

Please complete this form to advise HBF of your preferred payment method. Return by mail to GPO Box S1440, Perth WA 6809 or by fax to (08) 9265 6282.

1 Name of Doctor

Provider Numbers Location Address

Address for Correspondence Postcode

Phone Number Fax Number Contact Name

2 Preferred Payment Method
Please tick appropriate box

1. Direct Credit *I authorise HBF to credit the nominated account with benefit entitlements arising from health insurance claims.

Bank Details
Name of Financial Institution and Address

Account Type BSB/Financial Institution Number Account Number

Cheque Savings

Account in the Name of

Payee Name

OR 2. Cheque

3 Level of Cover - Please advise your choice of cover for your HBF patients:

Full Cover Specialty

All my HBF patients will be charged for in-hospital services in accordance with the conditions provided by HBF so that those with appropriate cover will not have to pay a gap.

OR

Opt In/Opt Out Known Gap Cover

Some of my HBF patients will be charged for in-hospital services in accordance with the conditions provided by HBF so that those with the appropriate cover will pay a reduced medical gap. I will advise those HBF members of the payment arrangements associated with the in-hospital services that I provide. Other HBF patients may be charged differently in which case, HBF will cover up to the Medicare Benefits Schedule fee only.

4 Declaration

This medical practitioner accepts the conditions supplied by HBF in relation to medical gap cover. I agree to advise HBF members of any financial interests I have in the particular products or services I have recommended.

Name of Authorised Person* Position/Title

Signature Date

*An authorised person is the Principal or Proprietor of the business, the Chief Executive Officer or the Chief Financial Officer of the organisation.

OFFICE USE ONLY

Date Processed / / User ID