



Queensland Country Health membership no.

Queensland Country Credit Union member no.

Your Details

Title Surname Sex F M

Given names Date of birth / /

Home address Postcode

Postal address (if different from home address) Postcode

Home phone Daytime phone Mobile

Email address

List of persons to be covered

	First name	Initial	Surname	Sex	Date of birth
Partner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Note: A dependant child must be under 21 years of age or a full time student or apprentice provided the following conditions are satisfied – Is a full time student at school, college or university who is not age 25 years or over and does not have a partner, or Is an apprentice who is not age 25 years or over and does not earn more than \$20,000 p.a. and does not have a partner. Please complete the Application to Register a Student/Apprentice Dependant form.

Do you, or your partner or dependants have a pre-existing ailment/medical condition? A pre-existing ailment is an ailment or illness where the signs or symptoms have existed at any time during the 6 months before you join or upgrade to a higher level of cover.

No Yes, please give name and complete details.

Person's name	Condition details
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

I would like my cover to start (please tick one box only)

Upon receipt of my application **OR** Nominated future date: / /

Level of cover required (please tick one box only)

Please indicate the level of cover you require by ticking one box only

- Private Hospital & Premium Extras (HPS)
- Private Hospital & Essential Extras (HPB)
- Private Hospital (HP)
- Private Hospital \$250 Excess & Premium Extras (EHPS)
- Private Hospital \$250 Excess & Essential Extras (EHPB)
- Private Hospital \$250 Excess Only (EHP)
- Private Hospital \$500 Excess & Premium Extras (MEHPS)
- Private Hospital \$500 Excess & Essential Extras (MEHPB)
- Private Hospital \$500 Excess Only (MEHP)
- Public Hospital & Premium Extras (HS)
- Public Hospital & Essential Extras (HB)
- Public Hospital (H)

Method of payment

I'd like to pay my premiums automatically by direct debit.

OPTION A - my bank, building society or credit union

OPTION B - my credit card account (Visa and Mastercard only)

Please choose only one of these options and fill in your frequency preference and account details below.

I would like my premiums to be deducted every: Month

Quarter

Six months

12 months

OPTION A - my bank, building society or credit union

Name of financial institution

Name(s) of account holder(s)

BSB

Account number

I/We request Queensland Country Health to arrange funds to be debited from my/our account in accordance with the terms described in the schedule.

OPTION B - my credit card account

I authorise Queensland Country Health to charge my:

Visa

Mastercard

Credit card number

Cardholders name (as shown on card)

Expiry (mm/yy)

I/We request Queensland Country Health to arrange funds to be debited from my/our account in accordance with the terms described in the schedule.

Account Holder's Signature - If joint account all signatures required

Signature

Credit Card Holder's Signature

Signature

Date

I want to claim the Federal Government Rebate on Private Health Insurance as a reduction in my contribution

Please complete this section to receive the Federal Government Rebate on Private Health Insurance as a reduction in your contribution. If you do not complete this section, full membership fees apply.

Are all 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, please do not complete this section of the form.

Your Medicare number

Valid to (mm/yy)



Your full name exactly as it appears on your Medicare card

Do you hold a concession card from Centrelink? Yes No

Do you hold a Veterans Affairs Card (NSW and ACT only)? Yes No

Declaration and authorisation

I declare all details provided in this application for membership to be true and correct. I agree to be bound by the rules of Queensland Country Health Limited. I understand what benefits I am eligible for on this level of cover. I understand the pre-existing ailment rule and waiting periods (including pregnancy waiting period) detailed in this brochure. I declare dependents aged between 21 and 25 years inclusive on this membership are a full time student or apprentice, without a partner, and earning under \$20,000 per year. I have read and accept the information contained in the Privacy Disclosure and Consent statement as detailed on page three. I authorise my previous health fund to release all requested and required information to Queensland Country Health Limited.

Signature

Date

Transferring from another fund or an existing Queensland Country Health membership

Please complete the following details. Queensland Country Health will arrange to cancel your existing health fund membership for you. If you have a periodic payment with your existing health fund, please remember to personally advise your financial institution to cancel your deductions.

To (name of other fund)

Membership number

List of transferring members

	First name	Initial	Surname	Sex	Date of birth
Self	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Partner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dependant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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I hereby authorise Queensland Country Health to terminate my membership with your organisation from / / and obtain details about my membership.

Please issue a clearance certificate directly to Queensland Country Health, PO Box 42, Aitkenvale, QLD 4814. Please refund any contribution owing to the undersigned. Please do not contact me further about this request.

Signature <input type="text"/>	Note: This signatory must have legal responsibility for the 'other fund' membership.	Today's date <input type="text"/> / <input type="text"/> / <input type="text"/>
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**Privacy Disclosure and Consent
Membership Application**

A Registered Private
Health Insurer
ABN 18 085 048 237

We, Queensland Country Health Ltd, collect personal information about you. When you join the Health Fund it is necessary for us to collect information about your identity. In addition, we collect your personal information to provide you with products or services you have requested, and to provide you with information about our products and services. We collect sensitive information about you to assess the risk in providing you with the products or services that you have requested and, if we provide the product or service, to provide you with that product or service.

