health cover for the whole of your life

rt health

Please make sure you've answered each question and signed the form before sending it to us.

Complete this form to join rt health

Join in your own right

You are eligible to join in your own right if you are currently, or have ever been, any of the below. Please tick the appropriate box and provide details of the organisation.

- ☐ 1) An employee of a government or privately operated land, sea or air transport company
  Name of organisation
- ☐ 2) An employee of a government entity charged with administering the land, sea or air transport industries
  Name of organisation
- ☐ 3) An employee of a government or privately operated energy generation and delivery entity including supply of electricity, gas, oil, petrol, coal, nuclear or renewable energy
  Name of organisation
- ☐ 4) An employee of a contract company where you are, or were, employed to provide services to an organisation described in 1, 2 or 3 above
  Name of organisation
- ☐ 5) A current or former member of Railways Credit Union Limited (now known as MOVE)

Join through a family relationship

You are eligible to join if you are related to someone who is eligible to join, or who is already a member. Please tick the box which best describes your relationship to that person, and write the name of the organisation for which they currently (or used to) work.

- ☐ Parent
- ☐ Brother or sister
- ☐ Brother or sister-in-law
- ☐ Partner / former partner (spouse or de facto)
- ☐ Child (natural, adopted, step child or foster child)
- ☐ Son or daughter-in-law
- ☐ Grandchild

Name of organisation your family member worked for:

Are you a current member of a Transport or Energy Industry union? (which one)

May we ask how you heard about us?

- ☐ Friend or family member
- ☐ Received information in the workplace
- ☐ Visited the website
- ☐ Internet search
- ☐ Met a relationship manager
- ☐ Saw an advertisement

Other

Let's get your details (please use capital letters)

The main member

If you're taking a couples or family membership, we need one person to be nominated as the 'main member.' All mail from us will be addressed to the main member, and he or she will be the only person who can suspend or cancel the membership. If your partner / spouse is also going to be covered by this membership, you can grant them authority to jointly manage the membership by ticking 'yes' to the 'partner authority' question over the page.

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss (other)

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy)

Home address (must be a residential address, not a PO box)

State

Postcode

rt health

Postal address (if different to your home address)

State

Home telephone number

Mobile telephone number

Work telephone number

Email address

How would you like to pay? (please tick one)

☐ **Direct debit**
Please complete direct debit form enclosed.

☐ **Salary deduction**
Please complete salary deduction form enclosed.
Please check with us or with your employer to make sure there is a salary deduction plan in place before choosing this option.

☐ **Billing frequency (please tick one option)**
☐ Monthly ☐ Half-yearly
☐ Quarterly ☐ Yearly

Who would you like to cover?

☐ Family ☐ Sole-parent family ☐ Couple ☐ Single

Who else is going to be covered?

Your partner / spouse

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss (other)

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy)

Postal address (if different to your home address)

State

Postcode

Would you like to give your partner / spouse authority to make changes to the membership and sign claim forms? ☐ Yes ☐ No

If you tick 'yes', the only thing your partner / spouse will not be able to do is to suspend or cancel the membership – that can only be done by the main member.

Your children (dependants)

The natural, adopted or foster children of either adult named on the membership can be covered under a family or sole-parent family membership up until the age of 21.

Children aged between 21 and 25 who are not married or living in a de facto relationship, and who are full-time students (at an approved Australian school, college or university) can be covered under a family or sole-parent family membership at no additional cost. Please note, part-time students and apprentices are not eligible for cover as student dependants.

Children aged between 21 and 25 who are not full-time students can be covered under a family or sole-parent family membership for a small additional fee, provided you choose our Gold Premium Hospital cover product.

