

APPLICATION FORM

OVERSEAS STUDENT HEALTH COVER

Please complete and return this form by email to oshc@bupa.com.au or post to Bupa Australia OSHC,
PO Box 14639 Melbourne VIC 3001 Australia

Please **PRINT** clear details in relevant spaces provided

Your personal details

Title: _____ Given Name: _____ Family Name: _____

Date of Birth: / / Gender:

How can we contact you in Australia?

Street Address: _____

Postcode: State: _____ Email: _____

Home Telephone Number: _____ Mobile Telephone Number: _____

Tell us your visa information

If you do not have this yet you can leave this section blank and complete at a later date

Expected date of arrival in Australia: / /

Student Visa Type: _____ Visa Number: _____

Visa Start Date: / / Visa Finish Date: / /

Where are you studying in Australia?

Name: _____ Student Number (if known): _____

Address: _____ Postcode: State: _____

Your cover details

It is an Australian Government requirement that you must have OSHC for the entire duration of your visa

Have you previously held Overseas Student Health Cover (OSHC) with another provider? Yes No

If **yes**, please state the provider name:

_____ Expiry Date: / /

Length of OSHC required: Months Membership Type: Single Couple/Family

We can also provide cover for your other healthcare needs including dental, optical, physiotherapy and so on.

Please check this box if you would like one of our friendly customer service advisors to contact you to discuss your needs or visit our website www.hba.com.au for more details.

Who else will be covered in your membership?

Please complete this section if you have selected either Family or Couple membership types

Partner

Title: _____ Given Name: _____ Family Name: _____

Date of Birth: / / Gender:

continued overleaf

A **Bupa** company



