GU Health

Effective date: 1 January 2024
Group No.: 88750

Caterpillar Voluntary Health Plan for Residents **Application form**

Before joining GU Health visit our website to refer to *Your Membership Guidelines* at **guhealth.com.au/membership-guidelines**
This document outlines the details regarding benefit and fund rules, and other conditions that apply to your membership with GU Health.

We're here to help

For assistance or for more information 1800 633 819 8.30am to 5pm (AEST), Monday to Friday

For members with full Medicare eligibility, please complete this form
To join GU Health, complete sections 1-10;
To Change your level of cover, complete sections 1,3, 5-6, 9-10;
To Transfer from another GU Health Plan, complete sections 1-6, 9-10;
To add partner/dependants, complete sections 1-3, 5-6, 8-10.

Complete this application form and email to:

corporate@guhealth.com.au or FreePost to: GU Health, Reply Paid 2988 Melbourne VIC 8060 (no stamp required)

If completing a paper form, Use black pen only and use capital letters – Please indicate with a X in the appropriate check boxes

GU Health Membership No. ☐☐☐☐☐☐☐☐ (leave blank if not currently a member)

I wish to:

Join GU Health ☐ Transfer from an existing GU Health plan ☐ Change my level of cover ☐ Add partner/dependant ☐

Fund join date, apply Rebate or cover change start: _____ (DD/MM/YYYY)

Are all people on the policy eligible for Medicare? YES ☐ OR NO ☐ If NO, Call GU Health on 1800 633 819

If you are unsure whether you are eligible for Medicare, go to: **servicesaustralia.gov.au/individuals/services/medicare/medicare-card**

1 Your personal details

Title _____ First name _____ Surname _____

Email address (current) _____ Telephone (current) _____

Date of birth _____ (DD/MM/YYYY) Gender Male ☐ Female ☐

Australian residential address _____

State _____ Postcode _____ Postal address *(if different from above)* _____

Postal address (continued) _____ State _____ Postcode _____ **Employee number** _____

When communicating to me about my membership or legislative requirements, please use: Email ☐ Mail ☐

We'll try to use your preference where possible.

2 Partner/dependant details – A full-time student dependant is aged 21-24 inclusive, a child is aged up to 21

Provide details of all people covered by the policy (do not include yourself) photocopy this section for more dependants and attach to this application form

Title	First Name	Surname	Gender M or F	Date of birth	Relationship to Membership holder	Name of Australian school/college/university	Student number

3 Health plan options

Please indicate with an X in the appropriate box.

Single ☐ Family ☐

☐ Option 1: Premier Gold Hospital ($100 single / $200 family excess) & Superior Benefits

☐ Option 2: Premier Gold Hospital ($250 single / $500 family excess) & Superior Benefits

☐ Option 3: Premier Gold Hospital ($250 single / $500 family excess) & Economy Benefits

☐ Option 4: Premier Gold Hospital ($250 single / $500 family excess) & Corporate Boost Benefits

☐ Option 5: My Choice Silver Plus Hospital Saver ($100 single / $200 family excess) & Superior Benefits

☐ Option 6: My Choice Silver Plus Hospital Saver ($100 single / $200 family excess) & Economy Benefits

☐ Option 7: My Choice Silver Plus Hospital Saver ($100 single / $200 family excess) & Corporate Boost Benefits

Please provide your direct debit details in Section 6.
It's the policyholder's responsibility to ensure any employee contributions are paid up to date at all times.

4 Medicare details – COMPLETE ONLY if all people to be covered have a current Medicare card

Medicare card number ☐☐☐☐ ☐☐☐☐☐ ☐ Valid to ☐☐/☐☐ (MM/YY)

Membership holder's name and initial **(exactly as it appears on your Medicare card)**

Is this Medicare card holder covered by the policy? Yes ☐ No ☐ **If Yes,** please proceed to Section 5.

(If No) Applicants not covered by the policy cannot claim the Australian Government Rebate on Private Health Insurance (excluding child only policies) and employers and trustees of organisations cannot claim the Australian Government Rebate on Private Health Insurance on policies paid on behalf of employees.

For more information about the Australian Government Rebate on Private Health Insurance, go to **privatehealth.gov.au**
Questions about Medicare eligibility can be made at any Medicare Service Centre or by calling **132 011**
Note: Call charges apply – calls from mobile phones may be charged at a higher rate. **Go to section 6**

5 Apply for the Australian Government Rebate on Private Health Insurance

Please complete this section for your Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium.