Given names

Gender ☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy)

☐ Under the age of 21 ☐ Student between 21 and 25 ☐ Non-student between 21 and 25

Name of school, college or university (for students aged between 21 and 25)

Given names

Gender
☐ Male ☐ Female

Family name

Date of birth (dd/mm/yy)

☐ Under the age of 21 ☐ Student between 21 and 25 ☐ Non-student between 21 and 25

Name of school, college or university (for students aged between 21 and 25)

PLEASE NOTE: If you have more than two dependent children, please attach details on a separate sheet.

Which one of our covers would you like?

Choose your hospital cover:	Choose your hospital cover excess:	Choose your extras cover:
☐ Gold Premium Hospital	☐ $250 excess ☐ $500 excess ☐ $750 excess	☐ Premium Extras
☐ Silver Plus Smart Hospital No Pregnancy	☐ $500 excess ☐ $750 excess	☐ Smart Extras
☐ Bronze Plus Step Up Hospital	☐ $350 excess ☐ $700 excess	☐ Value Extras
☐ Bronze Plus First Start Hospital	☐ $350 excess ☐ $700 excess	
☐ Basic Plus Public Hospital		
☐ Ambulance only		

When would you like your cover to begin?

(dd/mm/yy)

Government programs

Lifetime Health Cover

Only answer this question if you and / or your partner / spouse are over the age of 31.
Have you held continuous private hospital cover since July 2000?

You ☐ Yes ☐ No If no, what is your Lifetime Health Cover loading ☐☐ % ☐ Don't know

Your partner / spouse ☐ Yes ☐ No If no, what is your Lifetime Health Cover loading ☐☐ % ☐ Don't know

Have you received an exemption from the Commonwealth Department of Health and Ageing? (NSW and ACT only)

You ☐ Yes ☐ No
Your partner / spouse ☐ Yes ☐ No

If yes, please include a copy of the exemption letter with your application.

Do you hold a Commonwealth Concession Card? (NSW and ACT only)

You ☐ Yes ☐ No Concession Card number

Your partner / spouse ☐ Yes ☐ No Concession Card number

(If you are applying for pension rates, please ensure that your Commonwealth Concession Card covers you for ambulance.)

Application to receive the Australian Government Rebate on Private Health Insurance as a reduced premium

Are all the people on the private health insurance fund policy listed on a Medicare card or entitled to a Medicare card?

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

For more information about eligibility for Medicare, go to www.humanservices.gov.au/customer/services/medicare/medicare-card

☐ No

STOP

Individuals not eligible for Medicare cannot receive the Private Health Insurance rebate as a reduced premium. Do not progress with this application.

☐ Yes

Applicant's details

Name of private health insurance fund

Health fund membership number

Are you covered by the policy?

☐ 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.

☐ Yes

Date premium reduction to commence

Medicare card number

— —

Ref no.

Medicare card valid to:

OR

Interim or Reciprocal Health Care Agreements card valid to:

Family name (as listed on your Medicare card)

First given name (as listed on your Medicare card)

Permanent address

Postcode

Postal address (if different to above)

Postcode

Daytime phone number

Date of birth

Gender

☐ Male

☐ Female

Nominate your income tier

Policy holders must nominate the income tier they believe they are entitled to. If at any stage you want to nominate a new income tier or stop receiving the Australian Government Rebate as a reduced premium, you must notify your nominated private health insurance fund. For income tier thresholds, go to www.privatehealth.gov.au

☐ Base Tier

☐ Tier 1

☐ Tier 2

☐ Tier 3

Details of all the people covered by the policy

Provide details of all the people covered by the policy (do not include yourself)

Person 1

Family name (as listed on your/their Medicare card)

First given name (as listed on your/their Medicare card)

Date of birth

Gender

☐ Male

☐ Female

Dependent child

☐ No

☐ Yes

Person 2

Family name (as listed on your/their Medicare card)

First given name (as listed on your/their Medicare card)

Date of birth

Gender

☐ Male

☐ Female

Dependent child

☐ No

☐ Yes

Person 3

Family name (as listed on your/their Medicare card)

First given name (as listed on your/their Medicare card)

