UnitedHealthcare Confirmation Authority Form

Instructions:

- Please print in capital letters using a blue or black pen.
- Please complete all sections of the form in full for all persons to be covered by the policy.
- Please sign each of the 2 designated areas – Lifetime Health Cover loading and Declaration.
- Failing to provide any of the information below will cause a delay in the processing of your application.

Section 1: General information

If you do not complete this form you will not be enrolled with UnitedHealthcare Global's Australian ally nib Health Funds for cover in Australia. Where applicable this may have implications to your Visa conditions, or Australian Taxation requirements. If you have coverage through a local private health insurer in Australia and do not wish to transfer your cover to nib, you may opt out.

To opt out, please complete section 2 only and tick this box ☐

Section 2: Your personal details

Employer

ALT ID

nib policy number

Title

Surname

Given name

Date of birth (DD/MM/YYYY)

Gender

Male ☐ Female ☐

Residential address in Australia (include suburb, state and postcode)

Suburb State Please select Postcode

Postal address (if different from above)

State Please select Postcode Country

Preferred contact number

Alternate contact number

Email address

Preferred method of contact Email ☐ Post ☐

Country of citizenship (include dual citizenship details)

Are you a permanent resident of Australia?

Yes ☐ No ☐

Medicare information

Do you have a Medicare card? Yes ☐ No ☐ If you have indicated that you are a citizen or permanent resident of Australia and do not have a Medicare card, you must provide nib with additional information. Please refer to the Instructional Guide page 1.

Your Medicare card number (10 digits)

Your name as it appears on your Medicare card

Expiry date (MM/YYYY)

Visa details (for those visiting Australia)

Visa subclass

Visa start date (DD/MM/YYYY)

If you are the only person to be covered by this policy, please go to Section 4.

Section 3: Other people covered by this policy

About your spouse

Title | Surname | Given name

Date of birth (DD/MM/YYYY) | Gender

Male ☐ Female ☐

Country of citizenship (include dual citizenship details) | Is your spouse a permanent resident of Australia?

Yes ☐ No ☐

About your dependent children

Title	Surname	Given name	Date of birth (DD/MM/YYYY)	Gender
				M ☐ F ☐
				M ☐ F ☐
				M ☐ F ☐
				M ☐ F ☐
				M ☐ F ☐

About your dependents' Medicare eligibility

Complete this section even if the policy holder is not eligible for Medicare.

Are **any** of your dependents, including your spouse, eligible for Medicare? Yes ☐ No ☐ Go to the next question.

Surname	Given name	Listed on policy holder's Medicare Card?	Medicare Card number (10 digits) if not listed on policy holder's Medicare Card	Expiry date (MM/YY)
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		
		Yes ☐ No ☐		

About your children and spouse's dependents' visa

Complete this section only if you and your dependents are visitors to Australia.

Did/will **any** of your dependents, including your spouse, enter Australia on a different Visa to the policy holder?

Yes ☐ No ☐ Go to the next question.

Surname	Given name	Visa subclass	Expiry date (DD/MM/YYYY)

Section 4: Clearance Certificate

Complete these details if you are covered by another Australian Health Fund and would like to transfer your cover to nib. This will authorise nib health funds to obtain information about your previous cover in Australia, waiting periods already served and about any lifetime health cover loading you or your partner are required to pay. By completing this section you are also authorising nib to cancel your policy with your existing Australian health fund, and continue your cover with nib UnitedHealthcare Global. Lifetime health and cover loading information with your previous fund cannot be recognised without receipt of a transfer certificate.

Names of all people transferring to nib from your existing health fund

Given names	Surname	Date of birth (DD/MM/YYYY)	Gender	Dependant child
			M ☐ F ☐	Yes ☐ No ☐
			M ☐ F ☐	Yes ☐ No ☐
			M ☐ F ☐	Yes ☐ No ☐
			M ☐ F ☐	Yes ☐ No ☐
			M ☐ F ☐	Yes ☐ No ☐

Name of current health fund

Membership number

I authorise nib to cancel my cover from my existing health fund and obtain a transfer certificate.

Cancellation effective date (DD/MM/YYYY)

Signature

Date (DD/MM/YYYY)

Section 5: Authority

Direct Credit Authority

For the majority of claims, you will be able to use your nib customer card to claim benefits on the spot with no upfront payments, meaning you'll have nothing to pay. However, in some instances you may have upfront payments. If this happens, by providing your bank account details we can directly deposit any reimbursement into your nominated Australian bank account.

☐ **Yes, I would like to take advantage of Direct Credit**

Name of Bank, Building Society or Credit Union in Australia

BSB number

Name/s of account holder

Account number

Partner/Third Party Authority

The policy holder has the option of giving their partner, as nominated on the policy application, or a third party authority to operate the policy. In approving authority, you agree that the nominated person is able to make claims, enquiries regarding all persons covered by the policy and some changes to the policy.

Name of nominated person

Date of birth (DD/MM/YYYY)

Relationship

If any listed dependents have a Medicare status different to the primary policy holder, they will be set up on their own policy. For dependent children under the age of 16, parental authority will automatically be provided. However for any dependent (including a spouse) over the age of 16 they will need to nominate whether a 3rd party authority is able to operate the policy. Please complete for each applicable dependent.

Dependant name	Nominated Authority	Date of birth of Authority (DD/MM/YYYY)	Relationship

Section 6: Declaration

Privacy

The information provided on this form may be used for the purpose of registering you for the Australia Government Rebate on Private Health Insurance. Collection of this information is authorised by the Private Health Insurance Act 2007. This information may be disclosed to the Department of Health, Department of Human Services (Medicare) and the Australian Taxation Office or as authorised by law.

I declare:

- I confirm that the information that I have provided to nib is true and complete for myself and anyone else who is covered under the policy.
- I undertake to contact nib if my Medicare eligibility status changes at any time. I understand that failure to do so could affect my ability to claim and could have taxation implications.
- I consent to nib collecting, using and disclosing my personal information (including sensitive information, whether provided in this form or otherwise collected by nib) for the purpose of taking out health insurance, making and managing my claims and for other purposes described in the nib privacy policy at www.nib.com.au. I also consent to nib disclosing my personal information to UnitedHealthcare Global, located in the United States and to my employer for these purposes. If I do not consent to nib sending my information overseas, I will notify nib on 1800 244 466. I confirm that I have obtained the consent of persons covered on this policy to nib collecting, using and disclosing their personal information for these purposes. nib's privacy policy at www.nib.com.au explains how I can access or correct my personal information and how to make a privacy related complaint.

Policy holder signature

Date (DD/MM/YYYY)

Only complete the below section if any listed spouse or dependents over the age of 16 have a different Medicare status to the policy holder. As they will be set up with their own policy, the must also read and accept the above declaration.

Dependent signature

Date (DD/MM/YYYY)

Dependent signature

Date (DD/MM/YYYY)

Dependent signature

Date (DD/MM/YYYY)

Please forward this form (and any other forms required)

Email: uhcjoins@nib.com.au

Mail: nib Health funds, 22 Honeysuckle Drive
Newcastle NSW 2300, Australia