

1 APPLICATION FOR nib OSHC

I am joining (^fields are mandatory)

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

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

Your personal details

Title Given name Initial Surname

Home address in country of origin

Postcode

Postal address in Australia

Postcode

Date of birth / / Phone Mobile phone

Email address

Gender

- Male Female

Office use only ▶

Student visa details

Arrival date to Australia (DD/MM/YY) / / Student visa number (if known) Visa start date^ (DD/MM/YY) / /

Length of visa Visa end date^ (DD/MM/YY) / /

Details of educational institution in Australia

Name of educational institution State Student number

Is the cover for a single, couple or family?

- Single Couple Family

Length of cover

It is a requirement of your student visa that your nib OSHC policy is continuous for the full term of your student visa. Your nib OSHC policy will be valid until your student visa end date.

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.

Given name	Initial	Surname	Relationship*	Sex	Date of Birth
			Partner		/ /
			Dependant		/ /
			Dependant		/ /
			Dependant		/ /

* 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.

Authority to operate policy

Do you authorise your partner (as named on your policy) or Power of Attorney* to operate this policy?

- No
- Yes ▶ Name Relationship

* Power of Attorney requires appropriate documentation to be sighted.

nib Online Services

When you become a 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.

Direct Credit 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 Direct Credit.

Name of bank, building society or credit union BSB number -

Name(s) of account holder Account number

2 PAYMENT

- Credit Card Authority** (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.

Do you have an Australian Business Number (ABN) and are you entitled to claim GST back on your policy premium?^

- Yes No

If yes, what is your ABN?

Customer's signature

Date / /

nib health funds limited abn 83 000 124 381

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
- I declare that dependants on this policy are under the age of 18 years and are listed as a dependant on the student visa
- 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 OSHC 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 OSHC Privacy Policy

- 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
- Where the Direct Credit Authority has been completed, I hereby authorise nib health funds to directly credit claim benefits for this policy to the nominated account
- I acknowledge that upon requesting cancellation or refund of my OSHC Policy with nib, that my details will be forwarded to the Department of Immigration and Citizenship (DIAC)

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

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

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

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Customer's signature

Date / /

nib

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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.

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

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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