Police Health

EMERGENCY SERVICES HEALTH

COVER LIKE NO OTHER

APPLICATION & VARIATION FORM

A Members Health Fund

Application and Variation Form

This Application and Variation form will help make sure we get all the information we need to best take care of your health insurance needs. With this form you can:

- Sign up as a new member
- Modify your listed dependents
- Change your level of cover
- Update your payment details

To complete this form, please:

- Use a blue or black pen
- Write in block or capital letters
- Tick (don't cross) inside the boxes

Alternatively, you can complete a digital version of this form by downloading it at the respective website policehealth.com.au or eshealth.com.au.

Once you've completed this form, please submit it to us via post or email.

Email	Police Health **joinus@policehealth.com.au** Emergency Services Health **joinus@eshealth.com.au**
Post	**PO Box Reply Paid** **6111 Halifax Street** **Adelaide SA 5000**
Phone	Police Health **1800 603 603** Emergency Services Health **1300 703 703**
Contact Hours	**Monday, Wednesday - Friday** **8.00am - 6.00pm (SA Time)** **Tuesday 9.30am - 6.00pm (SA Time)**

If you have any questions, please get in touch. **We're here to help.**

REASON FOR APPLICATION / VARIATION | Tick which applies:

Date effective from ☐☐ / ☐☐ / ☐☐

- ☐ **New member** Complete all sections
- ☐ **Change of cover** Complete sections 2, 3 & 10
- ☐ **Add/delete dependents** Complete sections 3, 4 & 10
- ☐ **Payment Changes** Complete sections 3, 5, 6, 7, 8 & 10

1. ELIGIBILITY TO JOIN | Nominate which fund you are joining:

☐ **Police Health** ☐ **Emergency Services Health**

I am:

- ☐ The eligible person
- ☐ A partner/former partner of the eligible person
- ☐ A family member* of the eligible person
  If family member, please detail your relationship below:

* Eligible Family Members:

- Dependent Child
- Adult Child
- Adult Child's Partner/Spouse
- Adult Child's Dependent Child
- Sibling
- Sibling's Partner/Spouse
- Sibling's Dependent Child
- Parent
- Grandchild
- Grandchild's Partner/Spouse
- Grandchild's Dependent Child

Police Health

PLEASE COMPLETE IF YOU HAVE NOMINATED TO JOIN POLICE HEALTH

Choose the option that best relates to the eligible person:

☐ Currently or previously employed/volunteering by a State, Territory or Federal police department/service or association/union

Name of police department/service/association/union:

☐ Covered by a Police Health policy at anytime before 12 October 2007

Name of Policy Holder/Membership no. if known:

☐ An employee of Police Health or an approved contractor

Name of employee or approved contractor:

☐ A current police recruit enrolled in a State, Territory or Federal police academy

Name of organisation:

Emergency Services Health

PLEASE COMPLETE IF YOU HAVE NOMINATED TO JOIN EMERGENCY SERVICES HEALTH

Choose the option that best relates to the eligible person:

☐ Fire Response & Recovery Sector

Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Fire Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the Fire and Response & Recovery Sector.

☐ Ambulance & Medical Response & Recovery Sector

Currently or previously employed/volunteering (a) for a Not-for profit, Commercial, or a National, State or Territory Government Ambulance Department/Service or Association/Union or (b) for a Not-for-profit, Commercial, or a National, State or Territory Government Recognised Hospital Service or Association/Union or (c) in a medical, nursing or allied health capacity and is registered with the Australian Health Practitioners Regulation Agency (AHPRA), or currently or previously employed by such a person or related organisation or (d) for a registered training organisation and/or specialist emergency service equipment supplier in the Ambulance & Medical Response & Recovery Sector.

☐ Water Response & Recovery Sector

Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Life Saving or Sea Rescue Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the Water Response & Recovery Sector.

☐ State Emergency Response & Recovery Sector

Currently or previously employed/volunteering (a) for a Not-for-profit, Commercial, or a National, State or Territory Government Emergency Services Department/Service or Association/Union or (b) for a registered training organisation and/or specialist emergency service equipment supplier in the State Emergency Response & Recovery Sector.

