APPLICATION FORM *1 May 2006*

If you are an existing member please quote membership no. . . . .

PRINCIPAL MEMBER

Title. . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Aust Visa Code. . . . . (ie: sub class) Occupation. . . . .

Email. . . . .

Phone: Daytime. . . . .

Mobile. . . . .

Address in Australia. . . . .

. . . .

State. . . . . P'code. . . . .

Sponsored by. . . . .

Employed by. . . . .

Payrolled by (if applicable). . . . .

Insurance Broker (if applicable). . . . .

Previous Health Fund. . . . .

Previous Health Fund Last Date of Cover. . . . / . . . . / . . .

Arrival Date in Australia. . . . / . . . / . . .

Start Date of Cover

. . . . / . . . . . . / . . . .

Estimated date the policy is to end

. . . . / . . . . . . / . . . .

(Please note: If the estimated date the policy is to end is unknown, the policy will be issued for a maximum of 12 months, with continuation guaranteed until IMAN/AHI is advised of cancellation)

DETAILS OF PERSONS TO BE COVERED (including dependent children under 21 years)

Title. . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

PLEASE TICK COVER REQUIRED

	☐ Table 320			☐ Table 390			☐ Table 120		☐ Table 190	
	Weekly	**Monthly**	**Yearly**	**Weekly**	**Monthly**	**Yearly**	**Quarterly**	**Yearly**	**Quarterly**	**Yearly**
☐ **Single**	$48.00	$208.00	$2496.00	$35.77	$155.00	$1860.00	$230.00	$920.00	$189.00	$756.00
☐ **Family**	$96.00	$416.00	$4992.00	$71.54	$310.00	$3720.00	$460.00	$1840.00	$378.00	$1512.00

PLEASE TICK PAYMENT METHOD

	Weekly	**Fortnightly**	**Monthly**	**Quarterly**	**Half-Yearly**	**Yearly**
Payroll (Table 320 & 390 only)	☐	☐	☐	N/A	N/A	N/A
Direct Debit	N/A	N/A	☐ Table 320 & 390 only	☐	☐	☐
Credit Card	N/A	N/A	N/A	☐	☐	☐
Company Invoice	N/A	N/A	N/A	☐	☐	☐
First payment only by Cheque/Postal Order*	N/A	N/A	N/A	☐	☐	☐

*Please indicate how you would like to make ongoing payments ☐ Payroll ☐ Direct Debit ☐ Credit Card

Payroll or Company Contact. . . . . Email. . . . . Phone . . . . Fax. . . . .

CREDIT CARD DETAILS

☐ MasterCard ☐ Visa ☐ AMEX

Card number: |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_|

Expiry Date. . . . . / . . . . / . . . . .

Name on Credit Card . . . .

Cardholders Signature. . . . .

EXISTING AILMENTS DECLARATION

A claim arising from an Existing Ailment may not be covered under this policy.

Where we offer to **cover an Existing Ailment** then your policy is endorsed to confirm you are fully covered and your policy is renewable. Where we offer a policy which **excludes an Existing Ailment** your policy is endorsed to exclude the ailment during the first twelve months of continuous membership, and to confirm you are fully covered for all other Illness or Injury and your policy is renewable.

An Existing Ailment is an ailment, illness, condition or disability, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by the Health Fund, existed on the date of application, or on the date of upgrading to a higher level of cover.

You have a duty to disclose to us whether you are aware of any Existing Ailment affecting yourself or accompanying family member as this is relevant to our decision to offer you health insurance. If you do not disclose all relevant information at the time of applying to join the Health Fund, we may refuse to pay your claim, or may cancel the policy immediately. Should any decision need to be made about a claim for what may be an Existing Ailment, the Health Fund will appoint a Medical Arbiter to make a decision based on the information available.

Please answer the following questions in relation to yourself or any accompanying family members applying for an IMAN Australian Health Insurance Policy.

This declaration covers myself and

My Partner/Spouse

Name: ....

My Dependent Children

Names: ....

....

....

....

If you answer Yes to any question, you must provide us with all relevant details, including dates. Please give result of screening and full details of any existing ailments.

1. Did anyone listed have pre-employment health screening? ....

a) examination by a doctor? ☐ YES ☐ NO ....

b) xrays? ☐ YES ☐ NO ....

c) blood and urine tests? ☐ YES ☐ NO ....

