

CANCELLATION/TRANSFER CERTIFICATE REQUEST

Policy Number

Your family name. Your first name.

Your current postal address
.....

State. Postcode.

Date ___ / ___ / _____

To Whom It May Concern,

I have transferred to IMAN Australian Health Plans and my new policy is effective from Date ___ / ___ / _____.

I wish to maintain my continuity of health cover, please ensure:

- ✓ My policy with your health fund is cancelled on Date ___ / ___ / _____.
- ✓ My direct debit arrangement with your health fund is cancelled and refund any premiums that may be owing to me.
- ✓ COMPLETED TRANSFER CERTIFICATE is sent to info@austhealth.com within 14 days.

Optional:

My decision to transfer to IMAN Australian Health Plans is final and I do not wish to be contacted by your health fund.

OLD POLICY DETAILS

Your family name. Your first name.

Date of birth ___ / ___ / _____ Previous Health Fund.

Policy Number (if known)


Names of other persons transferring to IMAN (if applicable)
.....
.....

Signature (policyholder). Date ___ / ___ / _____


Signature (spouse). Date ___ / ___ / _____

TO SUBMIT YOUR FORM



Complete your form and submit in one of the following ways:

 Mail
IMAN Australian Health Plans
Reply Paid 62208
Locked Bag 2010
Newcastle NSW 2300

 Email
info@austhealth.com

 Fax
+61 2 9929 3818

If you have questions call the Customer Care Centre:
Monday to Friday 8.30am – 6.00pm (AEDT)

 Call **1800 22 11 33**  From overseas **+61 2 4914 1131**