

We can help you



A registered health benefits organisation
ABN 95 087 648 753

Customer Direct Debit Request Service Agreement



We want to make choosing private health insurance for you and your family as easy as possible. Here are your three options:

1 Call us

Just pick up the phone and call.
One of our member service specialists
can help you join immediately.

1800 808 700

2 Visit our website

You can join
online instantly.
It's that simple!

www.peoplecare.com.au

3 Fill out this application form

To send us your
completed
application
form you can:

Post it: PO Box 77, Port Kembla 2505

Email it: lysaght@peoplecare.com.au

Fax it: (02) 4224 4300



Our Commitment to You

This section outlines our service commitment to you, in respect of the Direct Debit Request (DDR) arrangements made between Lysaght Peoplecare (User ID 23022) and you. It sets out your rights, our commitment to you and your responsibilities to us together with where you should go for assistance.

Initial Terms of the Arrangement

In terms of the Direct Debit Request arrangements made between us and signed by you, we undertake to periodically debit your nominated account for the agreed amount of health insurance premiums.

Drawing Arrangements

- Your initial deduction date will be advised in writing by the fund. Regular debits will take place on your nominated day.
- If any drawing falls due on a non-business day, it will be debited to your account on the next business day following the scheduled drawing date.
- We will give you at least 14 days notice in writing when changes to the initial terms of the arrangements are made. This notice will state the new amount, frequency, next drawing date and any other changes to the initial terms.
- If you require changes to the direct debit arrangements, you must provide us with 3 working days notice of such change before it will be effective.
- If you wish to discuss any changes to the initial terms, you should contact us immediately via our details on the adjacent page.

Your Rights

Changes to the Arrangements

- If you want to make changes to the drawing arrangements, contact us at least 3 working days prior to the next scheduled drawing day via our details on the adjacent page.
- Changes may include deferring the drawing, stopping an individual debit, suspending the DDR or cancelling the DDR completely.

Please be aware that these changes will affect your financial status and hence membership entitlements until the amounts have been paid.

Enquiries

Direct all enquiries to us, rather than to your financial institution, and these should be made at least 3 working days prior to the next scheduled drawing day. All communication addressed to us should include your fund membership number and current postal address.

All personal customer information held by us will be kept confidential except that information provided to a financial institution to initiate the drawing to your nominated account.

Disputes

If you believe that a drawing has been initiated incorrectly, we encourage you to take the matter up directly with us by contacting us via our details on the adjacent page. If you do not receive a satisfactory response from us to your dispute, contact your financial institution who will respond to you with an answer to your claim:

- within 7 business days (for lodged claims within 12 months of the disputed drawing);
- within 30 business days (for claims lodged more than 12 months after the disputed drawing);

You will receive a refund of the drawing amount if we cannot substantiate the reason for the drawing.

Note: Your financial institution will ask you to contact us to resolve your disputed drawing prior to involving them.

Your Commitment to Us

It is your responsibility to ensure that:

- your nominated account can accept direct debit (your financial institution can confirm this);
- on the drawing date there is sufficient cleared funds in the nominated account;
- that you advise us if the nominated account is transferred or closed.

If your drawing is returned or dishonored by your financial institution, we will write to you to advise of an alternative deduction date. You also have the option of making a manual payment or have us deduct the returned amount on an alternative deduction date. If debits are returned on three consecutive occasions your membership will be closed. You may be asked to pay any transaction fees payable by us in respect of the above returned or dishonored payment.

Application Form



APRIL 2006

Membership Application Form



Step 1 - Apply for Membership

Join Lysaght Peoplecare
 Transfer from another fund
 If transferring from another fund please attach your clearance certificate if you have it. If not complete Step 9

MEMBER ELIGIBILITY SPECIFY ELIGIBLE COMPANY & LOCATION
 A Current Employee
 B Child/Dependant of current employee or member

REFERRED BY:
 GIVEN NAMES: _____ FAMILY NAMES: _____
 MEMBER NUMBER: _____

COMMENCEMENT DATE
 From the date my application is received
 Or from the date below
 / /
 DATE

Step 2 - Your details

TITLE: _____ FAMILY NAME: _____ GIVEN NAMES: _____
 STREET ADDRESS: _____ SUBURB/CITY: _____ POSTCODE: _____
 POSTAL ADDRESS: _____ SUBURB/CITY: _____ POSTCODE: _____
 HOME PHONE: _____ MOBILE PHONE: _____
 Lysaght Peoplecare is committed to reducing paper waste. Please tick here if you would prefer to receive your membership correspondence via email (where applicable).
 EMAIL ADDRESS: _____

Step 3 - Additional persons to be covered

Self, spouse, children under 21 and full time student dependants under 25. Please detail any conditions or ailments the signs or symptoms of which existed at any time during the last 6 months (attach a separate sheet if necessary).