Date of birth

Gender

- Male
- Female

Dependent child

- No
- Yes

Privacy notice

The privacy and security of your personal information is important to Human Services, and is protected by law. Human Services needs to collect this information so we can process and manage your applications and payments, and provide services to you. Human Services only shares your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to www.humanservices.gov.au/privacy

Applicant's declaration

I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Main member please sign here

Declaration and signature

- I declare the information I have provided is correct and accurate. I understand that there are penalties for giving false or misleading information.
- I declare that I am authorised to act on behalf of my partner / spouse and any dependants, and provide their personal information for all purposes associated with rt health assessing this application and administering any issued policy. I will inform my partner / spouse and any dependants of the existence of the rt health privacy policy.
- I authorise my previous health fund, any medical practitioner, hospital, or health service provider to release to rt health all information regarding me, my partner / spouse or my dependants to confirm my membership and our benefit entitlements, as well as to assess any claims made by me.
- I agree to become a member of rt health if this application is accepted and be bound by its Constitution, rules and policies.

Main member please sign here

✗

Today's date / /

Complete this form if you are transferring from another health fund

Please make sure you've answered each question and signed the form before sending it to us.

This form authorises rt health to cancel your membership with your current fund and obtain a transfer certificate which provides information about your membership. If you and your partner / spouse currently have separate health cover, we require a transfer form for each of you (download additional forms from rthealth.com.au). If you have a direct debit arrangement with your current fund, please contact them directly to cancel the debits.

Your details

Title ☐ Mr ☐ Mrs ☐ Ms ☐ Miss (other)

Given names

Family name

Date of birth (dd/mm/yy)

Current health fund details

Name of health fund

Membership number

Name of the person your membership is held in (if not in your own name)

Given names | Family name | Date of birth (dd/mm/yy)

Names of other people transferring (in addition to you)

Given names | Family name | Date of birth (dd/mm/yy)

Cover being transferred

☐ Hospital cover only ☐ Extras cover only ☐ Hospital and extras cover

Cancellation date

What date would you like this cover to be cancelled from? (dd/mm/yy)

Authorisation

I / We authorise rt health fund to terminate my / our membership from the date specified and to obtain from your organisation details relating to my / our membership, and details of any claims made in the previous 12 months. I understand that rt health will not be able to finalise my membership application or process claim payments until a transfer certificate has been provided.

Current health fund's main member please sign here

✗ Today's date / /

Partner / spouse (if covered by current health fund) please sign here

✗ Today's date / /

rt health

Complete this form if you would like to pay by direct debit

Please make sure you've answered each question and signed the form before sending it to us.

- We must receive this form at least ten business days before the first debit to allow enough time for your request to be processed.
- Please be aware that paying for another person's health cover does not entitle you to obtain information about the membership or to make decisions about the membership. For this type of authority a Third Party Authority form must be completed.

Main member's details (this is the person in whose name the membership is held)

Given names

Family name

Date of birth (dd/mm/yy)

Direct debit payment arrangements

Weekly or fortnightly payments

I / We would like my / our contribution of $. to be debited

☐ Weekly ☐ Fortnightly

Weekly and fortnightly payments will be debited on Fridays.
I / We would like the first weekly / fortnightly debit to occur on Friday

Monthly/Quarterly/Half-yearly/Yearly payments

I / We would like my / our contribution of $. to be debited

☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Yearly

All other payments will be debited on the 6th of the month, or the following banking day if the 6th falls on a weekend or public holiday.

I / We would like the first debit to occur on 0 6

Complete this section if you wish to have your contributions deducted from your credit card account

(Complete the bank account details over the page if you want to set up a debit from a bank, building society or credit union account.)

Name on card

Card number

Expiry date (mm/yy)

Type of card ☐ Mastercard ☐ Visa

I (insert your name) authorise rt health fund to debit the nominated credit card account for payment of contributions and to vary the amount of the debit as required for changes to contribution rates as notified or requested.

