

# Membership Application Form

To join, complete and return this form to:  
**GALIB, Reply Paid 484, Darlinghurst NSW 1300**

For assistance or more information call GALIB on 1300 13 69 69.  
Please print in **BLACK** ink, using **CAPITAL LETTERS** and mark check boxes with an **X**.

## Section 1: People to be covered by this membership

### About yourself

As the policyholder you have legal responsibility for the membership and for ensuring that membership contributions are kept up to date. All correspondence will be directed to the policyholder.

Title:  Family name:

Given name/s:  M/F:  Date of birth:

Home address:  State:  Postcode:

Postal address (if different to your home address):  State:  Postcode:

Home telephone number:  Daytime telephone number:

Email address:

### About your partner / adding a partner

If adding a partner, your current GU membership number:

Title:  Family name:

Given name/s:  M/F:  Date of birth:

### About your dependant children

Children can be covered under a Family Membership up to the age of 21 years; student dependants can be covered up to the age of 25 years. A student dependant is an unmarried child of the policyholder, who is between the ages of 21 and 25, and who is a fulltime student at an approved Australian school, college or university. Student dependants must re-register with Grand United Corporate Health at the beginning of each academic year to remain covered under a Family Membership.

First dependant's family name:

Given name/s:  M/F:  Date of birth:

If student dependant - name of university/college:  Expected course completion date:

Student ID number:

Second dependant's family name:

Given name/s:  M/F:  Date of birth:

If student dependant - name of university/college:  Expected course completion date:

Student ID number:

### Pre-existing conditions

A pre-existing condition is an ailment, illness or condition, the signs or symptoms of which existed at any time during the six months before the day on which you joined or upgraded to a higher level of Hospital Cover.

Yes  No

Do any of the people covered by this membership suffer from a pre-existing condition for which they are receiving treatment or will require treatment?

If YES, please provide the person's name and details of the condition (please provide a separate sheet if insufficient space):



## Section 4: Declaration

### I declare and acknowledge that:

All people to be covered by this membership are permanent residents of Australia and entitled to full Australian Medicare benefits. The information provided on this application form is true, correct and complete and I will notify Grand United Corporate Health of any changes. I understand that waiting periods may apply before claims are payable under this membership. I have read and understood this brochure, including rules for transferring from another health fund, pre-existing conditions, waiting periods and benefit exclusions. I accept and agree to be bound by Grand United Corporate Health's rules and by-laws, as amended from time to time.

Members aged 16 years and over, who are not the policyholder, may request that access to their personal health-related information be limited. If you wish for this information to be kept confidential and not privy to other people covered by the membership please indicate by ticking the privacy box next to your signature below.

**Each person aged 16 years and over to be covered by this membership must sign below.**

Signature of policyholder:

Privacy:

Date:

Signature of partner:

Date:

Signature of first dependant:

Date:

Signature of second dependant:

Date:

### More information

From time to time, Grand United Corporate Health will keep you informed about new products and services which may be of potential benefit to you or your family. If you do not wish to receive this information, please tick this box.

## Section 5: Your payment options

Grand United Corporate Health offers members a range of convenient payment options and a 3% discount for payments made via direct debit.

### Automatic payment options

#### Direct Debit

Save 3% with Direct Debit from any bank, building society or credit union account. Complete the Direct Debit Authority below.

#### Automatic Credit Card payment

Complete the Credit Card Authority over the page.

### Pay-as-you-go options

#### National Australia Bank

Contributions can be paid at any National Australia Bank with your billing notice.

#### Over the phone

Bankcard, Mastercard, Visa, Diners Club, American Express. Call 1800 814 159.

### Request and Authority for Direct Debit from bank, building society and credit union accounts

To nominate a credit card account, see over page.

