



YOUR OVERSEAS VISITORS APPLICATION

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: I'm applying to



Join



Transfer from another health fund or insurer

You'll also need to fill in the clearance certificate request or provide additional information – see 'Section F: Transferring from another Australian health fund?'



Add someone to my membership You, as the Policyholder, will need to fill in this form to add someone to your membership.



Change my Level of Cover or other membership details



Add a Level of Cover

SECTION B: Your details

Existing Bupa membership number (if relevant)

Surname

First name

Initial

Title

Date of birth



Male



Female

Your visa type and sub-class

What is the purpose for your visit?
(if for work purposes, please include the name of your sponsor company)

Note: The person named opposite is the Policyholder and has legal responsibility for the membership and for ensuring that premiums are kept up-to-date. Only the Policyholder is authorised to operate the membership and collect benefits on behalf of another insured person, unless they nominate an authorised person (see Section D). All correspondence will be directed to the Policyholder.

Which state will you be living in?



VIC



NSW/ACT



QLD



SA



NT



WA



TAS

If you are applying from outside of Australia, what is your home country address?

Postcode

SECTION C: Contact details

Your home address in Australia

Postcode

Australian postal address (if different from home address)

Postcode

Home phone number (including area code)

Mobile phone number

Fax number

Email address (mandatory for sending you visa info)



From time to time, we may contact you (by phone, post, sms or email) to notify you about products, services, member updates and special offers that may be of interest to you. **If you do not wish to receive this information please cross this box.**



If you would like to receive notifications of your tax statement, standard information statements and other membership statements (as they become available) via email, please cross this box.



SECTION D: Your partner and/or additional family member details

Due to space restrictions, we only have room to list four children. If you need to add more, please enclose a separate page with their details.

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
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

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.

Note: If you have any non full-time students (aged between 21-24 inclusive) they will be required to purchase their own singles membership.

Partner's visa type and sub-class (if applicable)

Partner Authority



If you wish to give your partner (as listed on this form) authority to operate this membership please cross this box. By authorising your partner you acknowledge that they will have the same rights and obligations as you, including access to health information, and they will be able to cancel the policy or remove you from the policy. You also acknowledge that you remain responsible for your membership and for the actions of the authorised person, that authorisation is given at your own risk and that you will have no recourse against Bupa for any acts or omissions by the authorised person. This authority will remain in place until you contact us to revoke it. **To authorise someone other than your partner, please contact us.**

SECTION E: Your Cover requirements

Which kind of Cover would you like? ☒ Singles ☒ Couples/Family

Working Visa

Packaged

- ☒ Platinum Visitors Cover
- ☒ Platinum Visitors Cover with Excess

Hospital

- ☒ Gold Visitors Cover
- ☒ Gold Visitors Cover with Excess
- ☒ Classic Visitors Cover
- ☒ Reciprocal Health Cover[#]

[^] This cover may not be available on Corporate Health Plans or with Reciprocal Health Cover.

[#] This cover is to avoid the Medicare Levy Surcharge only and must be taken in conjunction with another hospital cover product.

^{*} This cover is only available to limited visa types. Contact us for eligibility.

[†] If you chose Your Choice Extras, please indicate your four choices below:

1	2	3	4
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

I would like my membership to commence (please choose one option)

- ☒ as soon as my application has been accepted (an initial payment is required upon application and/or an adjusting payment may be required at a later date)
- ☒ from this date in the future
- ☒ from the date covered by the first direct debit deduction I've indicated in 'Section G: Paying your premium'

SECTION F: Transferring from another Australian health fund?

Clearance certificate request

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 existing health fund cover for you and receive the clearance certificate on your behalf, please complete this section. If you have a direct debit arrangement with your existing health fund, **please remember to personally advise them to cancel your deductions.** Your partner (if named above) must sign this form if they are included on your existing fund's health cover.

Name of existing health fund

Existing health fund cover/membership

Your health cover details with existing health fund

Surname

First name

Title

Date of birth

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:

If you are transferring from a recognised Overseas Health Insurer or General Insurer

If you are transferring from a recognised Overseas Health Insurer or General Insurer you will need to supply us with either; an International Clearance/Member Certificate or a Certificate of Currency. We will need to see: your previous level of cover, what you were covered for, your join date, the date you were paid to and the details of all persons covered. This will allow us to determine if we can offer you continuity of cover from your previous insurer.

Please cross the appropriate box (if applicable):

I am/we are currently eligible for the following Federal Government Rebate on private health insurance:

☒ 30% ☒ 35% ☒ 40%

If you or anyone on your membership are under 65 years of age and believe the higher rebate applies to you then 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 following date 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 signatory above 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 health cover at the 'existing fund'.

