



CESSNOCK HEALTH BENEFITS FUND LIMITED

ABN 14 728 326 233

Telephone: 02 4990 1385

Po Box 183, 151-153 Vincent

Facsimile: 02 4991 2155

Street Cessnock NSW 2325

Email: enquiries@cdhbf.com.au

Membership Application

Given Name: D.O.B

Surname:

Address:

Postal Address:

Contact Details: (H) (W) (M)

Email Address:

Family & Dependant Details

Given Names: Relationship: Date Of Birth:

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 FEDERAL GOVERNMENT REBATE FORM AND THE DIRECT DEBIT DETAILS FORM AND INCLUDED WITH THIS FORM. IF TRANSFERRING FROM ANOTHER FUND PLEASE INCLUDE THE CLEARANCE CERTIFICATE REQUEST FORM.

Signature: Date: