to add someone to your membership.
- Change my level of cover, other membership details, or nominate a tier for the Australian Government Rebate on private health insurance.**

### SECTION B: Your details

Existing Bupa Membership number (if relevant)

Surname

First name

Initial Title

Date of birth

 DDMMYY  Male  Female

Visa type and sub-class

Visa length

Employee number (if relevant)

**Note:** The person named opposite is the Policyholder and has legal responsibility for the membership and for ensuring that premiums are kept up-to-date. Only the Policyholder is authorised to operate the membership and collect benefits on behalf of another insured person, unless they nominate an authorised person (see Section D). All membership correspondence will be directed to the Policyholder unless indicated otherwise.

Which state will you be living in?

- NSW/ACT
- NT
- QLD
- SA
- TAS
- VIC
- WA

Current country of residence

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### SECTION C: Contact details

Residential address in Australia (if known)

Postcode

Australian mail address (if different from residential address)

Postcode

Please let us know how you'd like to hear from us

 Email  Mail

We'll stick to your preferences wherever possible. But, we are required to send some things by mail and some aren't available via email.

#### Migration Agent or HR Details (To provide the confirmation letter)

Contact Name

Email

If you are applying from outside of Australia, what is your residential country address?

Postcode

Country

Home phone (including area code)

Work phone (including area code)

Mobile

Email (Mandatory for sending your visa info)

### SECTION D: Your partner's details

Existing membership number (if relevant)

Surname

First name

Title

Initial

Date of birth

Sex (M/F)

Visa type and sub-class

Partner mail address (if different to yours)

Postcode

Home phone (including area code)

Work phone (including area code)

Mobile

Email

Partner communication preferences (if different to yours)

 Email  Mail

#### Partner or third party authority

- If you wish to give your partner (as listed on section D) or third party (as listed on section E) authority to operate this membership please cross this box. By authorising your partner or third party you acknowledge that they will have the same rights and obligations as you, including access to health information and the ability to cancel the policy or remove you from the policy. You also acknowledge that you remain responsible for your membership and for the actions of the authorised person, that authorisation is given at your own risk and that you will have no recourse against Bupa for any acts or omissions by the authorised person. This authority will remain in place until you contact us to revoke it. If at any time, you wish to change the Authorised person, please contact us.
- We are required to provide some personal communications, for example tax statements, to every adult on your membership (except dependent children). We will provide these communications directly to the policy holder, combined with their own (via their preferred communication method which they may vary at anytime). **If you would prefer us to issue your personal communications to you separately, please cross this box.**

## SECTION E: Authorised person's details

Surname			Home phone (including area code)		
First name			Work phone (including area code)		
Initial	Title	Date of birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Mobile
Residential address			Email address		
Postcode			My relationship to the Policyholder		
Mail address (if different from residential address)			<b>Authorised person's declaration</b>		
Postcode			<p><b>To be completed by the authorised person</b>          I, the authorised person named in section E, accept the rights and obligations conferred by this authority described in section D. I confirm I am over the age of 18 years and have the capacity to assume the rights and obligations conferred by the authority.</p>		
			Authorised person's signature	Date	
				D D M M Y Y	

## SECTION F: Your additional family member details\*

If you need to add more than 3 people to be covered under your policy, please enclose a separate page with the details of the additional person(s). By providing the details of your partner/additional family members, you acknowledge that you have the consent of each person aged 17 or over to provide this information to us.

	Surname	First name	Date of birth	Gender (M/F)	Relationship
Child 1					
Child 2					
Child 3					

Any full-time students can continue to be covered under this membership until age 25.

**Note:** If you have any non full-time students (aged between 21-24 inclusive) they will be required to purchase their own single health insurance cover.

	Child 1	Child 2	Child 3
Name of tertiary institution			
Expected date of completion	/ /	/ /	/ /

\*Not applicable to Short Stay Visitors Cover

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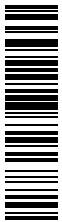


**SECTION G: Your cover requirements**

[Large greyed-out area for cover requirements]

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## SECTION H: Transferring from another health fund?