2. Has anyone signed a Department of Immigration and Citizenship Health Undertaking? ☐ YES ☐ NO ....

3. Is anyone applying aware of any existing signs or symptoms of an ailment, illness, condition or disability? ☐ YES ☐ NO ....

4. Has anyone applying had any ailment, illness, condition, or disability, for which medical treatment was received in the last 6 months? ☐ YES ☐ NO ....

5. Has anyone applying received hospital treatment in the last 3 years? ☐ YES ☐ NO ....

6. Does anyone applying have an implant of any kind? ☐ YES ☐ NO ....

7. Does anyone applying take pills, medicines and/or prescribed medication of any kind? ☐ YES ☐ NO ....

8. Has anyone applying received any other treatment (including physiotherapy or chiropractic) within the last 6 months? ☐ YES ☐ NO ....

9. Is any adult female applying pregnant? ☐ YES ☐ NO ....

(If you need more space for Existing Ailment information, please use a second form – available at www.austhealth.com)

MEDICARE CARD HOLDERS SECTION

Please complete if you have a current Reciprocal or Interim Medicare Card.

Please complete Medicare Card Information:

Medicare Card Type: ☐ Yellow - A Reciprocal Medicare Card

☐ Blue - An Interim Medicare Card

My full name as it appears on my Medicare Card:

. . . .

Medicare Card No.. . . . .

Expiry Date. . . . . / . . . . / . . . . .

Please list all family members **as they are listed** on this Medicare Card

Name	Relationship
. . . .	
. . . .	
. . . .	

If your spouse/partner is a holder of a different, current Reciprocal or Interim Medicare Card, please complete this section.

Please complete Medicare Card Information:

Medicare Card Type: ☐ Yellow - A Reciprocal Medicare Card

☐ Blue - An Interim Medicare Card

My spouse/partner's full name as it appears on their Medicare Card:

. . . .

Medicare Card No.. . . . .

Expiry Date. . . . . / . . . . / . . . . .

Please list all family members **as they are listed** on this Medicare Card

Name	Relationship
. . . .	
. . . .	
. . . .	

This section must be completed, dated and signed.

1. I HAVE COMPLETED THE EXISTING AILMENTS DECLARATION

2. I AUTHORISE IMAN/AHI TO LIAISE WITH ANY MEDICAL PRACTITIONER, HOSPITAL OR HEALTH PROVIDER

IMAN/AHI may need to obtain complete details relating to medical history, treatment, hospitalisation, injury and sickness, in respect of claims arising under your IMAN/AHI policy, and has consent, on behalf of each person listed on the policy document, to obtain said information.

3. I AUTHORISE IMAN/AHI TO LIAISE WITH ANY PREVIOUS PROVIDER OF HEALTH INSURANCE

IMAN/AHI may need to obtain personal information concerning your application for health insurance, and has consent, on behalf of each person listed on the application, to obtain said information.

4. I ACKNOWLEDGE IMAN/AHI'S PRIVACY POLICY

IMAN/AHI is committed to protecting the personal information you provide to us, or which is provided to us on your behalf.

Collecting your personal information

We collect your personal information directly from you, such as by email, phone or in documents such as an application form, or from third parties, such as your employer or sponsor.

Using your personal information

We use your personal information to administer and manage the services we provide to you, including collecting monies owed and paid.

Website Information

IMAN/AHI's webhosts gather usage statistics from our website, which is analysed for reporting purposes. There is no personally identifiable data collected and all site visitors remain anonymous.

Disclosing your personal information

We may disclose your personal information to your employer or sponsoring organisations; and Underwriters and health service providers with which you are associated, for the purpose of providing you with the services you are entitled to, or to meet any legal obligations imposed on your employer, sponsor, Underwriters or IMAN/AHI. Where appropriate, these disclosures are subject to privacy and confidentiality.

Accuracy of your personal information

We take reasonable steps to ensure the personal information we hold or disclose is accurate, complete and up-to-date -the accuracy of this information depends to a large extent on the information you provide us. That is why we recommend you keep us up to date with changes to your personal information at all times.

Signed . . . .
(Applicant or Agent)

Date . . . . / . . . . / . . . .

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