

APPLICATION FORM

PHOENIX HEALTH FUND LIMITED ABN: 93 000 124 863

PO Box 156, NEWCASTLE NSW 2300 Ph: (02) 4935 5738 or (02) 4935 5741 Freecall: 1800 028 817 Fax: (02) 4968 2229

Email: enquiries@phoenixhealthfund.com.au Web: phoenixhealthfund.com.au

1. This Application is to: *(Tick appropriate box)*

Join Phoenix Health Fund

Add/Change Dependant.....

Change My Cover

Phoenix Member Number *(if currently a member)*.....

Transfer from Another Fund *(complete attached transfer form)*

Previous fund name

Previous fund phone

Previous fund member number

Previous fund Paid-to-date

2. Please use BLOCK LETTERS

Title	Surname	First Name
Second Name	Date of Birth	M/F
Home Address – Number & Street		
Suburb & State	Postcode	
Postal Address <i>(if different from above)</i>		
Suburb & State	Postcode	
Ph: Home	Ph: Work	Ph: Mobile
Email Address		

3. Dependants – Please use BLOCK LETTERS (Advise in writing of additional dependants)

Family Name	Given Names	Relationship	Date of Birth	M/F	Where student dependant is 21 years or over, state name of School/College/Uni
1.					
2.					
3.					
4.					
5.					

4. Type of Cover *Please select all products required*

<input type="checkbox"/> Family or <input type="checkbox"/> Single	Amount:	Freq:
<input type="checkbox"/> Public Hospital	\$	
Or <input type="checkbox"/> Top Hospital	\$	
And/Or <input type="checkbox"/> Ancillary	\$	
<input type="checkbox"/> Single Parent Family Top Cover	\$	
TOTAL	\$	

5. Payment Method *(Tick one)*

Monthly Direct Debit *(Please complete form)*

Quarterly Account *(by Cheque, Credit Card or BPay)*

Payroll Deductions *(OneSteel & Associated Companies Only)*

Company/Division Details

Company Name:

Company Address:

.....

Payroll Number:.....

Pay Frequency: Weekly Fortnightly Monthly

6. Member Eligibility *Specify Reasons for Eligibility*

Current Employee of:

Former Employee of:

Immediate Family Member of current/former employee

Employee's Name:

7. Declaration

- I declare that these statements are true and complete and agree to be bound by the rules of Phoenix Health Fund Ltd and the determinations of the Board.
- I have read and understand the rules relating to WAITING PERIODS and PRE-EXISTING CONDITIONS / AILMENTS and understand the Fund may refuse payment of benefits if any of the details supplied herein are false in any respect.
- I authorise the deduction from my wages of contributions for the table nominated, as may be varied from time to time. Where payroll deductions are not available I agree to pay contributions in advance, until membership is cancelled by me in writing.
- I agree to make any changes to my payment method in writing.
- I consent to collection by the fund of the information in this form and other personal and health information required to be collected in connection with the policy, and consent to its use and disclosure by the fund in connection with the policy.
- I have read and understood the terms and conditions of my Phoenix Health Fund policy.

Signature of Applicant.....

Joining Date.....
or Date change effective

for OFFICE USE ONLY

No. Cov	Scale	Grp	Serve Qual?
Date Join	Date Paid to	T.P.T.	