Cardholder please sign here

Name (please print)

✗

Today's date / /

Complete this section if you wish to have your contributions deducted from your bank, building society or credit union account (Complete the credit card account details over the page if you want to set up a debit from a credit card account.)

Direct debiting is not available on all types of accounts, if you are in doubt as to whether it is available, please contact your financial institution.

If the account from which contributions are to be deducted is a joint account, please include both account holders' names below.

Given names

Family name

Given names

Family name

I / We request you, until further notice in writing, to debit my / our account any amounts which rt health (abn 93 087 648 744, user id number 018015) may debit me / us for health cover contributions through the Bulk Electronic Clearing System (BECS).

I / We understand and acknowledge that this agreement is governed by the terms of the Direct Debit Service Agreement (attached to this form) and the terms and conditions of my / our rt health membership.

I / We authorise rt health to debit the nominated account for payment of contributions and to vary the amount of the debit as necessary for changes to cover our contributions.

Name of bank, building society or credit union

BSB number –

Account number

Account name

Would you like to nominate this as the account your claim benefits are paid into?

Yes ☐ No ☐ If no, you can nominate a different account or elect to receive claim payments by cheque when you complete your first claim form.

Account holder please sign here

Name (please print)

✗

Today's date / /

Account holder please sign here

Name (please print)

✗

Today's date / /

Main member please sign here if not one of the account holders

Name (please print)

✗

Today's date / /

rt health

Direct Debit Request Service Agreement (DDR-SA)

Please copy this DDR-SA and keep for your records.

Definitions

account means the *account* held at *your financial institution* from which we are authorised to arrange for funds to be debited.

agreement means this Direct Debit Request Service Agreement between *you* and *us*.

banking day means a day other than a Saturday or a Sunday or a public or bank holiday listed throughout Australia.

debit day means the day that payment by *you* is due to *us*.

debit payment means a particular transaction where a debit is made.

direct debit request means the Direct Debit Request between *us* and *you*.

us or we means rt health *you* have authorised by signing a *direct debit request*.

you means the customer who signed the *direct debit request*.

your financial institution is the financial institution where *you* hold the *account* that *you* have authorised *us* to arrange to debit *your* contributions from.

Terms and conditions

1 Debiting

1.1 By signing a *direct debit request*, *you* have authorised *us* to arrange for funds to be debited ***from*** *your account*. *You* should refer to the *direct debit request* and this *agreement* for the terms of the arrangement between *us* and *you*.

1.2 We will only arrange for funds to be debited from *your account* as authorised in the *direct debit request*.

Or

We will only arrange for funds to be debited from *your account* if we have sent to the address nominated by *you* in the *direct debit request*, a billing advice that specifies the amount payable by *you* to *us* and when it is due.

1.3 If the *debit day* falls on a day that is not a *banking day*, we may direct *your financial institution* to debit *your account* on the following *banking day*. If you are unsure about which day *your account* has or will be debited you should ask *your financial institution*.

2 Changes by us

2.1 We may vary any details of this *agreement* or a *direct debit request* at any time by giving *you* at least twenty-one (21) days written notice.

3 Changes by you

3.1 You may change, stop or defer a *debit payment*, or terminate this *agreement* by providing us with at least twenty-one (21) days notification in writing to: rt health, PO Box 545, Strawberry Hills 2012, or arranging it through *your* own *financial institution*.

4 Your obligations

4.1 It is *your* responsibility to ensure that there are sufficient clear funds available in *your account* to allow a *debit payment* to be made in accordance with the *direct debit request*.

4.2 If there are insufficient clear funds in *your account* to meet a *debit payment*:

(a) *you* may be charged a fee and/or interest by *your financial institution*;

(b) *you* may also incur fees or charges imposed or incurred by *us*; and

(c) *you* must arrange for the *debit payment* to be made by another method or arrange for sufficient clear funds to be in *your account* by an agreed time so that we can process the *debit payment*.

