CHANGE TO MEMBERSHIP DETAILS

FAIRER TOGETHER union health

- Use this form to update details on your Union Health membership. You can also access and update your membership details on Member Services Online via unionhealth.com.au
- Only the main member or authorised spouse/partner may change membership details.

Member name

Membership number

1. I wish to change

My contact details Complete sections 2, 5 and 7.

A name on my membership Complete sections², 6 and 7.

My Union Health cover Complete sections 2-5 and 7. Also complete 6 if adding a person.

Primary ownership of my membership* Complete sections 2-3 and 5-7. *Please also send us a completed Australian Government Rebate form.

Please complete only the sections below that relate to the change you wish to make.

2. Contact details

Complete only if any details have changed (if you're not sure, please provide your current details).

Address		State	Postcode
Home phone	Work phone	Mobile phone	
Email address		Comn	nunication preference
		E	Email Mail

3. My cover is for

Single	Single parent	Family	Couple
Extended dependant	an alama alamatik kasila ala'ni arab		. This section is switchly as all some

If you require Extended Dependant Cove hospital covers except for Gold Hospital. Cover, please select this box in addition to the Single Parent Cover or Family Cover box. This option is available on all open

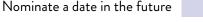
4. Cover type

Please select the cover required. Only select one box if choosing a package cover. Please refer to the product brochure(s) and the Important Information Guide (available from <u>unionhealth.com.au</u>) before completing this section.

Hospital cover	Excess (per adul	t)	Extras cover
Gold Hospital*	\$500		Comprehensive Extras
Silver+ Family Hospital	\$400	\$750	Family Extras
Silver+ No Pregnancy Hospital	\$400	\$750	Everyday Extras
Bronze+ Hospital	\$500	\$750	Healthy Options Extras
Basic+ Hospital	\$500	\$750	Mid Range Extras
*Only available in conjunction with an Extras pro	oduct		Basic Extras

5. Change date

Immediately when my request has been accepted An initial payment may be required and/or an adjustment premium may be required at a later date.



(dd/mm/yy)

3. Persons affected

Person 1								
Given name/s	Surname						Date of birth (dd/mm	ı/yy) /
Relationship	Please select where app	licable						
	Add to membershi	ip*	Remo	ove fro	m men	nbership†	Request member	rship card
Person 2								
Given name/s	Surname						Date of birth (dd/mm	ı/yy) /
Relationship	Please select where app	licable						
	Add to membershi	ip*	Remo	ove fro	m men	nbership†	Request member	rship card
Person 3								
Given name/s	Surname						Date of birth (dd/mm	ı/yy) /
Relationship	Please select where app	licable						
	Add to membershi	ip*	Remo	ove fro	m men	nbership†	Request member	rship card
Person 4								
Given name/s	Surname						Date of birth (dd/mm	ı/yy) /
Relationship	Please select where app	licable						
	Add to membershi	ip*	Remo	ove fro	m men	nbership†	Request member	rship card
*If applicable, previous health	fund t	'lf deceas	ed, date /	e of de /	ath (dd	/mm/yy)		

7. Declaration

I declare that:

- The information I've provided in this request is correct and complete;
- I agree to be bound by the fund's Rules and Constitution of Union Health as amended from time to time;
- I understand that any changes to my cover may change my premiums;
- I have had the opportunity to read the Important Information Guide and the product brochure for my cover;
- I understand the terms and conditions of my cover, including the benefit entitlements, waiting periods, pre-existing conditions rules, exclusions, restrictions and excesses that may apply;
- I am aware that details of Union Health's Privacy Policy are available on Union Health's website or on request. I consent to Union Health collecting, using and/or disclosing my personal information for the purposes in its Privacy Policy;
- (If applicable) I am authorised to act on behalf of my partner and/or dependants that I have named in this request; and
- I am aware that I have a 30 day cooling-off period that commences from the change of cover date.

I hereby authorise my spouse/partner to operate the policy as a primary member.

Signature



8. Returning this form

Email membership@unionhealth.com.au



This application is effective from the date received by

Union Health and cannot be backdated.