

Your MBF membership application



I am applying to

- Join MBF.** I, and the members of my family to be covered are permanent residents of Australia and entitled to full Medicare benefits.
- Transfer to MBF from another health fund.** You'll also need to fill in 'Transferring from another health fund?' on the back of this form
- Add someone to my membership.** You, as the Primary Member, will need to fill in this form. The person you are adding does not need to fill it in.
- Change my level of cover or other membership details.**
- Add a level of cover.**

Your details

Existing MBF membership number (if relevant)

Title	First name and initial	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>

Sex(M/F)	Age	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>

Home address

Postal address (if different from home address)

Home phone number	Mobile phone number
<input type="text"/>	<input type="text"/>

Email address	Fax number
<input type="text"/>	<input type="text"/>

If you would like to receive your membership bills (if applicable), payment reminders, benefit statements and/or Living Well magazine via email, and be kept up-to-date with MBF news and services via email please tick this box.

Note: the person named above has legal responsibility for the membership and for ensuring that premiums are kept up-to-date. All correspondence will be directed to this person.

Do you hold a Concession Card from Centrelink or Veteran's Affairs (NSW and ACT only)? Yes No

Is the cover for a single, couple or family?

- Single Couple
- Family Family with Dependant Extension (available on MBF HealthLink covers only).

Your partner and/or additional family member details

If you need to add more than 3 people, please attach a separate page with their details.

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

Child 1 First name	Initial	Surname	Sex	Age	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Student Dependant cover (if 21-24 years of age inclusive)	Name of University/College	Expected completion date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Child 2 First name	Initial	Surname	Sex	Age	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Student Dependant cover (if 21-24 years of age inclusive)	Name of University/College	Expected completion date
<input type="text"/>	<input type="text"/>	<input type="text"/>

Note: all children must be under 21 years of age, unless they meet Student Dependant or Dependant Extension criteria. See page 24 of the brochure.

Partner Authority If you wish to authorise your partner, as named above, to operate this membership please tick this box.

Your cover requirements

Please select your level of cover:

	Per person Excess level (tick one)		
HOSPITAL AND EXTRAS COVER			
MBF HealthSmart	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000
MBF HealthLink Essentials Plus	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500
MBF HealthLink Classic	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500
MBF HealthLink Advantage	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500
HOSPITAL COVER			
MBF Budget Hospital with exclusions	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000
MBF HealthLink Hospital	<input type="checkbox"/> Nil	<input type="checkbox"/> \$250	<input type="checkbox"/> \$500
EXTRAS COVER			
<input type="checkbox"/> MBF Young Extras	<input type="checkbox"/> MBF Premium Extras		
<input type="checkbox"/> OTHER	<input type="text"/>		

I would like my membership to commence (please choose one option):

- as soon as my application has been accepted (an initial payment is required upon application and/or an adjusting payment may be required at a later date)
- from the date covered by the first MBF AutoPay deduction overleaf
- from this date in the future

Federal Government Rebate

Please complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full premiums apply.

Are all people on your membership eligible for a current Medicare card?

- Yes No

If **Yes**, please complete the remainder of this section.

If **No**, you cannot apply for the rebate until you obtain a card from Medicare.

Are you covered by this membership? Yes No

If **No**, employers and trustees of organisations cannot claim the Federal Government Rebate on policies on behalf of employees.

Your Medicare card number

Your name exactly as it appears on your Medicare card Valid to

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 law, and information collected will be disclosed to the Department of Health and Ageing, the Health Insurance Commission and the Australian Taxation Office.

Your employment details

Employer's name	Commencement date
<input type="text"/>	<input type="text"/>

Name of Health Plan you are joining (if different from Employer's name above)

Looking after your health

If you join a selected MBF hospital or MBF package cover, you have access to MBF's special health programs (outlined on page 25). To receive information on these programs, simply tick the appropriate box(es) below. These programs are available to you at no additional cost. * Asthma and diabetes programs are not available on MBF Budget Hospital with exclusions.

- MBF Diabetes Program*** You Person 1 Person 2 Person 3
- MBF Asthma Program*** You Person 1 Person 2 Person 3
- MBF Preventive Program** You Person 1 Person 2 Person 3

Your MBF membership application

DO NOT DETACH

- Please complete all details that are relevant to you on both sides of this form.
- Read the declaration and sign all the signature panels you need to.
- To mail your application to MBF, simply use the reply paid envelope provided (no postage required).

