Latrobe Health Services Limited
ABN 94 137 187 010
Reply Paid 41, Morwell VIC 3840
info@lhs.com.au
latrobehealth.com.au
Member service enquiries 1300 362 144

Please complete:

Clearance Certificate Request Form

Use this form to authorise Latrobe Health Services to obtain details of your existing health insurance membership on your behalf.
Complete parts A to D and mail the form to Latrobe Health Services, Reply Paid 41, Morwell VIC 3840.

Part A My details

Full name | Date of birth

..... / ..... / .....

Residential address | Postcode

....

Postal address (if different to above) | Postcode

....

Part B Details of all persons transferring

Full name | Date of birth

..... / ..... / .....

Full name | Date of birth

..... / ..... / .....

Full name | Date of birth

..... / ..... / .....

Full name | Date of birth

..... / ..... / .....

Full name | Date of birth

..... / ..... / .....

Part C Previous health insurance details

Previous insurer membership number | Previous insurer name

....

This cancellation is effective from

..... / ..... / .....

Note: If you pay via direct debit or payroll deduction, remember to cancel your payments with your existing health insurer or financial institution.

Part D Declaration

I hereby authorise Latrobe Health Services to terminate my membership with your organisation and obtain a Clearance Certificate. Please forward a copy of the Clearance Certificate to PO Box 41, Morwell VIC 3840 within 14 days. Any refund of premiums paid in advance should be sent to the postal address on the reverse side of this form.

Note: Spouse/partner signature is required if they are to be cancelled and a clearance issued.

Signature | Date signed

1 .... / ..... / .....

Signature | Date signed

2 .... / ..... / .....

Private Health Insurance Code of Conduct

Latrobe Health Services proudly supports and complies with the Private Health Insurance Code of Conduct