

1 application for nib health cover

I am joining

- as a **new customer** - currently without health cover
- as a **previous nib customer** ▶ nib customer number (if known)
- as a **transferee** from another health fund* ▶ Fund name(s):

* If a **transferee** from another health fund please complete the Clearance/Cancellation Certificate to ensure continuity of benefits.

Your personal details

Title	Given name	Initial	Surname
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Insert your name **exactly** as it appears on your Medicare Card (call nib if you **DO NOT** have a Medicare Card)

Home address

Postcode

Postal address (if different from above)

Postcode

Date of birth	Home phone	Work phone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Mobile phone	Email address
<input type="text"/>	<input type="text"/>

Is the cover for a single, couple, family or single parent family?

- Single** **Couple** **Family** **Single parent family**

Details of other people to be covered by this policy

If insufficient room, please continue on the reverse side of this form in the notes section. Insert names exactly as they appear on a Medicare Card. Medicare Card colours are Green, Blue and Yellow (call nib if any person is NOT listed on a Medicare Card or if their card colour is Yellow).

Medicare Card Colour	Given name	Initial	Surname	Relationship*	Sex	Date of Birth
				Partner		/ /
				Child		/ /
				Child		/ /
				Child		/ /

* If anyone covered by this policy is living at another address, please provide details in the notes section on the reverse side of this form.

Office use only ▶

Authority to operate policy

Do you authorise your partner or Power of Attorney* to operate this policy?

- No**
- Yes** ▶ Name Relationship

* Power of Attorney requires appropriate documentation to be sighted.

Benefit card number (NSW/ACT only)

Do you hold a Commonwealth Concession Card? e.g. Pension Card, Disability Card, Health Care Card.

- No**
- Yes** ▶ Valid to

Policy commencement date

What date would you like your policy to commence?

Select your cover and excess

Excess only applies to the hospital component of your cover NOT Extras or Ambulance services.

- I want a package** (combined hospital and Extras)
Please tick the product and choice of hospital excess.

- | | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Top Cover
Excess
<input type="checkbox"/> nil
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Mid Plus
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Family Plus
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Young at Heart Top
Excess
<input type="checkbox"/> nil
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 |
| <input type="checkbox"/> Family Basic Saver
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Basic Plus
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Basic Saver
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Young at Heart Mid
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 |

or

- I want separate cover**
Please tick the product and choice of hospital excess.

- | | | |
|-----------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Just Hospital
Excess
<input type="checkbox"/> \$250
<input type="checkbox"/> \$500 | <input type="checkbox"/> Public Hospital
Excess
<input type="checkbox"/> nil
<input type="checkbox"/> \$200
<input type="checkbox"/> \$400 | <input type="checkbox"/> Dental Plus |
| | | <input type="checkbox"/> Just Extras |
| | | <input type="checkbox"/> Ambulance Only |

nib Online Services

When you become an nib customer, you will also be **automatically** registered for nib Online Services which will allow you to manage your policy and claim online. You will receive a login password by mail within 7 days of becoming a customer.

Federal Government Rebate

Complete this section if you wish to receive the Federal Government Rebate as a reduction on your premiums.

- You must have a current Medicare Card - if yours has expired you cannot qualify for the rebate until you have renewed your card.
- If you have any questions about your eligibility to claim the rebate call nib on **13 14 63**.

Do you want your premium reduction to commence from the date of joining nib? **Yes** **No** ▶ Effective date

Your Medicare Card number Valid to

What is the colour of your Medicare Card? **Green** **Blue** **Yellow** (please call nib on **13 14 63**)

Are all the people on this policy listed on an eligible Medicare Card or entitled to be listed on an eligible Medicare Card? **Yes** **No**

The information provided by you in this section will be used for the purpose of registering you for the Federal Government Rebate. Its collection is authorised by law and information collected will be disclosed to the Department of Health and Ageing, Medicare Australia and the Australian Taxation Office.

Lifetime Health Cover (LHC)

Lifetime Health Cover is where people who are over 31 and taking out hospital cover for the first time will pay a 2% loading on top of their premiums for each year they are aged over 30. For example, a person who takes out hospital cover for the first time at the age of 40 will pay higher premiums than someone who joined at the age of 30. Some situations apply where people may be eligible for reduced LHC loading. These situations include:

- people who turned 31 after 1 January 2000 and were overseas on their 31st birthday
- people who are purchasing hospital cover for the first time and who were overseas on 1 July 2000
- people who have held a Department of Veterans' Affairs Gold Card at any time after 30 June 1999
- migrants who first became eligible for Medicare after 30 September 1999.

If any of these situations apply to you, please contact nib for more details. Alternatively, visit **nib.com.au**

LHC does not affect people who were born on or before 1 July 1934 – they will not have to pay any LHC loading on their premiums.

You'll need to provide evidence that you/your partner are exempt from the LHC loading (e.g. previous health cover with another fund). Else, your date of birth (and your partner) will be used to calculate the LHC loading that applies to your premium.

- I may be eligible for a reduction in the LHC loading.
- I am not eligible for a reduction in the LHC loading.

SafeClaim Authority

Complete this section to have your claim benefits credited directly to your nominated bank, building society or credit union cheque or savings account (cannot be a credit card account).

Yes, I would like to take advantage of SafeClaim.

Name of bank, building society or credit union BSB number

Name(s) of account holder Account number

2 payment options

Please choose a payment frequency and then only **one** payment method

- Fortnightly** **Monthly** **Quarterly** **Half Yearly** **Yearly**
- (available Mon to Fri only) (available 1st to 27th of the month only) Preferred date to commence

* Ambulance Only - Half Yearly or Yearly **only**

- Direct Debit** - receive a discount of up to 4% on your premiums (automatic debit from a bank, building society, credit union, cheque or savings account) Direct Debit is not available on the full range of accounts. If in doubt contact your financial institution.

Direct Debit Request: I/we (your full name/s)

request you, until further notice in writing, to debit my/our account described below, any amounts which **nib health funds limited abn 83 000 124 381**, User ID number 000488, may debit or charge me/us for health cover premiums through the Direct Debit system. I/we understand and acknowledge that this agreement is governed by the terms of the Direct Debit Service Agreement received from nib and the terms and conditions of my nib policy. I/we authorise nib to debit the nominated account for payment of premiums and to vary the amount of the debit as necessary for changes of cover or premiums.

Please note: The first debit under this request will cover your standard amount plus any adjustment necessary to bring your policy in line with your required debit date.

Name of bank, building society or credit union Branch

Name(s) of account holder(s)/Business account name

BSB number

Account number

Signature of account holder(s)

Date / /

- Credit Card Authority** - no discount applies (automatic debit from a credit card)
- Card type ▶ Bankcard Mastercard Visa Diners Club American Express

Name of card holder (as shown on card) Expiry date

Card number

I authorise nib to debit the nominated credit card for payment of premiums and to vary the amount of the debit as necessary for changes of cover or premiums.

Signature of account holder

Date / /

- nib Retail Centre, Post Office, BPAY or by nib Phone Pay** - no discount applies, regular fortnightly payment frequency not available.

3 declaration

- I declare the details in this Application Form to be true and complete, and I agree to be bound by the rules and by-laws of nib as amended from time to time. I have read and understood nib's rules for transferring from another health fund, pre-existing health conditions, benefit waiting periods and the 30 day cooling off period.
- I declare that students on this policy aged between 21 and 25 years are unmarried and are in full-time education.
- I authorise my previous health fund, hospital, medical or other authorities to release to nib all information required to confirm my benefit entitlements.
- I acknowledge I have been given access to the nib Privacy Policy, and the opportunity to clarify any issues or concerns. I consent to nib collecting, using or disclosing my personal information for the purposes set out in the nib Privacy Policy.

I acknowledge nib is not responsible for the security of my personal information contained in this Application Form until it is received by nib.

I acknowledge that by signing this Application Form I am authorised by each person listed herein to consent to nib making disclosures about their health information to other people listed in this application.

I understand there are penalties for giving false or misleading information when applying for the Federal Government Rebate.

Where the SafeClaim Authority has been completed, I hereby authorise nib health funds to directly credit claim benefits for this policy to the nominated account.

nib may use your details for marketing purposes. See the nib Privacy Policy at **nib.com.au** for more details.

If you do not want nib to use your details for marketing purposes, please tick this box.

Customer's signature

Date / /

nib health funds limited abn 83 000 124 381

Clearance/Cancellation Certificate

(complete if you are transferring from another health fund)

nib customer number

Complete these details to authorise nib health funds to cancel your policy and obtain details of your existing health fund policy.

NB: If your premiums for your existing health fund are being deducted from your wages you should notify your paymaster to stop those deductions.

Personal details

(of main customer with existing fund)

Surname

Given name(s)

Date of birth

Home address

Postcode

Other persons transferring to nib from existing fund

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Existing health fund details

Fund name

Customer number

Cancellation date

I hereby authorise nib to terminate my policy with your organisation and/or obtain details about my policy, including a fully itemised claims statement for the previous 12 months. If applicable, any refund of premiums paid in advance of the cancellation date should be sent to me.

Customer's signature

Date / /

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