



CBHS Health Fund Limited
ABN 87 087 648 717

CBHS Corporate Health Pty Ltd
ABN 85 609 980 896

Provider Benefit Statement Registration

Please complete and return to:

By post

CBHS Health Fund Limited
Attn: Data and Technical Team
Locked Bag 5014 Parramatta NSW
2124

Fax

Attention: Data & Technical Team
02 9843 7677
Email: providers@cbhs.com.au

CBHS Health Fund Limited and CBHS Corporate Health Pty Ltd (CBHS) have developed a facility on its website for doctors and hospitals to download their Benefit Statements by logging on to our website at www.cbhs.com.au or www.cbhscorporate.com.au with a pre-determined password.

Due to the nature of information contained on Provider Benefit Statements, doctors and hospitals must nominate individuals who are authorised to access such Benefit Statements.

You may nominate an authorised user on this form by completing the section below and returning it to CBHS by post, email or fax.

It is important to ensure that CBHS is informed about any changes to personnel. Your password may be changed at any time by notifying CBHS in writing. Your details will be updated and confirmed in writing within 2 working days.

The doctor/hospital agrees to be bound by the terms and conditions of the CBHS Health Fund Limited website. The doctor/hospital understands that from time to time these Terms and Conditions may change and that CBHS may issue new passwords or suspend access to the website at any time. The doctor/hospital will promptly inform CBHS if it wishes to change any of its authorised users or if any of its authorised users cease to be employed. This application replaces all previous applications and remains valid unless otherwise notified by the doctor/hospital in writing.

User information

1. Doctor / Hospital name
2. Provide Number
3. Phone Number

Authorised user information

4. Title
Dr Mr Mrs Ms Miss
5. Surname
6. Given name(s)
7. Position title
8. Phone number ()
9. Fax number ()
10. Email
11. Nominated password

Declaration

I hereby declare that the above information is true and correct. Should any of the above details change, I will notify CBHS in writing within 5 days of the change.

I consent to CBHS collecting, using or disclosing my personal information for the purpose of accessing Benefit Statements from CBHS website facility. I declare that the 'authorised user' I have nominated has consented to CBHS collecting, using and disclosing their personal information for this purpose.

Signature

Date: