# Change of Membership Details

Westfund's Change of Membership Details form allows you to make changes to your membership. Please complete the sections of the form that relate to your required changes. Some changes require documentation to be attached and this information is provided in the corresponding section.
The Declaration - Section 11 - must be signed for all changes made to memberships.

1. Update Address/Phone/Email details
2. Change of Cover
3. Level of Cover
4. Add New Spouse/Partner/ Dependants to Membership
5. Change of Name
6. Remove Person from Membership
7. Notification of Deceased Member
8. Withdrawal from Australian Government Rebate on Private Health Insurance
9. Notification of New Medicare Card Details
10. Previous Fund Transfer Details
11. Declaration

## 1. Update Address/Phone/Email Details

Westfund Membership Number

Personal Details

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given names

Also known as

Home Address

State Postcode

Postal Address

State Postcode

Contact Details

Home ( )

Work ( )

Mobile

Fax ( )

Email Address

Do you wish to receive fund communications via email? Yes ☐ No ☐

Do you wish to receive fund communications via SMS? Yes ☐ No ☐

## 2. Change of Cover

Type of Cover?

| | | | |
|---|---|---|---|
| Single | ☐ | Family Extended* | ☐ |
| Couple | ☐ | Sole Parent Family Extended* | ☐ |
| Family | ☐ | Family Disability Dependant** | ☐ |
| Sole Parent Family | ☐ | Sole Parent Disability Dependant** | ☐ |

* Please select an extended cover to cover dependants aged 25-30

** Please select a Disability Dependant cover to cover dependants with a disability over the age of 31.

I would like my cover change to commence From (nominate a date in the future) / /

DAY MONTH YEAR

## 3. Level of Cover

***Hospital*** ***- Gold Ultimate Hospital is only available when packaged with an extras policy. Silver Plus Family is a package cover with Hospital and Extras combined.***

Gold Ultimate ($500 & $750 Excess Only) ☐

Silver Plus Assure (Nil, $250, $500 & $750 Excess Only) ☐

Silver Plus Family ($500 & $750 Excess Only) ☐
Please note: not available for extended or disability

Silver Plus Everyday ($250, $500 & $750 Excess Only) ☐

Bronze Plus ($500 & $750 Excess Only) ☐

Bronze ($500 & $750 Excess Only) ☐

Basic Plus ($500 & $750 Excess Only) ☐

Excess Options

Nil ☐
$250 ☐
$500 ☐
$750 ☐

***Extras*** ***- Mid Extras is only available when packaged with a hospital policy. Dental Saver Extras only available for singles and couples.***

| | | | | | |
|---|---|---|---|---|---|
| Ultimate Extras | ☐ | Freedom Extras | ☐ | Choice Extras | ☐ |
| High Extras | ☐ | Mid Extras | ☐ | Starter Extras | ☐ |
| Dental Saver Extras | ☐ | | | | |

***Ambulance***

Ambulance ☐

I have elected to use my "once-off' lifetime Mental Health exemption to access immediate in-hospital mental health services ☐

Patient's name: ...............................................................

## 4. Add New Spouse/Partner/Dependants to Membership

Spouse/Partner

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

Relationship to Main Member

Partner Authority-do you authorise your spouse/partner as named above to operate this membership? No ☐ Yes ☐

Please note:
Family Cover: Dependants are covered up to the age of 25.
Extended Cover: Dependants are covered up to the age of 31.
Disability Cover: Dependants are covered over the age of 31 where applicable criteria is met.

Dependant 1

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

Relationship to Main Member

NDIS Number Expiry / /


Westfund Head Office 59 Read Ave, Lithgow NSW 2790. PO Box 235, Lithgow NSW 2790. Phone: 1300 937 838 Email enquiries@westfund.com.au
Westfund Limited ABN 55 002 080 864.

## Dependant 2

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

Relationship to Main Member

NDIS Number Expiry / /

## Dependant 3

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

Relationship to Main Member

NDIS Number Expiry / /

## Dependant 4

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

Relationship to Main Member

NDIS Number Expiry / /

Lifetime Health Cover

Has the new member listed on this Change of Membership Details form had private hospital insurance cover since Ist of July 2000.

☐ Yes ☐ No

Pre-Existing Ailments & Conditions

Under the rules of Westfund, new applicants, those transferring from another fund and those upgrading their level of cover are subject to the pre-existing ailments and conditions rule.

A pre-existing ailment or condition is one that presents signs or symptoms which are considered to be in existence at any time during the 6 months preceding the day on which the member joins Westfund or upgrades level of Westfund cover. This may also include signs and symptoms not previously diagnosed by a medical officer.

A 12 month waiting period applies (or balance if a waiting period is already being served)to pre-existing ailments/conditions.

A medical practitioner appointed by Westfund will determine if an ailment/condition is pre-existing.

## 5. Change of Name

Member's Current Name

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given Names

Member's New Name

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given Names

Date of Birth / / Male ☐ Female ☐

DAY MONTH YEAR

A copy of your marriage certificate, official name change document or drivers license must be attached to this form to update your membership. If the change of name is for the primary member then a new Australian Government Rebate on Private Health Insurance form will need to be completed.

## 6. Remove Person from Membership

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given

Also known as

To remove this person from the membership, please provide their current address and contact number. Westfund must advise the person of the termination from this membership. Only the primary member or a Spouse/Partner with authority can remove a dependant from a membership.

Home address

State Postcode

Contact Number

Effective Date / /

## 7. Notification of Deceased Member

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐

Surname

Given Names

Also known as

Date Member Deceased / /

DAY MONTH YEAR

## 8. Withdrawal from the Australian Government Rebate on Private Health Insurance

☐ I/We no longer wish to receive the Australian Government Rebate on Private Health Insurance as a reduced premium.

Effective Date

/ /

DAY MONTH YEAR

## 9. Notification of New Medicare Card Details

Medicare number

Medicare card valid to: /

Medicare Reference No.

## 10. Previous Fund Transfer Details

If you are transferring from or have been a member of another health fund, please complete the information below and Westfund will cancel your existing health find membership for you. If you have a direct debit arrangement with your existing health fund, please remember to advise your existing health fund to cancel your deductions. Alternatively if you have a payroll arrangement, you should notify your paymaster to cease deductions.

| | |
|---|---|
| Name of existing fund | |
| Membership number | |
| Member's full name | |
| Date of Birth | / / |
| Date joined | / / |
| Date paid to | / / |
| Date of cancellation | / / |

*Note - the details of the above person must bear legal responsibility for the membership with the existing health fund.*

I hereby authorise Westfund to terminate my membership with your organisation and /or obtain personal details in relation to my membership, as indicated above. Please urgently refund any contributions paid in advance to the undersigned.

X Date / /

## 11. Declaration

The information supplied by me is true and correct and I have not withheld any material, information or circumstances which should be properly disclosed. Under the rules of Westfund Ltd, benefits are not payable and if paid may be recovered where false or inaccurate information is contained in the application or supplementary form.

Westfund will keep you informed about new products and services from all of their companies, which Westfund considers of potential benefit to you and your family.

If you do not wish us to communicate this information to you, please tick this box ☐

In the case of photocopies, faxes and emailed forms, original documents must be retained by you, the member, for a minimum of 24 months. Westfund may request to sight the original document during this time.

I am fully aware that if I grant my Spouse/Partner authority they will have full capacity to operate all aspects of the membership. However this authority may be revoked at any time (by written or recorded confirmation) by the primary member.

| Signature of Primary Member | Date |
|---|---|
| X | / / |