4.3 *You* should check *your account* statement to verify that the amounts debited from *your account* are correct.

4.4 If railway & transport health fund ltd abn 93 087 648 744 ("rt health") is liable to pay goods and services tax ("GST") on a supply made in connection with this *agreement*, then *you* agree to pay rt health on demand an amount equal to the consideration payable for the supply multiplied by the prevailing GST rate.

5 Dispute

5.1 If *you* believe that there has been an error in debiting *your account*, *you* should notify *us* directly on 1300 886 123 and confirm that notice in writing with *us* as soon as possible so that we can resolve *your* query more quickly.

5.2 If we conclude as a result of our investigations that *your account* has been incorrectly debited we will respond to your query by arranging for *your financial institution* to adjust *your account* (including interest and charges) accordingly. We will also notify *you* in writing of the amount by which *your account* has been adjusted.

5.3 If we conclude as a result of our investigations that *your account* has not been incorrectly debited we will respond to *your* query by providing *you* with reasons and any evidence for this finding.

5.4 Any queries *you* may have about an error made in debiting *your account* should be directed to *us* in the first instance so that we can attempt to resolve the matter between *you* and *us*. If we cannot resolve the matter *you* can still refer it to *your financial institution* which will obtain details from *you* of the disputed transaction and may lodge a claim on your behalf.

6 Accounts

You should check:

(a) with *your financial institution* whether direct debiting is available from *your account* as direct debiting is not available on all accounts offered by financial institutions.

(b) your *account* details which *you* have provided to *us* are correct by checking them against a recent *account* statement; and

(c) with *your financial institution* before completing the direct debit request if *you* have any queries about how to complete the *direct debit request*.

7 Confidentiality

7.1 We will keep any information (including *your account* details) in *your direct debit request* confidential. We will make reasonable efforts to keep any such information that we have about *you* secure and to ensure that any of our employees or agents who have access to information about *you* do not make any unauthorised use, modification, reproduction or disclosure of that information.

7.2 We will only disclose information that we have about *you*:

(a) to the extent specifically required by law; or

(b) for the purposes of this agreement (including disclosing information in connection with any query or claim).

8 Notice

8.1 If you wish to notify *us* in writing about anything relating to this agreement, *you* should write to: CEO, rt health, PO Box 545, Strawberry Hills 2012.

8.2 We will notify *you* by sending a notice in the ordinary post to the address *you* have given *us* in the *direct debit request*.

8.3 Any notice will be deemed to have been received two *banking days* after it is posted.

Complete this form if you would like to pay by salary deduction

Please make sure you've answered each question and signed the form before sending it to us.

Please check with us or with your employer to make sure there is a salary deduction plan in place before choosing this option. We need to ask for your name and other contact details again here as we forward this form to your employer for their records.

Main member's details (this is the person in whose name the membership is held)

Given names

Family name

Date of birth (dd/mm/yy)

Payer's details

Given names (only complete 'names' if different from the main member)

Family name

Date of birth (dd/mm/yy)

Employer's name

Location, section or department

Employee number

Salary deduction request

Please deduct the amount of $. from my pay each ☐ week ☐ fortnight ☐ month

- There may be a payment adjustment required to cover the period of time from when your cover commences to when your first salary deduction occurs. We will contact you to advise you of this amount (if any).
- If you change to another method of payment, you will need to make a payment adjustment to begin making payments in advance (salary deduction payments are generally paid for the period just ended).
- With four weeks' notice, rt health may choose to remove the option of salary deduction from your group.

Main member please sign here (if different from the payer)

Name (please print)

✗

Today's date / /

Payer please sign here (if different from main member)

Name (please print)

✗

Today's date / /

rt health

Call 1300 56 46 46, email
join@rthealthfund.com.au
or visit rthealthfund.com.au

rt health