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Join date

Member number

SECTION G: Paying your premium

Bupa membership number (if relevant)

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I'd like to pay my premiums automatically by direct debit from:

- ☒ **OPTION A:**
my bank, building society or credit union account,
- ☒ **OPTION B:**
my credit card account, or
- ☒ **OPTION C:**
payroll deduction
(please check with your employer if this option applies).

Please choose only one of these options, and fill in your frequency preference and account details below. Please allow up to 14 days for processing. Please note that we require at least two working days to cancel or amend a direct debit payment. For other payment options, call Bupa on 134 135.

If the payment date is a weekend or a public holiday, we will debit your account on the next business day. I understand Bupa may deduct a payment after receiving this form that will cover me until my nominated start date for direct debit.

Note: If you don't select any of the ongoing payment methods (listed here) you will receive renewal notices in the mail as your health insurance becomes due.

OPTION A: Bank/building society/credit union

(Australian statement accounts only)

I'd like my premiums to be deducted every:

- ☒ fortnight
on this day (Mon-Fri)

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- ☒ month ☒ quarter ☒ 6 months ☒ year

I would like the first debit
to occur on or after:

D	D	M	M	Y	Y
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Name of financial institution

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Name(s) of account holder(s)

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BSB number

--	--	--	--	--	--

Bank account number

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I/We request and give authority to Bupa (user ID 793) to arrange funds to be direct debited from my/our account in accordance with the terms described in the Bupa direct debit service agreement.

Account holder's signature

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Date

D	D	M	M	Y	Y
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Note: if joint account, all signatures required.

Joint account holder's signature

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Date

D	D	M	M	Y	Y
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OPTION B: Credit card

I authorise Bupa to charge my:

- ☒ Visa ☒ MasterCard ☒ American Express

Please deduct:

- ☒ a single payment for

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 month's premium, **and/or**

a recurring direct debit every:

- ☒ fortnight
on this day (Mon-Fri)

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- ☒ month ☒ quarter ☒ 6 months ☒ year

I would like the first debit
to occur on or after:

D	D	M	M	Y	Y
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Credit card number

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Cardholder's name (as shown on card)

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Expiry date

M	M	Y	Y
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Cardholder's signature

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Date

D	D	M	M	Y	Y
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OPTION C: Payroll deduction

(please check with your employer if this option applies to you)

Please deduct my premiums (in line with my pay cycle) every:

- ☒ week ☒ fortnight ☒ month

Start date

D	D	M	M	Y	Y
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I understand that my cover will commence from the start date selected. I will make an initial payment for one month to cover me until my first payroll deduction and have enclosed a cheque/completed the credit card section. I hereby authorise my employer to deduct my health insurance premiums from my salary/wages. If your employer pays premiums to us on your behalf, it is your responsibility to ensure premiums are paid, for example during periods of unpaid absence or if your employment ceases.

Employer's name

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Employer's address

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Employee number

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SECTION H: Application to receive the Federal Government Rebate as a reduced premium

If you are from a country that has a Reciprocal Health Care Agreement with Australia, you may be eligible to receive the Federal Government Rebate on private health insurance. The Rebate is available on Extras Cover and Reciprocal Health Cover. Please complete this section to receive the Rebate as a reduced premium. If you do not complete this section, full premiums apply.

1. Are all the people on your membership eligible for a current Medicare card?

☒ Yes.
Please complete the remainder of this section.

☒ No. *You cannot apply for the rebate until you obtain a card from Medicare.*

2. Are you covered by this membership?

☒ Yes.

☒ No. *Employers and trustees of organisations cannot claim the Federal Government Rebate on memberships on behalf of employees.*

Your Medicare card number

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Your name exactly as it appears on your Medicare card

Valid to

M	M	Y	Y	Y	Y
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Some of the information provided on this form will be used for the purpose of registering you for the Federal Government Rebate on private health insurance. Its collection is authorised by law, and information collected will be disclosed to the Department of Health and Ageing, Medicare and the Australian Taxation Office.



Applicant, please read then sign this declaration

Privacy Statement

Your privacy and maintaining the confidentiality of your personal information is important to Bupa Australia Pty Ltd (“we”, “us”, “our”). This statement provides a summary of how we handle your personal and health information. For further information about how we handle your personal information, you should refer to our *Information Handling Policy*, available on our website or by calling us.

