Cigna

GUHealth™
Your ultimate solution

Global Health Benefits

Customer Information Form

Mailing Address: Cigna Global Health Benefits
1 Knowe Road
Greenock, PA15 4RJ, Scotland
Fax: +44 (0) 1475 492 413
Email: International.team@cigna.com

Please note the following:

- Print in black ink, using capital letters and mark check boxes with an X.
- Return form to the address, fax or email listed above.
- Failing to provide any of the information below will cause delay in the processing of your application.

YOUR EMPLOYER:	CIGNA ID NO.:

It is essential that you complete this form, in full, if you wish to receive a GU Health policy to assist you with obtaining medical treatment in Australia. **If you do not complete this form you will not be enrolled with Cigna's regional partner GU Health.**

If you already have coverage through a local health fund in Australia and wish to transfer coverage to GU Health, please ensure you complete all sections.

OR if you already have coverage through a local health fund in Australia **and** do not wish to transfer coverage, you can opt out (please check with your employer).

To opt out of the CignaLinks Australia programme simply complete Section 1 only and check here ☐

SECTION 1. – POLICYHOLDER'S DETAILS

(the person whose name membership is held)

FAMILY / LAST NAME:				
GIVEN / FIRST NAME:		MIDDLE INITIAL:		
DATE OF BIRTH (DD/MM/YYYY):		GENDER: ☐ MALE ☐ FEMALE		
ADDRESS LINE 1*:		ADDRESS LINE 2*:		
CITY:	DISTRICT / PROVINCE:	STATE CODE:	POSTAL CODE:	COUNTRY:

*If you intend for this address to be your primary mailing address for all GU Health correspondence, please inform your employer. Please note however, that some employers utilise 'restricted' addresses for correspondence and may not be willing to change your primary mailing address.

WORK TELEPHONE NUMBER:	HOME TELEPHONE NUMBER:	MOBILE NUMBER:
EMAIL ADDRESS:		
PLEASE CONFIRM YOUR COUNTRY OF CITIZENSHIP:	DO YOU CURRENTLY HOLD AN ACTIVE MEDICARE CARD? ☐ YES ☐ NO	

HAVE YOU RESIDED IN ANY ONE OF THE FOLLOWING LIST OF COUNTRIES DIRECTLY PRIOR TO YOU ARRIVING IN AUSTRALIA?
IF YES, PLEASE SELECT THE COUNTRY YOU RESIDED IN:

☐ BELGIUM ☐ FINLAND ☐ REPUBLIC OF IRELAND ☐ ITALY ☐ MALTA ☐ THE NETHERLANDS ☐ NEW ZEALAND

☐ NORWAY ☐ SLOVENIA ☐ SWEDEN ☐ UNITED KINGDOM

SECTION 2. – TRANSFER CERTIFICATE REQUEST

(Complete this form only if you are transferring from another Australian health fund and GU Health will cancel your existing health fund membership for you. Please note, you must personally advise your bank to cancel your deduction if you have a direct debit arrangement with your existing health fund.)

GU Health will contact your previous Australian health fund to cancel your membership and request a Transfer Certificate. If GU Health does not receive your Transfer Certificate, any applicable Lifetime Health Cover (LHC) loading will be applied to your membership from the date you joined.

Lifetime Health Cover status with your previous fund cannot be recognised without receipt of a Transfer Certificate.

If any person nominated on your GU Health membership is transferring from another Australian health fund (or separate policy) please make a copy of this section and complete separately.

TITLE:	FAMILY / LAST NAME:	
GIVEN / FIRST NAME:	MIDDLE INITIAL:	
DATE OF BIRTH (DD/MM/YYYY):	NAME OF EXISTING HEALTH FUND:	MEMBERSHIP NUMBER:
HOME ADDRESS:	STATE:	POSTAL CODE:

I AUTHORISE GU HEALTH TO TERMINATE MY MEMBERSHIP WITH MY EXISTING HEALTH FUND AND OBTAIN DETAILS CONCERNING: (PLEASE MARK)

☐ MYSELF ☐ MY PARTNER ☐ MY DEPENDENT(S)

CANCELLATION EFFECTIVE DATE:

I further request my previous health fund to forward a Transfer Certificate directly to GU Health GPO Box 2968 Melbourne Vic 8060

PREVIOUS POLICYHOLDER'S SIGNATURE: _____ **DATE SIGNED:** _____

SECTION 3. – FASTBACK CLAIMS

WOULD YOU LIKE TO SAVE TIME AND EFFORT WHEN YOU CLAIM?

Now you can take advantage of the GU Health FastBack Claims system, to get your money back even faster! FastBack Claims mean we can directly deposit any claim reimbursement into your nominated Australian financial institution account. Just complete and return this authority form and we'll set it up for you.

Authority for FastBack Claims

I request GU Health, until further notice, to credit my/our nominated Australian account with any amount which may be payable by GU Health in response to a claim on my membership.

MEMBER'S NAME:

Australian Bank Details

NAME OF AUSTRALIAN FINANCIAL INSTITUTION AT WHICH YOUR ACCOUNT IS HELD:	
BRANCH ADDRESS:	
NAME OF ACCOUNT TO BE CREDITED:	
BSB NUMBER:	ACCOUNT NUMBER:

SECTION 4. – DECLARATION

Privacy
GU Health is committed to meeting the requirements of applicable privacy laws including the Privacy Act 1988 and the U.S. Health Insurance Portability and Accountability Act (HIPAA). GU Health will assist all health fund members to access, update and/or correct personal information held by the fund. Personal information will be protected by appropriate security measures and will be used by GU Health for regulatory reporting purposes and for the provision of eligibility information for service providers/agents/brokers and hospitals as well as to provide and assist in the development of member services, which may include use by its related agencies, including the collection, use and disclosure of information on the member and their family by Cigna, but will not be used for any other purpose, such as sale or disclosure to an unrelated third party, without the member's approval. A copy of GU Health's Privacy Policy can be obtained by calling our Member Relations Team on 1300.794.624 (FreeCall from Australia).

Partner authority
If your partner is named on this membership, they will have access to membership information and may make changes to the policy (with the exception of being able to cancel the policy). If your partner is not named on this membership and you would like to allow them access, please contact GU Health. If Power of Attorney already exists, please attach a copy to this application.

I declare and acknowledge that:
The information provided on this membership form is true, correct and complete and I will notify GU Health of any changes. I accept and agree to be bound by GU Health's rules and by-laws, as amended from time to time.

POLICYHOLDER'S SIGNATURE: _____ **DATE SIGNED:** _____

CHECKLIST

IMPORTANT: Please note that your starting date with GU Health is subject to receipt of a fully completed form.

Please note that failing to provide any of the information below will cause delay in the processing of your application.

- ☐ Have you completed and supplied your full name, address and all contact details? (Section 1)
- ☐ Have you completed the Transfer Certificate request for GU Health to cancel your current Australian health fund? (Section 2)
- ☐ Have you correctly provided your Australian financial institution account details? (Section 3)
- ☐ Has the policyholder signed the declaration? (Section 4)