### If you are transferring to a working visa cover from a recognised Overseas Health Insurer or General Insurer

If you are transferring from a recognised Overseas Health Insurer or General Insurer you will need to supply us with either; an International Clearance/Member Certificate, a Certificate of Currency or a document on an official letterhead confirming your membership. We will need to see: your previous level of cover, what you were covered for, your join date, the date you were paid to and the details of all persons covered. This will allow us to determine if we can offer you continuity of cover from your previous insurer. Benefits will be payable upon receipt of a Clearance Certificate to determine your entitlements.

### If you are transferring to a non-working visa cover from any recognised Overseas Insurer or General Insurer.

If you are transferring to a non-working visa cover from any recognised Overseas Insurer or General Insurer, you will need to re-serve all waiting periods.

Name of existing health insurer

Existing health fund cover/membership number

### Your health cover details with existing health insurer

Surname

First name

Title

Date of birth

Level of Cover

The other health insurance cover relates to:

myself  my partner  my children  my parents

I confirm that I/we have held this cover for a minimum of 12 months from the date I/we request to join Bupa.

If not, date joined:

Date to which health cover is paid:

I authorise Bupa to terminate my health cover with your organisation (if still current) from the cancellation date and obtain details about my health cover. Please issue a clearance certificate to Bupa. Please urgently refund any excess premiums owing to the undersigned. Please do not contact me further about this request.

Cancellation date

Policyholder signature

Date

**Note:** The signatory above must have legal responsibility for the health cover at the 'existing fund'.

Partner's signature

Date

**Note:** This signature is required if your partner is covered on the health cover at the 'existing fund'.

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Join date

Member number

## SECTION I: Transferring from Bupa overseas?

Your overseas Bupa membership number

Your partner's overseas Bupa membership number (if relevant)

Surname

First name

Title

Date of birth

Level of cover

The overseas Bupa cover relates to:

myself  my partner  my children  my parents

I confirm that I/we have held this cover for a minimum of 12 months from the date I/we request to join Bupa.

If not, date joined:

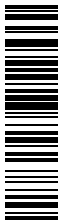
Date to which health cover is paid:

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**SECTION J: Paying your premium**

[Redacted content]



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## SECTION K: To receive the Australian Government Rebate on private health insurance as a reduced premium

If you are from a country that has a Reciprocal Health Care Agreement with Australia, you may be eligible to receive the Australian Government Rebate on private health insurance. The Rebate is available on Extras Cover and Reciprocal Health Cover. Please complete this section to receive the Rebate as a reduced premium. If you do not complete this section, full premiums apply.

By completing this form I acknowledge that I am authorising Bupa to advise my employer that I have elected to change my Australian Government Rebate tier and the details of my new rebate tier.

### 1. Are all the people on your membership eligible for a current Medicare card?

**Yes.** Please complete the remainder of this section.

**No.** You cannot apply for the Rebate until you obtain a Medicare card.

### 2. Are you covered by this membership?

**Yes.**

**No.** Employers, trustees of organisations, organisations and, generally, any individual cannot claim the Australian Government Rebate on private health insurance.

Your Medicare card number

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Your name exactly as it appears on your Medicare card


Valid to

M	M	Y	Y
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Some of the information provided on this form will be used for the purpose of registering you for the Australian Government Rebate on private health insurance. Its collection is authorised by law, and information collected will be disclosed to the Department of Health, Department of Human Services and the Australian Taxation Office.

