

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.

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

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	<input type="text"/>
Work	<input type="text"/>
Mobile	<input type="text"/>
Fax	<input type="text"/>

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 | <input type="checkbox"/> | Family Extended* | <input type="checkbox"/> |
| Couple | <input type="checkbox"/> | Sole Parent Family Extended* | <input type="checkbox"/> |
| Family | <input type="checkbox"/> | Family Disability Dependant** | <input type="checkbox"/> |
| Sole Parent Family | <input type="checkbox"/> | Sole Parent Disability Dependant** | <input type="checkbox"/> |

* 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)

 / /

3. Level of Cover

DAY MONTH YEAR

Hospital - Gold Ultimate Hospital is only available when packaged with an extras policy

- | | | | |
|--|--------------------------|----------------|--------------------------|
| Gold Ultimate (\$500 & \$750 Excess Only) | <input type="checkbox"/> | Excess Options | |
| Silver Plus Assure (Nil, \$250, \$500 & \$750 Excess Only) | <input type="checkbox"/> | Nil | <input type="checkbox"/> |
| Silver (\$250, \$500 & \$750 Excess Only) | <input type="checkbox"/> | \$250 | <input type="checkbox"/> |
| Bronze Plus (\$500 & \$750 Excess Only) | <input type="checkbox"/> | \$500 | <input type="checkbox"/> |
| Basic (\$750 Excess Only) | <input type="checkbox"/> | \$750 | <input type="checkbox"/> |

Extras - Mid Extras is only available when packaged with a hospital policy

- | | | | | | |
|-----------------|--------------------------|----------------------|--------------------------|----------------|--------------------------|
| Ultimate Extras | <input type="checkbox"/> | High Extras Over 50s | <input type="checkbox"/> | Choice Extras | <input type="checkbox"/> |
| High Extras | <input type="checkbox"/> | Mid Extras | <input type="checkbox"/> | Starter Extras | <input type="checkbox"/> |

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 / /

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 1st 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 spousal 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 fund 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	<input type="text"/>	
Membership number	<input type="text"/>	<input type="text"/>
Member's full name	<input type="text"/>	
Date of Birth	<input type="text"/>	<input type="text"/>
Date joined	<input type="text"/>	<input type="text"/>
Date paid to	<input type="text"/>	<input type="text"/>
Date of cancellation	<input type="text"/>	<input type="text"/>

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.

<input type="text"/>	Date	<input type="text"/>	<input type="text"/>
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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 spousal 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

<input type="text"/>	<input type="text"/>
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