HUNTER HEALTH INSURANCE
By CDH BENEFITS FUND

ACN 14 728 326 233
Ph: 02 4990 1385
151 Vincent Street Cessnock NSW 2325
Po Box: 183, Cessnock NSW 2325
www.hunterhi.com.au
Email: enquiries@Hunterhi.com.au

Membership Application

Given Name:			**D.O.B**	**M / F**
Surname:				
Address:				
Postal Address:				
Contact Details:	(H)	(W)	(M)	
Email Address:				

Family & Dependant Details

Given Names:	**Relationship:**	**Date Of Birth:**	**M / F**

Cover Details

Effective Date:

Membership Type		**Hospital Cover**		***Extras Cover***	
Single:	☐	**Bronze Hospital:**	☐	**Bronze Extras:**	☐
Family:	☐	**Silver Hospital Young**	☐	**Healthy Extras**	☐
		Silver Hospital Nil Excess Only	☐	**Classic Extras**	☐
		Gold Hospital:	☐	**Silver Extras:**	
Ambulance:		**Thrifty:**	☐	**Gold Extras:**	☐
Ambulance Additional:	☐	**Excess $250**	☐		
		$500	☐		
Ambulance Only:	☐	**Dependant Extension:**	☐		
		Smart Cover:	☐		

Contribution Details

Payment Type:	**Contribution Amount:**
Certified Age of Entry to a Fund:	**CDH Start Date Required:**

Checklist

***Licence or Passport:**		***Medicare Card:**	
Federal Government Rebate Form:		**Pension or Health Care Card:**	
Student Declaration:		**Pension/ Health Number:**	

(*Licence and Medicare Card Must be Sent)

Pre- Existing Illness

Do you or any members have any illness pre-existing? Please indicate below:	**Yes: If yes please indicate below**	
	No:	

(A Pre- Existing form maybe required from your doctor.)

Member Declaration

I hereby wish to apply for membership to Cessnock District Health Benefits Fund and agree to abide by the rules and regulations as laid down by this organisation.
I would further certify that neither myself nor any dependant covered under this membership, has to the best of my knowledge any pre-existing or chronic illness other than those listed below at the date of this application.
(Should any pre-existing or chronic illness be present, please indicate in the space provided)

I HAVE COMPLETED THE FEDRAL GOVERNMENT REBATE FORM AND THE DIRECT DEBIT DETAILS FORM AND INCLUDEDWITH THIS FORM. IF TRANSFERRING FROM ANOTHER FUND PLEASE INCLUDE THE CLEARANCE CERTICATE REQUEST FORM.

Signature: …… Date: ……