**I request and authorise Grand United Corporate Health Limited (Id No: 012495) to arrange for any amount Grand United Corporate Health Limited may debit or charge me 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.**

Name of financial institution at which your account is held:

Branch address:

Name of account to be debited:

BSB number:

Account number:

The first debit can be made between the 1st and 27th of each month, please nominate the date you would like your first debit to occur:

Please nominate the frequency with which you would like debits to occur:

 weekly  fortnightly  monthly

FastBack claims:

Would you like claim benefits to be deposited directly into this account?  Yes  No

### Declaration

**By signing this Direct Debit Request you acknowledge having read and understood the terms and conditions governing the debit arrangements between you and Grand United Corporate Health Limited as set out in this Request and in your Direct Debit Request Service Agreement. If this is a joint account each account holder must sign.**

Accountholder's signature:

Date:

Accountholder's signature:

Date:

## Section 5: Your payment options continued

### Request and Authority for Direct Debit from credit card accounts.

Please charge my:

Visa  Mastercard  Bankcard  Diners Club  American Express

Card number:

Expiry date:

Cardholder's name (as it appears on the card):

The first charge will be made on the first working day of each month for Visa, Mastercard, Bankcard and Diners Club cardholders, and the 15th of each month for American Express cardmembers.

Please nominate the frequency with which you would like charges to be occur:

Weekly  Fortnightly  Monthly

I authorise Grand United Corporate Health Limited to charge my credit card on receipt of this application and thereafter as required to maintain a financial membership. The amount of each charge may be varied by Grand United Corporate Health Limited with revised rates of contribution or any transfer to another cover. I understand that health insurance benefits will commence from the date that this application is received and accepted by Grand United Corporate Health Limited under the conditions of membership and that the initial payment will cover me from the commencement date and in advance for the payment frequency nominated.

Cardholder's signature:

Date:

## Section 6: Transferring from another health fund

Complete this section if you are transferring from another Australian registered health fund to authorise Grand United Corporate Health to terminate your current membership (if still current), request a Clearance Certificate and obtain any necessary details about your membership. Lifetime Health Cover loading will apply until clearance is received from your current fund. Any necessary adjustments will be made to your membership when it is received.

**Note:** If you have a direct debit payment arrangement with your existing health fund, please remember to personally advise your bank, building society or credit union to cancel your deductions.

To (name of current health fund):

Membership number:

Type of cover:

Date joined:

Date paid to:

### Names of all people transferring

Policyholder's family name:

Given name/s:

Date of birth:

Partner's family name:

Given name/s:

Date of birth:

First dependant's family name:

Given name/s:

Date of birth:

Second dependant's family name:

Given name/s:

Date of birth:

Date:

I authorise Grand United Corporate Health to terminate my membership with your organisation from:

Grand United Corporate Health is authorised to obtain full details, including claims history, about myself and all others on my membership.

Signature of policyholder:

Date:

# Direct Debit Request Service Agreement

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.

**business day** means a day other than a Saturday or a Sunday or an Australian public holiday listed throughout Australia.

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

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

**direct debit request** means the direct debit request between us and you.

**us or we** means Grand United Corporate Health Limited, the Debit User you have authorised by signing a direct debit request.

**you** means the Grand United Corporate Health Limited member 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.

## 1. Debiting your account

- 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 form 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 form.
- 1.3 If the debit day falls on a day that is not a business day, we may direct your financial institution to debit your account on the following business 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 fourteen (14) days written notice.

## 3. Changes by you

- 3.1 Subject to 3.2 and 3.3, you may change the arrangements under a direct debit request by contacting us on 1800 249 966.
- 3.2 If you wish to stop or defer a debit payment you must notify us in writing at least three (3) business days before the next debit day. This notice should be given to us in the first instance.
- 3.3 You may also cancel your authority for us to debit your account at any time by giving us three (3) business days notice in writing before the next debit day. This notice should be given to us in the first instance.

## 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 Grand United Corporate Health Limited is liable to pay goods and services tax ("GST") on a supply made in connection with this agreement, then you agree to pay Grand United Corporate Health Limited 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 1800 249 966 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 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 us and you. 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 the 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 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:  
Grand United Corporate Health Limited  
Reply Paid 3697, GPO Box 3697, Sydney NSW 2001.
- 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 (2) business days after it is posted.

Here's how  
you can  
contact us



**FreePost** Reply Paid 3697  
Sydney NSW 2001

**FreeCall** 1800 814 159

**FreeFax** 1800 656 778

**Email** [corporate@grandunited.com.au](mailto:corporate@grandunited.com.au)