CESSNOCK HEALTH BENEFITS FUND LIMITED
ABN 14 728 326 233
Telephone: 02 4990 1385
Facsimile: 02 4991 2155
Po Box 183, 151-153 Vincent Street Cessnock NSW 2325
Email: enquiries@cdhbf.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 Table**		***Extras Cover***	
Single:	☐	**Bronze Hospital:**	☐	**Bronze Extras:**	☐
Family:	☐	**Silver Hospital:**	☐	**Silver Extras:**	☐
		Gold Hospital:	☐	**Gold Extras**	☐
		Thrifty:	☐		
		Excess $250 ☐ **$500**	☐		
Ambulance Additional:	☐	**Dependant Extension:**	☐		
Ambulance Only:	☐	**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: ……