Membership
Variation Form

Current Primary Member details

Member number: | Title:

First name: | Surname:

Date of birth:

Add or delete Members

☐ **Add** / ☐ **Delete** | Title:

First name: | Surname:

Date of birth: | Gender:

Relationship:

Is this person a student and older than 21 years? ☐ Yes / ☐ No

Name of tertiary institution: | Year applicable for:

☐ **Add** / ☐ **Delete** | Title:

First name: | Surname:

Date of birth: | Gender:

Relationship:

Is this person a student and older than 21 years? ☐ Yes / ☐ No

Name of tertiary institution: | Year applicable for:

☐ **Add** / ☐ **Delete** | Title:

First name: | Surname:

Date of birth: | Gender:

Relationship:

Is this person a student and older than 21 years? ☐ Yes / ☐ No

Name of tertiary institution: | Year applicable for:

Are all people listed above eligible for full Medicare benefits? ☐ Yes / ☐ No

Medicare card number: | Reference number: | Expiry:

Information correct as at 29 September 2022

Membership Variation Form

Switching funds

Please complete this section if any person being added to this membership is transferring from another health fund:

Members name:

Current health fund: Member number:

Do you wish to transfer any dependents on your previous policy to HIF too? ☐ Yes / ☐ No

Lifetime Health Cover loading

Have all people transferring to HIF, who are over 30 years of age held continuous Hospital Cover since their 30th birthday? ☐ Yes / ☐ No

If the answer is no, you may be subject to the Government's Lifetime Health Cover loading but your previous fund will confirm this when we receive your information from them.

Spouse/Partner Authority

This Spouse/Agent authority allows for a nominated person to access personal information about your membership and claim on your behalf in accordance with the current *Privacy act*.

Declaration

I hereby give authority for the person named above to make any changes or alterations to my HIF Membership on my behalf, and claim for benefits on my behalf. However, there is no provision for cancellation of this membership by the Spouse / Partner named above. By signing this authority, I declare that the above information is true and correct and that the above membership is in my name. I understand that consenting will allow the above-nominated agent to make any changes that the contributor is allowed to make in accordance with HIF Fund Rules. However, there is no provision for cancellation of this membership.

I give my spouse or partner authority to make changes on our membership. ☐ Yes

Membership Variation Form

Change of cover type

Choose hospital cover

Gold Top

☐ 500/1000 ☐ 750/1500

Silver Plus

☐ 200/400 ☐ 500/1000 ☐ 750/1500

Silver

☐ 200/400 ☐ 500/1000 ☐ 750/1500

Bronze Plus

☐ 200/400 ☐ 500/1000 ☐ 750/1500

Bronze

☐ 200/400 ☐ 500/1000 ☐ 750/1500

Basic Plus

☐ 500/1000 ☐ 750/1500

Choose extras cover

☐ Top Extras ☐ Simple Extras

☐ Advanced Extras ☐ Value Extras

☐ Essential Extras ☐ Basic Extras

Overseas visitor hospital & medical cover

Working visa cover

Comprehensive

☐ No excess ☐ 500/1000

Intermediate

☐ No excess

Essentials

☐ No excess

Basic

☐ 500/1000

If your current product is not listed it may be closed.

If you're on a closed product, you're able to stay on it but if you decide to leave the product, you won't be able to return to it.

Please contact us to discuss your options.

Change of payment method

Payment frequency

☐ Fortnightly* ☐ Monthly ☐ Quarterly ☐ 6 monthly ☐ Yearly

Payment method

☐ Direct debit^ ☐ Payroll Deduction ☐ Invoice

**Fortnightly payment frequency is only available via Direct Debit. ^If changing to Direct debit you will also need to fill in a Direct debit application form at www.hif.com.au/health-insurance/forms-library*

What date do you wish this change to be effective? _____

Membership Variation Form

Declaration

Privacy

I acknowledge that personal information provided herein will be used by HIF to deliver the products and services of my membership. All information will remain confidential. This information may be disclosed to third parties and authorised Government agencies to deliver services associated with my health insurance. Failure to provide personal information may result in the failure to process or deliver the service requested. I confirm that the information supplied on this variation form is provided with the consent of those individuals listed on this form and includes consent from those individuals to act on their behalf.

Variation

I declare that all details are true and correct and agree to be bound by the rules of HIF. I understand the pre-existing condition rule, waiting periods and benefit limitations may be applied to my membership*. I declare that students aged 21 – 31 years on this membership are attending a full-time course of study and are not married or in a defacto relationship. I certify that any dates of birth shown on this form are correct. I understand if a date of birth has been stated incorrect and this resulted in incorrect premiums being paid, HIF reserves the right to deduct the additional premium from the next claim benefit entitlement or to adjust my next payment amount.

I have read and understood the above declaration and variation information. ☐ Yes

Signature: _____ Date: _____

**Please refer to the Health Cover Guide at hif.com.au for more information regarding the pre-existing condition rule, waiting periods and benefit limitations*

Click to submit

*Once you have completed the form, please email it to us at **hello@hif.com.au** or mail to Claims Department, Health Insurance Fund of Australia Whadjuk Country GPO Box X2221 Perth WA 6847*