Name of organisation:

2. HEALTH COVER REQUIRED

- ☐ Single
- ☐ Single Parent Family
- ☐ Family/Couple
- ☐ Gold Hospital ONLY
- ☐ Rolling Extras ONLY
- ☐ Gold Combined Combined Gold Hospital and Rolling Extras

Note: If your Family or Single Parent Family policy will include non-student children (aged 21 and over but under 25) and/or children registered with us as a dependent person with a disability, the only available option is Gold Combined.

3. YOUR DETAILS (CONTRIBUTOR)

Title | First and middle names | Existing membership number (if applicable)

Surname

Email

Communication preference Our primary communication is through email. If you'd prefer to receive your information by post, please tick this box. ☐

Home phone | Work phone | Mobile

Residential address line 1

Residential address line 2 | State | Postcode

Postal address line 1 (if different from residential address)

Postal address line 2 | State | Postcode

Date of birth ☐☐ / ☐☐ / ☐☐

Gender ☐ Male ☐ Female

Partner/Spouse authority (if applicable) If you wish to give your partner (as listed overleaf on this form) authority to operate this membership please tick this box.* ☐

*Please acknowledge that your spouse/partner has rights under your membership such as viewing information, making claims and adding dependents. If you tick this box you give them full authority to act as you in making policy changes, however they will not be able to cancel the policy or remove you from the policy. You also acknowledge that you remain responsible for your membership and for the actions of the authorised person, that authorisation is given at your own risk and that you will have no recourse against Police Health Limited for any acts or omissions by the authorised person. This authority will remain in place until you contact us to revoke it. To authorise someone other than your partner, please contact us.

Previous Health Fund (if applicable) | Please cancel my previous cover from: ☐☐ / ☐☐ / ☐☐ | Previous membership number

3. YOUR DETAILS (CONTRIBUTOR) CONT.

All Australian registered health insurers are required to issue you with a Transfer Certificate when you cancel your health cover with them. When you transfer from another insurer you'll be able to access the same or equivalent level of benefits once we receive a Transfer Certificate that tells us what you were covered for with your previous insurer. By completing this section you authorise us to terminate your cover and receive your Transfer Certificate on your behalf.

I authorise Police Health Limited to terminate my health cover with my previous insurer (if still current) from the cancellation date and obtain details about my health cover, including my Lifetime Health Cover (LHC) certified age of entry held with previous fund. I authorise and request my previous insurer to issue a Transfer Certificate to Police Health Limited. Please urgently refund any excess premiums owing to the undersigned. Please do not contact me further about this request.

Signature Date / /

4. PROVIDE DETAILS OF ALL PEOPLE COVERED BY THE POLICY (DO NOT INCLUDE YOURSELF)

Partner/Spouse Details (if applicable)

Title First and middle names

Surname

Residential address line 1

Residential address line 2 State Postcode

Postal address line 1 (if different from residential address)

Postal address line 2 State Postcode

Home phone Work phone Mobile

Email

Communication preference Our primary communication is through email. If you'd prefer to receive your information by post, please tick this box. ☐

Date of birth / / Gender ☐ Male ☐ Female

Previous Health Fund (if applicable) Please cancel my previous cover from: / / Previous membership number

I authorise Police Health Limited to terminate my health cover with my previous insurer (if still current) from the cancellation date and obtain details about my health cover, including my Lifetime Health Cover (LHC) certified age of entry held with previous fund. I authorise and request my previous insurer to issue a Transfer Certificate to Police Health Limited. Please urgently refund any excess premiums owing to the undersigned. Please do not contact me further about this request.

Signature of Spouse/Partner Date / /

Additional Family Member Details (if applicable) – DEPENDENT PERSONS who are children of the Contributor/Spouse/Partner

CHILD 1

First and middle names Date of birth / /

Surname Gender ☐ Male ☐ Female

Relationship Previous Health Fund (if applicable) Previous membership number

The child is a dependent person who is:

- ☐ Under the age of 21 years
- ☐ A dependent student aged between 21 and 31 years (inclusive)
- ☐ A dependent non-student aged between 21 and 24 (inclusive)
- ☐ A dependent person with a disability (aged over 18 years and does not meet any of the other dependent person types)

Is the child married or in a defacto relationship? ☐ Yes ☐ No

Note: Other than for a dependent person with a disability, a child who is married or in a defacto relationship will require their own membership

Complete if applying for Child 1 as a dependent student aged between 21 and 31 (inclusive)

School, college or university being attended on a full-time basis Date commences as full-time student / /

Note: Student declaration is for the current calendar year only. A new application to register student dependents must be lodged by the 1st of March each year, we will forward you a request each year.