All the people listed on the membership must be eligible to claim Medicare entitlements for you to receive the rebate as a reduced premium.

Please nominate the rebate tier to be applied to your membership: **Base Tier** ☐ **Tier 1** ☐ **Tier 2** ☐ **Tier 3** ☐

Date Rebate premium reduction to commence (If different from the 'Join Date' in Section 1): ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

If the rebate tier you select doesn't accurately reflect your actual entitlement as determined by the Australian Taxation Office (ATO), this will be reconciled as part of your tax return. Refer to *Your Membership Guidelines* for details and visit the Australian Taxation Office website to calculate your rebate tier or for more information at **ato.gov.au**

If you wish to stop receiving the Australian Government Rebate on Private Health Insurance or would like to change your income tier you must notify GU Health.

Do you declare that the information that you have provided is complete and correct? Do you understand that giving false or misleading information is a serious offence?

☐ I declare that the information I have provided is true and accurate. I make this declaration on ☐☐/☐☐/☐☐☐☐ (DD/MM/YYYY)

Health insurers are not permitted to provide tax advice. For assistance in determining your appropriate rebate tier, please contact your registered tax agent, or visit the ATO at **ato.gov.au**

Please refer to Services Australia's Privacy Notice below
The privacy and security of your personal information is important to us and is protected by law. We need to collect this information so we can process and manage your applications and payments and provide services to you. We only share your information with other parties where you have agreed, or where law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacy**

6 Payment details

Name of Australian financial institution

Name/s on the account to be debited

BSB number

Account number

To ensure security of your credit card details, we don't collect your credit card information via application form. Once your membership is set up using your bank account details and you receive your membership number, you can change your payment method through Online Member Services at **guhealth.com.au** or call us on **1800 633 819.**

I/We authorise nib health funds limited ABN 83 000 124 381 trading as GU Health (BECS ID 012495) to arrange funds to be direct debited from my/our account/credit card via the Bulk Electronic Clearing System with the terms described in the GU Health Direct Debit Service Agreement provided on the last page.

I/We would like the first debit to occur on or after (DD/MM/YYYY)

Please note: if no date provided direct debit will occur five business days after processing the application and direct debits will occur monthly.

If this is a joint account each account holder must sign.

1. Account holder's signature

2. Account holder's signature

I agree that if I digitally insert my name that this will the electronic representation of my signature and have the same effect as a pen-and-paper signature.

Date signed (DD/MM/YYYY)

Date signed (DD/MM/YYYY)

7 FastBack details

GU Health will pay any eligible benefits you claim by direct crediting the funds into your nominated Australian financial institution account.

Please use my bank account details provided in Section 6 OR Please use the financial institution account nominated below

Name of Australian financial institution

Name/s on the account to be credited

BSB number

Account number

8 Transfer Certificate request

Complete only if you are transferring from another Australian health fund so we can assess your continuity of cover.

	Transferring from (name of previous fund)	Previous fund membership number
Myself		
My partner		
My dependant/s		

I authorise GU Health to cancel my/my partner's/my dependant/s membership with the above listed health fund/s, where my partner/ dependant is transferring from another Health Fund I confirm I also have consent to and obtain a Transfer Certificate for:

Myself My partner My dependant(s)

Please note you must personally advise your bank to cancel your deductions if you have a direct debit arrangement with your previous health fund.

9 Privacy statement

GU Health is committed to meeting all applicable privacy requirements. GU Health collects personal information, including sensitive information (such as health information) from you and, if necessary, from third parties such as health service Providers and third parties who provide analytics services. By purchasing and maintaining a health Membership, you authorise us to request and receive personal information about you. This includes, for example, health information in connection with your health insurance policy, audits of health provider records from health service Providers, and predicted health outcomes from third parties who provide analytics services.

GU Health may need to inform your employer of hospital claims made under your membership where your employer has agreed to pay, on your behalf, any hospital excess under your health plan. In these circumstances, GU Health will not disclose the reasons for hospitalisation, or the medical treatment received. GU Health may need to contact practitioners to enable us to efficiently answer enquiries to process transactions.

Your spouse/partner, if listed on the membership, will have access to membership information and may make changes to the policy with the exception of cancelling the policy. If your partner (or another third party) is not on the membership and you would like to allow them access to your membership please download the Third Party Access form from **guhealth.com.au** and return the completed form to GU Health. The ways in which GU Health, uses, discloses and manages your personal information is set out in our Privacy Policy, which can be viewed at **guhealth.com.au**

You can opt-out of your information being used for analytics purposes for Us to provide personalised health information and related products and services at any time by contacting your Member Relations Team or emailing **corporate@guhealth.com.au**.