You are able in most cases to gain access to your personal information by contacting us using the contact details below. In order to provide you with a product or service you have requested, we may need to disclose your personal information to other organisations which supply various services to the Health Fund eg information technology services providers and mailing houses. When you are admitted to hospital, personal information about you and your condition is provided by the hospital to the health fund to enable your claim to be paid. This process occurs via our agent the Australian Health Service Alliance Ltd, who is a privacy compliant organisation. For more information visit www.ahsa.com.au.

If you fail to provide us with your personal information, we may be unable to provide you with the products or services you have requested, assess the risk of supplying the products or services to you, or to provide you with information about our products and services. We also use your personal information to provide you with information about other products and services we or companies within our group offer. We keep your application form and any other records of our dealings with you.

By completing the membership application form you consent to us using and disclosing that information. You can elect not to receive marketing information by completing and returning the request form which is available at all our offices.

You can contact us by visiting your local office or writing to:
The Privacy Officer
PO Box 42
Aitkenvale QLD 4814

Branch <input type="text"/>	Initiating Staff <input type="text"/>	Required changes <input type="text"/>	Staff actioning <input type="text"/>
Date <input type="text"/> / <input type="text"/> / <input type="text"/>	Completing Staff <input type="text"/>		

**Definitions:**

- Account means the account held at your financial institution from which we are authorised to arrange for funds to be debited.
- Agreement means this Direct Debit Request Service Agreement between you and us.
- Business day means a day other than a Saturday or Sunday or a national public holiday.
- Debit day means the day that payment by you to us is due.
- Debit payment means a particular transaction where a debit is made.
- Direct Debit Request means the Direct Debit Request between you and us.
- Us or We means Queensland Country Health (ABN 18 085 048 237) whom you have authorised by signing a Direct Debit Request.
- You means the customer who signed the Direct Debit Request.
- Your financial institution is the financial institution where you hold the account that you have authorised us to arrange to debit.

Debiting your Account

- By signing a Direct Debit Request you have authorised us to arrange for funds to be debited from your account. You should refer to the Direct Debit Request and this Agreement for the terms of the arrangement between us and you.
- We will only arrange for funds to be debited from your account as authorised in the Direct Debit Request.
- If the debit day falls on a day that is not a business day, we may direct your financial institution to debit your account on the following business day. If you are unsure about which day your account will be debited you should ask your financial institution.

Changes by us

- We may vary any details of this Agreement or a Direct Debit Request at any time by giving you at least fourteen (14) days' written notice.

Changes by you

- If you wish to stop or defer a debit payment, you must notify us in writing at least seven (7) days before the next debit day. This notice should be given to us in the first instance.
- You may cancel your authority for us to debit your account at any time by giving us seven (7) days notice in writing before the next debit day. This notice should be given to us in the first instance.
- You may change the arrangement (but not stop, defer or cancel) under a Direct Debit Request by telephoning us on 1800 813 415.
- It is your responsibility to ensure that there are sufficient clear funds available in your account to allow a debit payment to be made in accordance with the Direct Debit Request.
- If there are insufficient funds in your account to meet a debit payment:
 - you may be charged a fee and/or interest by your financial institution;
 - you may also incur fees or charges imposed or incurred by us; and
 - you must arrange for the debit payment to be made by another method or arrange for sufficient clear funds to be in your account by an agreed time so that we can process the debit payment.
- You should check your account statement to verify that the amounts debited from your account are correct.

Disputes

- If you believe that there has been an error in debiting your account, you should notify us directly on 1800 813 415 and confirm that notice in writing with us as soon as possible so that we can resolve your query more quickly.
- If we conclude, as a result of our investigations, that your account has been incorrectly debited we will request your financial institution to adjust your

account (including interest and charges) accordingly. We will also notify you in writing of the amount by which your account has been adjusted.

- If we conclude, as a result of our investigations, that your account has not been incorrectly debited we will provide you with reasons and any evidence for this finding.
- Any queries you may have about an error made in debiting your account should be directed to us in the first instance so that we can attempt to resolve the matter between you and us.

If we cannot resolve the matter you can still refer it to your financial institution which will obtain details from you of the disputed transaction and may lodge a claim on your behalf.

Accounts

You should check:

- with your financial institution whether direct debiting is available from your account as direct debiting is not available on all accounts offered by financial institutions;
- your account details which you have provided to us are correct by checking them against a recent account statement, and
- with your financial institution before completing the Direct Debit Request if you have any queries about how to complete the Direct Debit Request.

Confidentiality

- We will keep any information (including your account details) in your Direct Debit Request confidential. We will make reasonable efforts to keep any such information that we have about you secure and to ensure that any of our employees or agents who have access to information about you do not make any unauthorised use, modification, reproduction or disclosure of that information.
- We will only disclose information that we have about you
 - to the extent specifically required by law, or
 - for the purposes of this Agreement (including disclosing information in connection with any query or claim).

Notice

- If you wish to notify us in writing about anything relating to this Agreement you should write to:

Queensland Country Health Limited
PO Box 42, Aitkenvale QLD 4814
- We will notify you by sending a notice in the ordinary post to the address you have given us in the Direct Debit Request.
- Any notice will be deemed to have been received two business days after it is posted.