**Policyholders should nominate a rebate tier based on their estimated income for the financial year.**

Tier	APPLICABLE REBATE % <sup>^</sup>			INCOME THRESHOLDS 2015-2016 <sup>*</sup>		
	Under 65	65-69yrs	70+	Single	Couples/ Family <sup>~</sup>	
Base	<input checked="" type="checkbox"/>	27.820%	32.457%	37.094%	Up to \$90,000	Up to \$180,000
Tier 1	<input checked="" type="checkbox"/>	18.547%	23.184%	27.820%	\$90,001 to \$105,000	\$180,001 to \$210,000
Tier 2	<input checked="" type="checkbox"/>	9.273%	13.910%	18.547%	\$105,001 to \$140,000	\$210,001 to \$280,000
Tier 3	<input checked="" type="checkbox"/>		0%		\$140,001 or more	\$280,001 or more

<sup>^</sup>Applicable rebate % changes annually from 1 April. <sup>\*</sup>For more information visit ato.gov.au. Thresholds also apply to single parents and increase by \$1500 for each child after the first.

If you are entitled to a Savings Provision Entitlement, a Savings Provision Clearance Certificate must be provided by your previous health fund.

There are no penalties for nominating an incorrect rebate tier. If a policyholder claims a rebate tier that is different to their actual entitlement any adjustments required will be made when their annual tax return is completed.

I'd like to make this change from my first payment on or after:

D	D	M	M	Y	Y
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## SECTION L: Applicant, please read then sign this declaration

### Privacy Statement

Your privacy is important to Bupa. This statement summarises how we handle your personal information. For further information about our information handling practices or our complaints handling process, please refer to our *Information Handling Policy*, available on our website at [www.bupa.com.au](http://www.bupa.com.au) or by calling us on 134 135. When you join, you agree to the handling of your personal information as set out here and in our *Information Handling Policy*.

We will only collect personal information that we require to provide, manage and administer our products and services and to operate an efficient and sustainable business. We are required to collect certain information from you to comply with the *Private Health Insurance Act 2007* (Cth). We may also collect information about you from health service providers for the purposes of administering or verifying any claim, and from your employer, broker or agent if you are on a corporate health plan or have joined through a broker or agent. We may disclose your personal information to our related entities, and to third parties including healthcare providers, government and regulatory bodies, other private health insurers, and any persons or entities engaged by us or acting on our behalf. If we send your information outside of Australia, we will require that the recipient of the information complies with privacy laws and contractual obligations to maintain the security of the data. If you are on a corporate health plan, we may disclose your information to your employer to verify your eligibility to be on that corporate plan. The policy holder is responsible for ensuring that each person on their policy is aware that we handle their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 17 or over may complete a *'Keeping your personal information confidential'* form to specify who should receive information about their health claims. You are entitled to reasonable access to your personal information within a reasonable timeframe. We reserve the right to charge a fee for collating such information. If you or any insured person does not consent to the way we handle personal information, or does not provide us with the information we require, we may be unable to provide you with our products and services. We may use your personal (including health) information to contact you to advise you of health management programs, products and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

### Direct Debit Service Agreement

This agreement outlines the responsibilities of Bupa Australia Pty Ltd ("we", "us", "our") and you. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we will deduct the previous period's payment together with the current amount due. If you pay premiums at three, six, and twelve month intervals, then should your financial institution dishonour a drawing, we will draw the payment on the nominated day of the following month. If two or more drawings are returned unpaid by your financial institution, we will also stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or allows us to do so). We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

### Terms and Conditions

I accept to be bound by the Overseas Visitors Rules of Bupa Australia Pty Ltd (available on our website, or by calling us), as amended from time to time. I acknowledge that I have read the brochure in full and understand the terms and conditions of my cover, including those relating to pre-existing conditions, waiting periods, restricted benefit periods or any exclusions that apply to my cover. I declare that the information I have provided is true and correct. I have read and consent to, and have made the other people on this policy aware of, the collection, use and disclosure of my personal information as set out in this Privacy Statement and in the *Information Handling Policy* (available on our website, or by contacting us). I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates.

Signature of Policyholder

Date

Partner's signature

Date

D D M M Y Y

D D M M Y Y

## Just before you send

### OFFICE USE ONLY

Document name

Consultant

Session ID

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