If you wish to opt-out please indicate with an X ☐

10 Declaration

By signing this form:

- I am authorising GU Health to create a membership based on the information provided in this form.
- I declare that the information I have provided in this form is complete and correct. I accept and agree to abide by the fund rules of GU Health and by-laws of the organisation as registered and accept the applicable waiting periods.
- I acknowledge that I have read and understood *Your Membership Guidelines* with the Terms and Conditions listed. A copy of *Your Membership Guidelines* can be accessed online at: **guhealth.com.au**
- I confirm that where this form contains personal information about other persons, I have obtained all necessary consents to disclose that information to GU Health, and have the authority to act on those persons' behalf. I authorise all such persons to make claims on this cover where eligible.
- I have read GU Health's **Privacy Policy** and agree to GU Health collecting and using my personal information to issue and manage my cover as set out in that policy.
- I authorise GU Health to obtain from my previous fund/s personal information about me or any others to be covered, for the purpose of continuity of cover and recognition of Lifetime Health Cover status. I understand that Lifetime Health Cover loading may apply to hospital contributions for any adult who is covered by this membership on or after the 1 July following their 31st birthday and is either: new to health insurance, hasn't provided proof of continuous private hospital cover, or is a new migrant who hasn't enrolled in an appropriate level of hospital cover within 12 months of becoming eligible for full Medicare entitlements.
- I understand that this application does not become effective until GU Health accepts this application and I am notified in writing.

Membership holder's signature

Date signed (DD/MM/YYYY)

I agree that if I digitally insert my name that this will the electronic representation of my signature and have the same effect as a pen-and-paper signature.

Please check and ensure all required sections of the form are completed and that you have signed and dated the form

Direct Debit Service Agreement

This is a Direct Debit Service Agreement for your credit card and bank account debits toward your membership.

Please keep this for your records.

Our commitment to you

This document sets out your rights, our commitment to you and your responsibilities to us, together with where you should go for assistance in respect of your direct debit arrangement with nib health funds limited ABN 83 000 124 381 trading as GU Health (BECS ID No. 012495).

Initial terms of the arrangement

In terms of the Direct Debit Request (DDR) arrangement made between us and signed by you, we undertake to periodically debit your nominated account in accordance with your signed authority to direct debit.

Drawing arrangements

- If a drawing is due on a non-business day, it will be debited on the next business day following the scheduled drawing date
- We will give you at least 14 days notice if we intend to make changes to the initial terms of the arrangement
- We will debit all contributions in advance along with any applicable arrears, and will vary the contributions as necessary in line with changes to level of cover, scale, legislation and/or contribution adjustments.

Your rights

Changes to the arrangement

If you want to make changes to the drawing arrangement, please notify us in writing at least four business days prior to your next scheduled drawing date. These changes may include:

- deferring the drawing; or
- altering the schedule; or
- stopping an individual debit; or
- suspending the DDR; or
- cancelling the DDR completely.

Enquiries

If you have any enquiries they should be directed to GU Health, rather than to your financial institution.

All information relating to the DDR held by us will remain confidential except for information that may be provided to our financial institution to initiate the drawing to your nominated account, or information disclosed to a third party as required by law. Information may also be provided to nib Holdings Limited or any of its wholly-owned subsidiaries to enable this DDR to be effected.

Disputes

- If you believe that a drawing has been initiated incorrectly, you should raise the matter directly with GU Health
- If you do not receive a satisfactory response to your dispute from us, contact your financial institution who will respond to you with an answer to your claims in accordance with their dispute resolution procedures.

Note: Your financial institution will ask you to contact us to resolve your disputed drawing prior to involving them.

Your commitment to us

It is your responsibility to ensure that:

- your nominated account can accept direct debits (your financial institution can confirm this); and
- that on the drawing date there are sufficient cleared funds in the nominated account; and
- that you advise us if the nominated account is transferred or closed
- your membership is financial at all times
- you notify GU Health if your bank account or credit card details change.

If your drawing is returned or dishonoured by your financial institution, we will notify you.

Any transaction fees payable by us in respect of the above may be passed on to you. Consecutive returns or dishonours may result in the direct debit facility being withdrawn.

GU Health reserves the right to cancel a membership if contribution payments are in arrears for more than 60 days.

SAVE AS EMAIL PRINT