APPLICATION FORM

Updated 8th March 2010.

If you are an existing member please quote membership no. . . . .

PRINCIPAL MEMBER

Title. . . . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of birth. . . . . / . . . . / . . . . .

Country of citizenship. . . . .

Country of last residence. . . . .

Email. . . . .

Phone: Work . . . .

Home. . . . .

Mobile. . . . .

Address in Australia. . . . .

. . . .

State. . . . . P'code. . . . .

Sponsored by. . . . .

Sponsors address. . . . .

. . . .

Sponsors Contact Name. . . . .

Phone. . . . .

Email. . . . .

Employed by. . . . .

Employers address. . . . .

. . . .

Employers Contact Name. . . . .

Phone. . . . .

Email. . . . .

Agent e.g. Migration, Lawyer, Accountant. . . . .

Agent Contact Name. . . . .

Email. . . . .

Previous Health Fund . . . .

Previous Health Fund Last Date of Cover. . . . / . . . . / . . . .

DETAILS OF PERSONS TO BE COVERED (including dependent children under 25 years)

Title. . . . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Title. . . . . . . Surname. . . . .

Given Names. . . . .

Male/Female. . . . . Date of Birth. . . . . / . . . . / . . . . .

Country of Citizenship. . . . .

Country of Last Residence. . . . .

Occupation. . . . . Relationship to Applicant. . . . .

Aust Visa Code . . . . Visa Issued Date . . . . / . . . . / . . . . Occupation. . . . .
ie: sub class

Arrival Date in Australia . . . . / . . . . / . . . . **Start date of Plan** . . . . / . . . . . . / . . . .

All IMAN Australian Health Plan memberships are continuous until such time as the plan is cancelled.
Should you require your membership for a specified period (ie. less than 12 months) please complete end date of Plan . . . . / . . . . . . / . . . .

PLAN COSTS (inclusive of gst)

Plan Option	Monthly			Quarterly			Annually		
	Single	Couple	Family	Single	Couple	Family	Single	Couple	Family
320 Plan	$233	$466	$499	$699	$1398	$1497	$2796	$5592	$5988
390 Plan	$166	$332	$360	$498	$996	$1080	$1992	$3984	$4320
120 Plan	$83	$166	$172	$249	$498	$516	$996	$1992	$2064
190 Plan	$66	$132	$135	$198	$396	$405	$792	$1584	$1620

Choose your Plan **Choose your payment frequency**	☐ **320 Plan**			☐ **390 Plan**			☐ **120 Plan**			☐ **190 Plan**		
	Monthly ☐	Quarterly ☐	Yearly ☐	Monthly ☐	Quarterly ☐	Yearly ☐	Monthly ☐	Quarterly ☐	Yearly ☐	Monthly ☐	Quarterly ☐	Yearly ☐

Choose your Method Of Payment (Details to be completed overleaf) ☐ Direct Debit ☐ Credit Card

Plan costs are subject to change. Please refer to the 'How much does each Plan cost?' section in the Product Disclosure Statement. For more information refer to www.austhealth.com.

CREDIT CARD DETAILS

☐ **I authorise IMAN/AHP to charge my Credit Card for my Plan payments. I understand that Plan costs may change, and that IMAN/AHP will give me 30 days notice of any change in my Plan payments.**

☐ MasterCard ☐ Visa ☐ AMEX

Card number: |_|_|_|_| |_|_|_|_| |_|_|_|_| |_|_|_|_|

Expiry Date: |_|_| |_|_|

Name on Credit Card . . . .

Cardholders Signature. . . . .

If paying on behalf of the applicant, please provide

Company Name. . . . .

Phone No . . . .

Email Address. . . . .

REQUEST AND AUTHORITY TO DEBIT THE ACCOUNT NAMED BELOW TO PAY IMAN INTERNATIONAL PTY. LTD

Please refer to the Direct Debit Request Service Agreement, found on our website:- www.austhealth.com

Request and Authority to debit	Surname or company name. . . . . Given names or ACN/ABN. . . . . (“you”) Request and authorise IMAN International Pty. Ltd. (135990) to arrange for any amount IMAN International Pty. Ltd. may debit or charge you to be debited through the Bulk Electronic Clearing System from an account held at the financial institution identified below subject to the terms and conditions of the Direct Debit Request Service Agreement (and any further instructions provided below).
Insert the name and address of financial institution at which your account is held	Financial institution name. . . . . Address. . . . .
Insert the details of account to be debited	Name of account. . . . . (your name(s) as it/they appears on your bank statements) BSB number __ __ __ - __ __ __ Account number __ __ __ __ __ __ __ __ __ __ __
Acknowledgement	By signing this Direct Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and IMAN International Pty. Ltd. as set out in this request and in your Direct Debit Request Service Agreement.
Frequency of debit	If your plan start date is 1st - 15th of the month, your direct debit will be processed on the 15th of the month or the nearest working day thereafter. If your plan start date is 16th - 31st of the month, your direct debit will be processed on the last day of the month or the nearest working day thereafter. And at Monthly/Quarterly/Half Yearly/Yearly Intervals thereafter as indicated on Page 1 of this application form.
Insert your signature and address	Signature . . . . Address. . . . . Date . . . . . / . . . . / . . . . .