We will only collect personal information (including health information) about you and those people insured under your policy to provide, manage and administer our products and services to you and to operate an efficient and sustainable business. We are required to collect and maintain certain information about you and those on your policy to comply with the *Private Health Insurance Act 2007* (Cth) and related legislation. We may also collect personal and health information about you from health service providers for the purposes of administering or verifying any claim. We may disclose your personal information to our related entities and bodies corporate, or to third parties such as healthcare providers, government and regulatory bodies, other private health insurers and any persons or entities engaged by us or acting on our behalf. If you are the policy holder, you’re responsible for ensuring that each person on your policy is aware that we collect, use and disclose their personal information as set out here and in our *Information Handling Policy*. Each person on a policy aged 17 or over may complete a ‘*Keeping it confidential*’ form to specify who should receive information about their health claims. You’re entitled to reasonable access to your personal information. We reserve the right to charge a reasonable fee for collating such information. If you or any other person on your membership do not consent to the way we handle personal information, or do not provide us with the information we require, we may be unable to provide you with our products and services. We may use your personal (including health) information to offer you health management programs and services. When you take out cover with us, you consent to us using your personal information to contact you (by phone, email, SMS or post) about products and services that may be of interest to you. If you do not wish to receive this information, you may opt out by contacting us.

Direct Debit Service Agreement

This agreement outlines the responsibilities of Bupa Australia Pty Ltd (“we”, “us”, “our”) and you. We will confirm the direct debit arrangements prior to the first drawing (including the premium amount and frequency) and debit your nominated account. Deductions will occur on the nominated day, except for deductions nominated for the 28th, 29th, 30th or 31st, which will occur on the first day of the following month. If the nominated day falls on a weekend or public holiday, deductions will be made on the closest business day. We will debit all payments in advance and will automatically vary the deduction amount if your premiums or level of cover change. If we vary the deduction amount, we will give you at least 14 days written notice, except when the previous deduction is dishonoured, when we will deduct the previous period’s payment together with the current amount due. If you pay premiums at three, six, and twelve month intervals, then should your financial institution dishonour a drawing, we will draw the payment on the nominated day of the following month. If two or more drawings are returned unpaid by your financial institution, we will also stop deducting your premiums from your nominated account and will start sending you renewal notices, pending further instructions from you. We will maintain the privacy and confidentiality of your billing information (unless you have requested or consented that we can disclose it to a third party or the law requires or allows us to do so). We may provide information to our or your financial institution to resolve a dispute on your behalf. You must ensure your nominated account permits direct debiting and that sufficient cleared funds are available in that account on the due date to cover the premiums due. Your financial institution may charge a fee if the payment cannot be met. You must ensure the authorisation given to draw on the nominated account is identical to the account signing instruction held by the financial institution where the account is based. You must notify us if the nominated account is transferred or closed. You must pay your premium by an alternative method if either you or we cancel the direct debit arrangements. You must ensure your payments are up-to-date, whether a notice is received from us or not. If paying by credit card, you need to advise us of your new expiry date prior to expiry. You may request that we cancel or alter the debit drawing arrangements by contacting us and providing at least five working days notice of any requested changes. These changes may include deferring the debit, altering the debit dates, stopping an individual debit, suspending the direct debit arrangement or cancelling the direct debit completely. You can dispute any debit drawing or terminate the deductions at any time by notifying us in writing not less than seven days before the next scheduled debit drawing. If you have any queries about your direct debit agreement, please contact us. We undertake to respond to queries concerning disputed transactions within five working days of notification.

Transferring from another fund

I am transferring from another private health insurer and hereby authorise Bupa Australia Pty Ltd to cancel my previous membership with that other insurer and obtain information about my previous policy on my behalf from other private health insurers as applicable.

Terms and Conditions

I accept to be bound by the Overseas Visitors Rules of Bupa Australia Pty Ltd (available on our website, or by calling us), as amended from time to time. I acknowledge that I have read the brochure in full and understand the terms and conditions of my cover, including those relating to pre-existing conditions, waiting periods, restricted benefit periods or any exclusions that apply to my cover. I declare that the information I have provided is true and correct. I have read and consent to, and have made the other people on this policy aware of, the collection, use and disclosure of my personal information as set out in this Privacy Statement and in the Information Handling Policy (available on our website, or by contacting us). I acknowledge that, where practicable, information is provided with the consent of the individual to whom it relates.

Signature of Policyholder

Date

D	D	M	M	Y	Y
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Partner’s signature

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

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 to us using the reply paid envelope provided (no postage stamp required) or address to:

Bupa GPO Box 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

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Document name

Consultant

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