Complete if applying for Child 1 as a dependent person with a disability (participates in the National Disability Insurance Scheme (NDIS) and holds a NDIS plan)

Plan commencement date / / Plan cease date (if available): / /

Evidence of an active NDIS plan will need to be provided to Police Health within 14 days of application

CHILD 2

First and middle names Date of birth / /

Surname Gender ☐ Male ☐ Female

Relationship Previous Health Fund (if applicable) Previous membership number

The child is a dependent person who is:

- ☐ Under the age of 21 years
- ☐ A dependent student aged between 21 and 31 years (inclusive)
- ☐ A dependent non-student aged between 21 and 24 (inclusive)
- ☐ A dependent person with a disability (aged over 18 years and does not meet any of the other dependent person types)

Is the child married or in a defacto relationship? ☐ Yes ☐ No

Note: Other than for a dependent person with a disability, a child who is married or in a defacto relationship will require their own membership

Additional Family Member Details (if applicable) – DEPENDENT PERSONS who are children of the Contributor/Spouse/Partner

CHILD 2 (CONTINUED)

Complete if applying for Child 2 as a dependent student aged between 21 and 31 (inclusive)

School, college or university being attended on a full-time basis

Date commences as full-time student

/ /

Note: Student declaration is for the current calendar year only. A new application to register student dependents must be lodged by the 1st of March each year, we will forward you a request each year.

Complete if applying for Child 2 as a dependent person with a disability (participates in the National Disability Insurance Scheme (NDIS) and holds a NDIS plan)

Plan commencement date / /

Plan cease date (if available): / /

CHILD 3

First and middle names

Date of birth / /

Surname

Gender ☐ Male ☐ Female

Relationship

Previous Health Fund (if applicable)

Previous membership number

The child is a dependent person who is:

- ☐ Under the age of 21 years
- ☐ A dependent student aged between 21 and 31 years (inclusive)
- ☐ A dependent non-student aged between 21 and 24 (inclusive)
- ☐ A dependent person with a disability (aged over 18 years and does not meet any of the other dependent person types)

Is the child married or in a defacto relationship? ☐ Yes ☐ No

Note: Other than for a dependent person with a disability, a child who is married or in a defacto relationship will require their own membership

Complete if applying for Child 3 as a dependent student aged between 21 and 31 (inclusive)

School, college or university being attended on a full-time basis

Date commences as full-time student

/ /

Note: Student declaration is for the current calendar year only. A new application to register student dependents must be lodged by the 1st of March each year, we will forward you a request each year.

Complete if applying for Child 3 as a dependent person with a disability (participates in the National Disability Insurance Scheme (NDIS) and holds a NDIS plan)

Plan commencement date / /

Plan cease date (if available): / /

Evidence of an active NDIS plan will need to be provided to Police Health within 14 days of application

5. APPLICATION TO RECEIVE THE AUSTRALIAN GOVERNMENT REBATE ON PRIVATE HEALTH INSURANCE

Your information may be provided to the Australian Government Services Australia. Services Australia uses this information for administering the Australian Government Rebate on private health insurance as a reduced premium. The collection of this information is permitted by the Privacy Act 1988. Services Australia may disclose this information to other Commonwealth departments or agencies, anyone who you have agreed to have your information or other parties where the release is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which Services Australia will manage your personal information, including its privacy policy, at servicesaustralia.gov.au/privacy.

Privacy and your personal information
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**

Are all people on the policy eligible for Medicare? ☐ Yes ☐ No

Your name as it appears on your Medicare card

Your Medicare card no. Reference no. Medicare card valid to / /

Are you covered by the policy? ☐ Yes ☐ No

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 Services Australia Service Centre or by calling 132 011.
Note: Call charges apply – calls from mobile phones may be charged at a higher rate.

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.

