APPLICATION FORM *1 July 2008*

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. . . . . Occupation. . . . .
ie: sub class

Email. . . . .

Phone: Work . . . .

Home. . . . .

Mobile. . . . .

Address in Australia. . . . .

. . . .

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

Sponsored by. . . . .

Sponsors address. . . . .

. . . .

Employed by. . . . .

Employers address. . . . .

. . . .

Sponsor/Employment/Agent . . . .
Contact

Sponsor/Employment/Agent . . . .
Phone No.

Previous Health Fund . . . .

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

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

DETAILS OF PERSONS TO BE COVERED (including dependent children under 25 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. . . . .

Start date of Plan . . . . / . . . . . . / . . . .

Estimated end date of Plan . . . . / . . . . . . / . . . .

Please note: If the estimated date the plan is to end is unknown, the Plan will be issued for a maximum of 12 months, with continuation guaranteed until IMAN/AHP is advised of cancellation.

Do you wish to automatically renew your plan?

☐ Yes, automatically renew my plan

☐ No, do not automatically renew my plan

If yes, please tell us what date you wish to automatically renew to

i.e. visa expiry date . . . . / . . . . . . / . . . .

PLAN REQUIRED AND PAYMENT SCHEDULE

Please tick **one**	**320 Plan**		**390 Plan**		**120 Plan**		**190 Plan**	
	Single	**Family**	**Single**	**Family**	**Single**	**Family**	**Single**	**Family**
Monthly	☐ $208	☐ $416	☐ $155	☐ $310	N/A	N/A	N/A	N/A
Quarterly	☐ $624	☐ $1248	☐ $465	☐ $930	☐ $230	☐ $460	☐ $189	☐ $378
Half-Yearly	☐ $1248	☐ $2496	☐ $930	☐ $1860	☐ $460	☐ $920	☐ $378	☐ $756
Yearly	☐ $2496	☐ $4992	☐ $1860	☐ $3720	☐ $920	☐ $1840	☐ $756	☐ $1512

Please tick payment method (Details to be completed overleaf)

☐ Credit Card ☐ Direct Debit

CREDIT CARD DETAILS

☐ **I authorise IMAN/AHP to charge my Credit Card for my Plan payments**

☐ MasterCard ☐ Visa ☐ AMEX

Card number:

Expiry Date:

Name on Credit Card . . . .

Cardholders Signature. . . . .

If paying on behalf of the applicant, please provide

Company Name. . . . .

Phone No . . . .

Email Address. . . . .

REQUEST AND AUTHORITY TO DEBIT THE ACCOUNT NAMED BELOW TO PAY IMAN INTERNATIONAL PTY. LTD

Please refer to the Direct Debit Request Service Agreement, found on our website:- www.austhealth.com

Request and Authority to debit	Surname or company name. . . . . Given names or ACN/ABN. . . . . (“you”) Request and authorise IMAN International Pty. Ltd. (135990) to arrange for any amount IMAN International Pty. Ltd. may debit or charge you to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement (and any further instructions provided below).
Insert the name and address of financial institution at which your account is held	Financial institution name. . . . . Address. . . . .
Insert the details of account to be debited	Name of account. . . . . (your name(s) as it/they appears on your bank statements) BSB number ___ ___ ___ - ___ ___ ___ Account number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Acknowledgement	By signing this Direct Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and IMAN International Pty. Ltd. as set out in this request and in your Direct Debit Request Service Agreement.
Frequency of debit	If your plan start date is 1st - 15th of the month, your direct debit will be processed on the 15th of the month or the nearest working day thereafter. If your plan start date is 16th - 31st of the month, your direct debit will be processed on the last day of the month or the nearest working day thereafter. And at Monthly/Quarterly/Half Yearly/Yearly Intervals thereafter as indicated on Page 1 of this application form.
Insert your signature and address	Signature. . . . . Address. . . . . Date . . . . . / . . . . / . . . . .

EXISTING AILMENTS DECLARATION

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 us, existed prior to or on the date of application.

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 membership of a Plan.

We may offer for an Existing Ailment:

- a Plan without a waiting period
- a Plan with a twelve month waiting period
- a Plan which excludes an Existing Ailment for the term of the membership.

In each case, your Membership Certificate is endorsed to confirm our offer, and that your Plan is renewable and that you retain all other benefits for sickness and injury, relating to your Plan.

If you do not disclose all relevant information at the time of applying to join, we may refuse to consider your claim, or may cancel your Plan immediately.

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

This declaration includes:

Self (principal member):	Membership Number (if applicable)	Spouse/Partner's Name:
....	....	....

Signature:.. Date:...../..../.....

Children's Names:..

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

Please give details, including dates ....

....

....

....

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

Please give details, including dates ....

....

....

....

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

When were they in hospital?..

Why were they in hospital? ....

....

....

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

When was it inserted?...

What type of implant is it?..

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

Please list medication, including the condition/ailment it is used for......................................

....

....

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

When? ....

What for? ....

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

If yes, when is the expected date of delivery? ....

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

MEDICARE CARD HOLDERS SECTION

As a holder of a Reciprocal or Interim Medicare Card, you should be aware that **Overseas Visitors Health Cover** (OVHC), **Health Insurance Policies for Overseas visitors** and **Working Visa Health Plans** are classified as ineligible products for Medicare Levy Surcharge (MLS) exemption purposes. You should seek financial advice about the tax implications which may effect you. Further information is available on our website:
www.austhealth.com/reciprocal.php

Please complete the following:

Type of Medicare Card held:
☐ Yellow - A Reciprocal Medicare Card
☐ Blue - An Interim Medicare Card

Are all members of your family listed on a Reciprocal or Interim Medicare Card?
☐ Yes
☐ No

If no, please list names of those who are excluded:

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

This section must be completed, dated and signed.

1. I HAVE COMPLETED THE EXISTING AILMENTS DECLARATION

2. PRODUCT DISCLOSURE STATEMENT

I have downloaded and read the Product Disclosure Statement to help me decide whether Working Visa Health Plans suit my needs.

3. GENERAL ADVICE

Information on our website is classified as general advice and is believed to be accurate and reliable at the time it was sourced.

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

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

5. I AUTHORISE IMAN/AHP TO LIAISE WITH ANY PREVIOUS PROVIDER OF HEALTH INSURANCE

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

6. I ACKNOWLEDGE IMAN/AHP'S PRIVACY POLICY

IMAN/AHP 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/AHP'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, and/or sponsor, 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, or IMAN/AHP. 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 . . . . / . . . . / . . . .

AUSTRALIAN HEALTH PLANS a division of
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