APPLICATION FOR HCF RECOGNITION AS A SUPPLIER OF CLAIMABLE GOODS (hearing aids, orthoses, glasses/contact lenses ordered online).

If you supply therapeutic goods that may be claimable under some extras products, you must be recognised by HCF for your customers and patients to be able to claim. HCF recognises suppliers/dispensers of certain goods in independent private practice (i.e. not working in a hospital or a subsidised facility). Please complete a separate form for each additional product type and practice address for which you seek recognition. This application must be completed by a person who has authority to contract on behalf of the proprietor/s.

Complete and return via:

Email **provider_relations@hcf.com.au**
Mail **Provider Relations**
GPO Box 4242,
Sydney NSW 2001

1 YOUR DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Type of goods for which you are seeking recognition

Business or trading name

ABN or ACN

Parent company name (if applicable)

ABN or ACN

Proprietor/s full name

Head office address:

Unit no.

Street no.

Street name

Suburb

State

Postcode

2 RETAIL ADDRESS AND CONTACT DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Location/s where the goods are fitted and/or supplied to the public (please use separate sheet if necessary)

Phone

Mobile

Postal address if different from the above

Postal address line 1

Postal address line 2

Suburb

State

Postcode

Email

Website

3 NAME AND QUALIFICATIONS OF THE PEOPLE WHO FIT OR SUPPLY THE GOODS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Name

Qualifications

Member details of the board or industry that governs your profession

Name

Qualifications

Member details of the board or industry that governs your profession

Name

Qualifications

Member details of the board or industry that governs your profession

4 QUALITY AND ASSURANCE (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

In addition to a consumer's rights under the Australian Consumer Law, please provide details of any additional express/manufacturer's warranties provided with the goods (eg state the length of time the goods are guaranteed against defects:)

What options are available to customers who find the goods unsuitable?

How are the goods checked for quality before dispatch?

Do you have an express returns policy? (If so, please attach a copy) Yes ☐ No ☐

5 DECLARATION

I wish to apply for HCF provider recognition. I understand that I must meet the HCF recognition criteria for my profession, and I understand that HCF provider recognition is at HCF's sole discretion. I have read and agree to abide by the **Terms and Conditions for HCF Recognised Providers of Extras Services** and **HCF Privacy Policy**. I certify that the above details are true and complete.

Signature

Date (DD MM YYYY)

Name

Position

Phone

Mobile

Call us on **1300 799 275** for more information.