Income Tier:

☐ Base Tier (Full Rebate) ☐ Tier 1 ☐ Tier 2 ☐ Tier 3 (No Rebate) Date to commence Rebate / /

Household Income	Base Tier	Tier 1	Tier 2	Tier 3
Singles	$101,000 or less	$101,001 to $118,000	$118,001 to $158,000	$158,001 or more
Family/Couples*	$202,000 or less	$202,001 to $236,000	$236,001 to $316,000	$316,001 or more

* Income thresholds increase by $1,500 for every child after the first.

Please refer to the State Premiums & Benefits Guide for more information.

Declaration Note

Do you declare that the information that you have provided is complete and correct? ☐ Yes ☐ No

Do you understand that giving false or misleading information is a serious offence? ☐ Yes ☐ No

Signature Date / /

6. PAYMENT OPTIONS

☐ Direct Debit: ☐ Fortnightly ☐ Monthly

I would like the first monthly direct debit to occur on or after: / /

Monthly deductions must occur between the 1st and the 27th of each month. Refer to the Direct Debit Service Agreement available on the respective fund website for more information.

☐ Renewal Notice:

Please send my renewal notice: ☐ Quarterly ☐ Half-Yearly ☐ Yearly

7. DIRECT DEBIT REQUEST

Please complete your account details and sign for direct debit deductions.

Financial Institution

Account name BSB - Account number

7. DIRECT DEBIT REQUEST CONT.

I request and authorise Police Health Limited, user ID 049196, to arrange, through its own financial institution, a debit to my nominated account any amount Police Health Limited has deemed payable by myself. This debit or charge will be made through Bulk Electronic Clearing System (BECS) from my account held at the financial institution nominated previously and will be subject to the terms and conditions of the Direct Debit Service Agreement available on the respective fund website policehealth.com.au or eshealth.com.au

Signature Date / /

8. ACCOUNT TO PAY CLAIMS INTO

Please complete your account details and sign for direct credit transactions if your account details are different and/or you have left section 7 blank.

☐ Where applicable, please pay to my nominated bank account when paying benefits.

Note: If your partner/spouse wishes to register their own bank account details for their claims please complete the *Registering Partner's Details Form* on our website.

Financial Institution

Account name BSB - Account number

Account Holder Signature Date / /

9. COMMUNICATION

Membership Correspondence: We will communicate with you and other insured persons, if any, about the membership and any transactions undertaken.

News and Marketing Communications: I/We agree to Police Health Limited using my/our personal information (including sensitive information) to provide me/us with information on products and services, and relevant promotions and offers (whether provided by Police Health Limited or other parties). I/We also agree to Police Health Limited providing me and/or other insured persons with newsletters, updates and general product information.

☐ Yes ☐ No

10. DECLARATION

I declare that:

- The statements in this application are true and complete and I agree to be bound by the Rules of the Fund. I acknowledge that this application form and the Health Fund brochure do not contain all the Rules of Police Health Limited and I understand the pre-existing condition rule and other waiting periods.
- Police Health Limited has made me aware of the Privacy Policy and its availability to me, and I have made, or will make, other people on the application aware of the Policy's availability.
- I acknowledge, where practicable, information is provided with the consent of the individual to whom it relates and I confirm I have the authority to act on behalf of other persons named in this Application Form.
- I (and on behalf of the other persons) consent to the use and disclosure of my (or our) personal information, including health information, in accordance with the Privacy Policy, and note that personal information about a person insured on the health insurance policy may be disclosed to other people insured under the same health insurance policy.
- I (and on behalf of the other persons) authorise Police Health Limited to collect and authorise any third party to supply from time to time full and complete details of all or any information necessary to the assessment of any claim or any operation of the health insurance policy.
- I (and on behalf of the other persons) acknowledge that, from time to time, Police Health may request information or evidence of a person's eligibility to be insured under the policy or confirm their classification of registration, and I (and on behalf of the other persons) agree to providing the requested information or evidence.

Signature Date / /

Your Privacy: Police Health Limited is committed to protecting all personal information entrusted to us. Police Health Limited ensures all personal information that we collect is treated and stored confidentially. For further information see our Privacy Policy at **the respective fund websites policehealth.com.au or eshealth.com.au.**

Police Health EMERGENCY SERVICES HEALTH

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Privacy Notice

In this Privacy Notice, reference to "we", "us" or "our" is reference to Police Health Limited (ABN 86 135 221 519), the registered not for profit, restricted access private health insurer, including the brands Police Health and Emergency Services Health. Reference to "you" or "your" is reference to a customer or a person insured under a private health insurance policy.

