

# CLEARANCE CERTIFICATE REQUEST

1. Please complete this form **USING BLACK INK** and write within the boxes in **CAPITAL LETTERS**. Mark appropriate answer boxes with a **CROSS**. Start at the left of each answer space and leave a gap between words. **PLEASE DO NOT STAPLE**.
2. Please complete all details that are relevant to you on all pages of this form.
3. Read the declaration and sign all the relevant signature panels.

## SECTION A: Your details

Membership number	First name	
<input type="text"/>	<input type="text"/>	
Surname	Initial	Title
<input type="text"/>	<input type="text"/>	<input type="text"/>
	Date of birth	Age
	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

## SECTION B: Your partner and/or additional family member details (if applicable)

By providing the details of your partner/additional family members, you acknowledge that you have the consent of each person aged 17 or over to provide this information to us.

Surname	First name	Date of birth	Gender (M/F)	Relationship
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>

All children will be covered under this membership until the age of 21. Any full-time students can continue to be covered under this membership until age 25.

## SECTION C: Clearance certificate - important information

When transferring to Bupa from another Australian registered health fund, a clearance certificate may entitle you to continuity for services provided by and common to both funds. This means that you may not need to re-serve any Waiting Periods when you join Bupa, provided that you have already served the relevant Waiting Periods and transferred to Bupa within two months of ceasing membership with your previous fund.

If you transfer to a level of Bupa cover that provides Benefits not covered by your previous fund or covered by Bupa at a higher level (including a lower Excess amount), you must serve the relevant Waiting Periods for the additional Benefits. This means that Benefits will be payable at the original Level of Cover or Excess entitlement until you have satisfied the Waiting Periods.

If you transfer to Bupa more than two months after you have ceased membership with your previous fund, you will have to serve all the Waiting Periods applicable to your new level of Bupa cover.

Where Waiting Periods apply, any Benefits already paid with your previous fund will be taken into account.

All Australian registered health funds are required to issue you with a clearance certificate when you cancel your health cover with them. If you would like us to cancel your other health fund cover for you, and to receive the clearance certificate instead of the other fund sending it to you, please complete this form. If you have a direct debit arrangement with the other health fund, **please remember to personally advise the other fund to cancel your deductions.**

If your partner (as named above) is included on your health cover with the other fund and now your membership with us, he/she must also sign this form. Otherwise, by law, their clearance certificate cannot be sent directly to us.

## SECTION D: Your health cover details with existing health fund

Name of existing health fund

Existing health fund cover/membership number

Level of cover

The other health fund cover relates to:

myself  my partner  my children  my parents

I confirm that I/we have held this cover for a minimum of 12 months prior to the date I/we request to join Bupa.

If not, date joined: \_\_\_\_\_ Date to which health cover is paid: \_\_\_\_\_

Please cross the appropriate box (if applicable)

I/we currently receive the  30%  35%  40%

If you or anyone on your membership are under 65 years old and believe the higher rebate applies to you it is essential that we receive a Savings Provision Clearance Certificate from your previous health fund.

**I authorise** Bupa to terminate my health cover with your organisation (if still current) from the date shown and obtain details about my health cover. Please issue a clearance certificate to Bupa.

Please urgently refund any excess premiums owing to the undersigned. Please do not contact me further about this request.

Cancellation date

Signature of Policyholder

Date

*Note - the above signatory must have legal responsibility for the health cover at the 'existing fund'.*

Signature of partner

Date

*Note - this signature is required if your partner is covered on the 'existing fund'.*

## Just before you send

Check that you have signed all the signature boxes relevant to your application, including the declaration above.  
**PLEASE DO NOT STAPLE.**

Please mail your application (no postage stamp required) to:

**Bupa Reply Paid 9809 BRISBANE QLD 4001**

If you would like any assistance, please call us on **134 135**.

Bupa Australia Pty Ltd ABN 81 000 057 590

### OFFICE USE ONLY

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Consultant

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