MEDICARE CARD HOLDERS SECTION

As a holder of a Reciprocal or Interim Medicare Card, you should be aware that **Overseas Visitors Health Cover** (OVHC), **Health Insurance Policies for Overseas visitors** and **Working Visa Health Plans** are classified as ineligible products for Medicare Levy Surcharge (MLS) exemption purposes. You should seek financial advice about the tax implications which may effect you. Further information is available on our website: www.austhealth.com/reciprocal.php

Please complete the following:

Type of Medicare Card held: ☐ Yellow - A Reciprocal Medicare Card

☐ Blue - An Interim Medicare Card

Are all members of your family listed on a Reciprocal or Interim Medicare Card? ☐ Yes

☐ No

If no, please list names of those who are excluded:

Name	Relationship

EXISTING AILMENTS

DEFINITION:
Existing Ailment includes an ailment, illness, condition or disability, the signs or symptoms of which, in the opinion of a Medical Practitioner appointed by us, existed at any time in the six month period prior to you becoming a Plan member as detailed on the Certificate, or prior to you upgrading your Plan membership as detailed on the Certificate. This clause is consistent with Section 75.15 of the Private Health Insurance Act 2007.
This Exclusion does not apply where a Medical Practitioner certifies, and we agree, that you require emergency treatment, or treatment for a life threatening illness in Australia.

WARNING:
All expenses incurred by you or your family members from existing ailments as defined above, are expressly excluded from all Plans in accordance with the Department of Immigration and Citizenship regulation, during the first 12 months of membership. This 12 months exclusion applies to all providers of OVHC - Overseas Visitor Health Cover.

HIGH COSTS:
If you or your family members have an existing ailment, which may require ongoing treatment during the first 12 months in Australia, you should be aware that medical and hospital treatment is very expensive. Even in a Public Hospital, you could be charged in excess of $1000 a day in hospital fees alone.

EXISTING AILMENT INFORMATION

We require you to provide information regarding ailments, illnesses, conditions or disabilities in relation to yourself or any accompanying family members who are listed on this application for membership.

Please give details of medical treatment received in the last 6 months, prescribed medication taken in the last 6 months, and hospital treatment received in the last 3 years.

Name. . . . .

Details. . . . .

Name. . . . .

Details. . . . .

Name. . . . .

Details. . . . .

Name. . . . .

Details. . . . .

Name. . . . .

Details. . . . .

Name. . . . .

Details. . . . .

THIS SECTION MUST BE COMPLETED, DATED AND SIGNED.

1. I HAVE READ AND UNDERSTAND THE ADVICE REGARDING EXISTING AILMENTS AND HAVE COMPLETED THE EXISTING AILMENTS QUESTIONNAIRE.

2. PRODUCT DISCLOSURE STATEMENT

I have downloaded and read the Product Disclosure Statement to help me decide whether Working Visa Health Plans suit my needs.

3. GENERAL ADVICE

Information on our website is classified as general advice and is believed to be accurate and reliable at the time it was sourced.

4. I AUTHORISE IMAN/AHP TO LIAISE WITH ANY MEDICAL PRACTITIONER, HOSPITAL OR HEALTH PROVIDER

IMAN/AHP may need to obtain complete details relating to medical history, treatment, hospitalisation, injury and sickness, in respect of claims arising under your IMAN/AHP plan, and has consent, on behalf of each person listed on the Certificate of Membership, to obtain said information.

5. I AUTHORISE IMAN/AHP TO LIAISE WITH ANY PREVIOUS PROVIDER OF HEALTH INSURANCE

IMAN/AHP may need to obtain personal information concerning your application for a health plan, and has consent, on behalf of each person listed on the application, to obtain said information.

6. I ACKNOWLEDGE IMAN/AHP'S PRIVACY POLICY

IMAN/AHP is committed to protecting the personal information you provide to us, or which is provided to us on your behalf.

Collecting your personal information

We collect your personal information directly from you, such as by email, phone or in documents such as an application form, or from third parties, such as your employer or sponsor.

Using your personal information

We use your personal information to administer and manage the services we provide to you, including collecting monies owed and paid.

Website Information

IMAN/AHP's webhosts gather usage statistics from our website, which is analysed for reporting purposes. There is no personally identifiable data collected and all site visitors remain anonymous.

Disclosing your personal information

We may disclose personal information regarding the status of your membership Plan to the Department of Immigration and Citizenship ('DIAC') as well as to your sponsor/employer/agent. This disclosure is to enable DIAC and your sponsor/employer/agent to ascertain whether your Plan is current and maintained in accordance with Visa Condition 8501. We may also disclose your personal information to the health service providers with which you are associated, for the purpose of providing you with the services you are entitled to. Where appropriate, these disclosures are subject to privacy and confidentiality.

Accuracy of your personal information

We take reasonable steps to ensure the personal information we hold or disclose is accurate, complete and up-to-date. The accuracy of this information depends to a large extent on the information you provide us. That is why we recommend you keep us up to date with changes to your personal information at all times.

Signed ....
(Applicant or Agent)

Date ..../......./.......

AUSTRALIAN HEALTH PLANS a division of
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INTERNATIONAL MEDICAL ASSISTANCE NETWORK