Like all health insurers, we are required to collect personal information.

We respect your privacy and treat this information confidentially and store it securely.

Personal information is collected and managed by us in accordance with our Privacy Policy (available at the respective websites policehealth.com.au or eshealth.com.au) and the Australian Privacy Principles. You should read and be familiar with the Privacy Policy, and ensure that other persons that are covered by your health insurance policy also read and are aware of the Privacy Policy. This Notice contains a summary of some important issues, but the Privacy Policy has more detail.

We will collect personal information from you, a responsible person, or a third party, either directly or indirectly, when:

- You apply for membership with us to purchase a health insurance policy, and if accepted, you are the policy holder (Contributor) of the policy.
- You are a dependent (spouse or child) of a Contributor and the Contributor holds or has applied to purchase a health insurance policy which covers you.
- A claim for benefit is made on your health insurance or when dealing with us through one of our communication channels.

Personal information collected includes names, addresses, ages, bank account details, telephone numbers, email addresses and sensitive (health) information.

You should be aware that once you have been accepted by us and you are insured under a health insurance policy, we will collect personal information on a recurring basis for the duration of your health insurance policy. It is necessary for us to collect your personal information when you or a responsible person on your behalf interact with us, especially when making a claim for health treatment either by post, facsimile, through electronic channels or through a third party such as a hospital, medical practitioner or other service provider who may claim directly from us on your behalf.

Collection and disclosure of your personal information is required by us, and is permitted under the Private Health Insurance Act 2007 and the Australian Privacy Principles. We collect personal information for the purposes described in the Privacy Policy and, in particular to manage the health insurance and health-related services we provide.

If we do not receive the necessary information or the information is not accurate or complete, then we will not be able to provide you with our services, including:

- Processing your application for a health insurance policy and insuring you or other people on the health insurance policy.
- Providing services associated with billing and claiming of benefits.
- Effectively dealing with your enquiries, issues or complaints.
- Providing you with other benefits and services in relation to your health insurance cover.

Personal information may also be used in advising you of direct marketing offers such as products or services provided by us, or in conjunction with other organisations, which we consider may be of interest to our members.

We may need to disclose personal information to other people insured under the same health insurance policy, government agencies, other health insurers, organisations or individuals with whom we contract for services, health service providers, financial institutions and your employer. We are not likely to disclose personal information to overseas recipients.

The Privacy Policy contains further information on how you may:

- Have reasonable access to and seek correction of your personal information;
- Complain to us about a breach of the Australian Privacy Principles and how we will deal with such a complaint.

Our contact details may be found on our forms, brochures and websites.

The policy holder (Contributor) or another insured person must only provide personal information relating to other people on the policy if authorised to do so.

It is important that all persons (currently insured, or who become insured, or considering joining us) are aware of and understand this Notice and our Privacy Policy. It is the responsibility of the policy holder (Contributor) to ensure that every other person covered under the policy is aware of this Notice and the Privacy Policy. Other people on the policy should be made aware that the policy holder (Contributor) receives and can view through our On-line Member Services (OMS) all information relating to their claims for benefits and hence the policy holder (Contributor) has access to their health information, unless an individual has requested their claims information be kept private in which case claims information will not be shown on OMS.

If any insured person aged 18 years or older wishes to ensure that their personal information is not disclosed to other people on the policy, they should purchase their own health insurance policy.

A copy of our Privacy Policy can be obtained from the respective websites policehealth.com.au or eshealth.com.au or by contacting our office. The Australian Privacy Principles, and information about privacy, are available from the website of the Office of the Australian Information Commissioner at www.oiac.gov.au.

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Call	**1800 603 603**	**1300 703 703**
Email	**joinus@policehealth.com.au**	**joinus@eshealth.com.au**
Web	**policehealth.com.au**	**eshealth.com.au**
Post	**PO Box Reply Paid 6111 Halifax Street, Adelaide SA 5000**	

Police Health Limited ABN 86 135 221 519 A registered not-for-profit, restricted access private health insurer.
Effective 1 July 2025