MBF Australia Limited
ABN 81 000 057 590
A registered health benefits organisation

Existing MBF membership no. (if relevant)

Your Lifetime Health Cover details (see page 36 of the brochure)

Do you have a Certified Age of Entry (CAE) of 30 at time of joining? Yes No

Does your partner have a CAE of 30 at time of joining? Yes No

If Yes and your CAE or your partner's CAE of 30 is due to membership of another health fund, please also fill in the 'Transferring from another health fund?' section below or provide a copy of your clearance certificate if you already have one. If you don't, we may need to add the appropriate loading for your age to your premiums.

Transferring from another fund?

Clearance certificate request

If you are transferring from another Australian registered health fund, please fill out the form below and MBF will arrange to cancel your existing health fund membership for you. If you have a direct debit arrangement with your existing health fund, please remember to personally advise your existing health fund to cancel your deductions.

Name of previous fund

Previous fund membership/customer number

Membership details of previous health fund

Title	Surname	First name	Initial	Date of birth
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

The previous health fund cover relates to:

myself my partner my children my parents

Level of cover

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

If not, date joined:

 / /

Date to which membership is paid

 / /

Please tick the appropriate box (if applicable):

I am/we are currently eligible for the 30% 35% 40% Federal Government Rebate

If you or anyone on your membership are under 65 years old and believe the higher rebate applies to you then when transferring from another fund, it is essential that we receive a Savings Provision Clearance Certificate from the previous fund.

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

Signature of Primary Member

X	DATE / /
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Note: the signature above must have legal responsibility for the 'previous fund' membership

> All applicants: please read, then sign this declaration

I declare that information provided on this form is true, correct and complete and will notify MBF of any changes. I agree to be bound by MBF's By-laws, a summary of which I have read in this brochure. I have read the full brochure including the MBF Healthcare Cover Guidelines, which may change from time to time, meaning that my premiums may increase or my benefit entitlements may change. I understand that if I am joining MBF or upgrading cover, waiting periods may apply (depending on the level of cover) including • pregnancy and birth-related services - 12 months • pre-existing ailment - 12 months • major dental - 12 months • optical - 6 months • hearing aids - 3 years. Proof of identity including my age may be required. MBF may decide not to accept my application. I understand that, by joining MBF Budget Hospital, MBF will not pay a benefit for Excluded Services for those levels of cover.

I confirm that I have read the Privacy Statement on pages 39-41 of this brochure. I consent to MBF collecting, using and/or disclosing my personal information for the purposes set out in MBF's Privacy Statement.

Signature of Primary Member

X	DATE / /
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I'd like to pay my premiums automatically by MBF AutoPay from

Option A: my bank, building society or credit union account, or

Option B: my credit card account.

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

I'd like MBF to direct credit benefits into

My bank, building society or credit union account.

Tick this box if you'd like benefits on paid accounts (ie. refunds on dentists' bills, etc) credited directly into your bank, building society or credit union account. Please note that direct credit is not available on credit card accounts. Please also fill in your account details under Option A below.

Payment deductions will be made on the nominated day or the next business day. If no date is nominated, deduction will occur on the 1st or next business day. The first deductions will include any adjusting payment required. Deductions nominated for the 28th, 29th, 30th or 31st will occur on the first day of the following month.

Option A – bank/building society/credit union

Name of financial institution

Name(s) of account holder(s)

BSB number

Account number

I/we request MBF Australia Limited (user ID000745 or 657 depending on the state you are registered in) to arrange funds to be debited from my/our account in accordance with the terms described in the MBF Direct Debit Service Agreement on page 35.

Option B – credit card

I authorise MBF Australia Limited to charge my:

Bankcard Diners Club American Express

Visa MasterCard

Credit card number

Cardholder's name (as shown on card)

Expiry date

 / /

Account holder(s) signature(s) Note - if joint account, all signatures required

X	DATE / /
X	DATE / /

OFFICE USE ONLY

Branch/Rep no.

Receipt no.

Amount

Date

 / /

Reply code

Group no.

 N37590

Section no.

Agent

MBF cover note no.

Signature of Primary Member

X NOT APPLICABLE	DATE / /
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