Given Names	Birth Date	Relationship	Sex	Existing Conditions	Student Dependants
A		Member	M F		Details for full-time students under 25yrs, name of educational institution
B		Partner	M F		
C			M F		
D			M F		
E			M F		

Step 4 - Select your level of cover

SELECT YOUR COVER
 Single Couple
 Single Parent Family

COMBINATION PACKAGES
 Rewards Plus
 Value Plus
 Triple S

HOSPITAL COVER
 PRIVATE PLUS HOSPITAL
 No Excess
 Excess 150/300
 Excess 250/500
 Excess 500/1000
 Public Hospital

ANCILLARY
 Ancillary Plus
 Basic Ancillary
 Lifestyle (add on)
 Ambulance Only

Step 5 - Choose how you wish to pay

HOW DO YOU WISH TO PAY?
 DIRECT DEBIT (complete form below)
 CHEQUE (payment enclosed)
 BPAY (BPAY details will be forwarded to you)

PAYROLL DEDUCTION
 Eligible employers only
 Company: _____
 Payroll Number: _____

DIRECT DEBIT REQUEST

I/We request Lysaght Peoplecare Limited (user ID 23022) to arrange for funds to be debited from my/our nominated account/ credit card at the financial institution shown below, according to the instructions specified below.

EITHER A NOMINATED ACCOUNT
 NAME AND BRANCH OF FINANCIAL INSTITUTION: _____
 NAME(S) OF ACCOUNT HOLDER(S): _____
 ACCOUNT NUMBER: _____ BSB No: _____

OR CREDIT CARD
 CREDIT CARD: Mastercard VISA
 CARD NUMBER: _____
 NAME ON CREDIT CARD: _____
 EXPIRY DATE: _____
 D M Y Y

Please debit my Lysaght Peoplecare contributions from the above account
 Weekly Fortnightly Which day (Mon-Fri?) _____
or
 Monthly Quarterly 6 Monthly Annually Which day (1st - 28th) _____

Please debit my Lysaght Peoplecare contributions from the above credit card account on:
 1st day of each month 20th day of each month

I understand that I/we will be notified in writing of the initial amount to be deducted and that subsequent monthly deductions will be in accordance with the level of cover I hold. When this deduction amount changes from time to time, I will be given notification in writing of the new deduction amount. I have read and understand the Direct Debit Service Agreement overleaf.

SIGNATURE(S): _____ IF DEBITING FROM A JOINT ACCOUNT, BOTH SIGNATURES ARE REQUIRED

Step 6 - Choose our Easy Claim - Fast Benefits Service

EASY CLAIM - FAST BENEFIT SERVICE Please pay my claim benefit (where relevant) directly to my BANK, BUILDING SOCIETY or CREDIT UNION account
 NAME AND BRANCH OF FINANCIAL INSTITUTION: _____
 ACCOUNT NAME: _____ ACCOUNT NUMBER: _____ BSB No: _____

Step 7 - Apply for the Government Private Health Insurance Rebate

Complete this section to receive the Federal Government Rebate on private health insurance as a reduced premium. If you do not complete this section, full rate membership fees will apply.

Are all the people on the policy listed on a Medicare card or entitled to a Medicare card? Yes No
 Your Medicare card details No. _____ Valid to _____ / _____

Are you covered by this policy? Yes No
 Your full name as it appears on your Medicare card _____

If no, you may register for this scheme if the policy is ONLY for your dependant child and you are the parent of that child.

Step 8 - Declaration

I declare these statements are true and complete and agree to be bound by the rules of LYSAGHT PEOPLECARE. I have read and understand the rules relating to WAITING PERIODS and PRE-EXISTING CONDITIONS/AILMENTS and RESTRICTIONS FOR THE TRIPLE S PRODUCT (if applicable). I understand the fund may refuse payment of benefits if any of the details supplied herein are false in any respect. I understand there are penalties for giving false or misleading information in regards to the Government Private Health Insurance Rebate.

SIGNATURE: _____ DATE: _____

Step 9 - Transferring from another fund

If you are transferring from another Australian registered health fund, Lysaght Peoplecare can arrange for your existing health fund membership to be cancelled. We will recognise any waiting and Lifetime Health Cover periods already served. Please note: You must personally advise your existing fund, bank or pay office to cancel any direct debit or payroll deductions.

TITLE: _____ FAMILY NAME: _____ GIVEN NAMES: _____
 STREET ADDRESS: _____ SUBURB/CITY: _____ POSTCODE: _____
 DATE OF BIRTH: _____ NAME OF EXISTING FUND: _____ MEMBERSHIP NUMBER: _____ DATE CANCELLATION TO BE EFFECTIVE: _____
 I hereby authorise Lysaght Peoplecare to terminate my membership with your organisation from this date and obtain appropriate details about my membership. Please forward a clearance certificate to Lysaght Peoplecare and refund any excess premiums.
 SIGNATURE: _____ DATE: _____