Aboriginal and Torres Strait Islander Medicare enrolment and amendment form (MS018)

Use this form if you are an Aboriginal or Torres Strait Islander Australian who cannot provide normal proof of identity documents such as: birth certificate, driver licence, current passport, marriage certificate or legal documents. If these documents can be provided, use the **Medicare enrolment form (MS004)** or **Application to copy or transfer from one Medicare card to another (MS011)** forms available at **servicesaustralia.gov.au/forms**

You can also use this form to add someone of Aboriginal or Torres Strait Islander Australian descent to your Medicare card (including newborns) if they do not have normal proof of identity documents. Ask a referee to sign the form and it will count as proof of identity.

A newborn is a child who has not yet passed their first birthday.

- ☐ New enrolment (Sections 1, 2, 3, 6, 7, 8 and 9)
- ☐ Adding someone – (Sections 1, 2, 3, 6, 7, 8, and 9)

  For a child in the care of someone other than a parent, provide one of the following:
  - Letter from parent giving permission for child(ren) to be included on the applicant's Medicare card.
  - Centrelink documents confirming applicant is receiving benefits for the child(ren).
  - Document from a state or territory government department to confirm child(ren) are in applicant's care.
- ☐ Changing name (Sections 1, 2, 5 (if required), 6, 7 (if required) and 8)
- ☐ Changing address (Sections 1, 2 and 8)
- ☐ Duplicate card (Sections 1, 2, 3 and 8)
- ☐ Replacement card (Sections 1, 2, 4 and 8)
- ☐ Moving to a new Medicare card (Sections 1, 2, 3, 5, 6, 7 and 8)

Section 1 Applicant or cardholder details (mandatory)

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other ☐ Family name

First given name Second given name

Other name(s) you are or have been known by (provide previous name here if notifying us of a name change)

Provide current or new address

Permanent address

Postal address (if different to above)

Provide previous address, if known (or if you are telling us about a change of address)

Daytime phone number (including area code) Gender: Male ☐ Female ☐ Non-binary ☐ Date of birth (DD MM YYYY)

This question is voluntary.
Are you of Aboriginal or Torres Strait Islander Australian descent? Yes – Aboriginal Australian ☐ Yes – Torres Strait Islander Australian ☐ Yes–Both ☐

Medicare card number (if known) Ref no.

Section 2 Proving your identity (mandatory)

No ID—no worries! One of the following people can act as a referee to prove your identity: • community elder • nurse • health service manager • school principal • any permanent Commonwealth employee with 5 or more years of continuous service • council chairperson • minister of religion • welfare organisation worker.

I (full name of referee)

am providing this reference because the applicant cannot provide ID. I have known the applicant personally for year(s) month(s)

OR I can confirm their identity from the following information:

Medical records ☐ School records ☐ Church records ☐ Other ☐ Give details

I declare that the information I have provided in this form is complete and correct.
I understand that giving false or misleading information is a serious offence and that I may be contacted to confirm my statement.

Referee signature On completion, print and sign by hand. Date (DD MM YYYY)

Daytime phone number (including area code) Name of the organisation

Section 3 Duplicate card (available if there is more than one person on the card)

Do you want to have a second copy of your card? No ☐ Yes ☐

Section 4 Replacement card

Was your card: Lost ☐ Stolen ☐ Damaged or destroyed ☐ Expired ☐

Section 5 Moving to a new Medicare card (tick one only)

- ☐ Copy to a new Medicare card – get your own individual Medicare card number. You will also stay on your current Medicare card.
- ☐ Transfer to a new Medicare card – for customers 15 years or older only. Get your own individual Medicare card number. You will be removed from your current Medicare card.
- ☐ Copy to an existing Medicare card – move to another person's Medicare card. You will also stay on your current Medicare card. Existing cardholder to complete **Section 1** and people to be added to be listed in **Section 7**.
- ☐ Transfer to an existing Medicare card – for customers 15 years or older only. Move to another person's Medicare card. You will be removed from your current Medicare card. Existing cardholder to complete **Section 1** and people to be added to be listed in **Section 7**.

Section 6 Additional information

You can write extra information to help us understand your request. For example, my child is going to boarding school and needs their own Medicare card.

Section 7 Details of other people to be included or changed on the card

If you need to add more than 2 people on the Medicare card, print or photocopy this page and return it with this form.
You can also provide the required information on a separate piece of paper and attach it.

☐ New enrolment - list all other people to be on the card

☐ Adding a new person only - children under 15 will remain on their existing Medicare card and be added to your card

☐ Changing the name of a person on the card

Provide proof of identity documents for each additional person being enrolled, added to the card or having their details changed.

No ID—no worries! If proof of identity documents are not available for the additional people, one of the following people can act as a referee to prove their identity:
• community elder • nurse • health service manager • school principal • any permanent Commonwealth employee with 5 or more years of continuous service
• council chairperson • minister of religion • welfare organisation worker.

Additional person 1

Partner ☐ Dependent child ☐ Other ☐ Give details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other

Family name

First given name

Second given name

Gender: Male ☐ Female ☐ Non-binary ☐

Date of birth (DD MM YYYY)

Other name(s) the person is or has been known by (provide previous name here if notifying us of a name change)

This question is voluntary.
Is this person of Aboriginal or Torres Strait Islander Australian descent? Yes-Aboriginal Australian ☐ Yes-Torres Strait Islander Australian ☐ Yes–Both ☐

Medicare card number (if already enrolled)

Ref no.

Declaration for person 15 years or older

I declare that:

- I have read and understood the **Privacy notice** at **Section 8** on this form
- I am aware of my legal obligation to provide true and accurate information.

I consent to:

- Services Australia collecting my personal information in this form.

I understand that:

- I must notify Services Australia of any change(s) to this information
- if I am enrolled in Medicare, I will be registered for the Medicare Safety Nets as an individual
- giving false or misleading information is a serious offence.

Additional person 1 signature: On completion, print and sign by hand.

Date (DD MM YYYY)

Referee statement and declaration. Only required if Additional Person 1 cannot provide ID.

I (full name of referee)

am providing this reference because the above mentioned person cannot provide ID. I have known this person personally for year(s) month(s)

OR I can confirm their identity from the following information:

Medical records ☐ School records ☐ Church records ☐ Other ☐ Give details

I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Referee signature: On completion, print and sign by hand.

Date (DD MM YYYY)

Daytime phone number (including area code)

Name of the organisation

Section 7 *Continued*

Additional person 2

Partner ☐ Dependent child ☐ Other ☐ Give details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other ☐ Family name

First given name Second given name

Gender: Male ☐ Female ☐ Non-binary ☐ Date of birth (DD MM YYYY)

Other name(s) the person is or has been known by (provide previous name here if notifying us of a name change)

This question is voluntary.
Is this person of Aboriginal or Torres Strait Islander Australian descent? Yes-Aboriginal Australian ☐ Yes-Torres Strait Islander Australian ☐ Yes–Both ☐

Medicare card number (if already enrolled) Ref no.

Declaration for person 15 years or older

I declare that:

- I have read and understood the **Privacy notice** at **Section 8** on this form
- I am aware of my legal obligation to provide true and accurate information.

I consent to:

- Services Australia collecting my personal information in this form.

I understand that:

- I must notify Services Australia of any change(s) to this information
- if I am enrolled in Medicare, I will be registered for the Medicare Safety Nets as an individual
- giving false or misleading information is a serious offence.

Additional person 2 signature On completion, print and sign by hand. Date (DD MM YYYY)

Referee statement and declaration. Only required if Additional Person 2 cannot provide ID.

I (full name of referee)

am providing this reference because the above mentioned person cannot provide ID. I have known this person personally for year(s) month(s)

OR I can confirm their identity from the following information:

Medical records ☐ School records ☐ Church records ☐ Other ☐ Give details

I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Referee signature On completion, print and sign by hand. Date (DD MM YYYY)

Daytime phone number (including area code) Name of the organisation

Section 8 Applicant or cardholder declaration (mandatory)

Privacy notice – The privacy and security of your personal information is important to Services Australia, and is protected by law. We collect this information to provide payments and services. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacypolicy**

I declare that:

- I have read and understood the **Privacy notice**
- I am aware of my legal obligation to provide true and accurate information
- any additional person(s) 15 years or older, named in **Section 7** (if applicable), has filled in their own personal details and consented to their declaration(s).

I understand that:

- Services Australia is collecting and using my healthcare identifier for purposes of establishing and maintaining an accurate record of healthcare identifiers
- if I am enrolled in Medicare, I will be registered for the Medicare Safety Nets as an individual
- I must notify Services Australia of any change(s) to this information
- giving false or misleading information is a serious offence.

Applicant's or cardholder's signature On completion, print and sign by hand. Date (DD MM YYYY)

If you or another person on this form are enrolling in Medicare for the first time, go to **Section 9** and answer the My Health Record question.
If you or another person on this form are **not** enrolling in Medicare for the first time, go to **Section 10** for information on how to return this form.

Australian Government
Australian Digital Health Agency

My Health Record

Section 9 My Health Record

You only need to fill in this section for new Medicare enrolments. You do not need to fill this in if you are only changing your details.

A My Health Record is an online summary of an individual's health information. It can be accessed at any time by the individual and their healthcare providers.

You and any other person enrolling in Medicare on this form can get a My Health Record.

We cannot process the following My Health Record questions if you or the other people have:

- an existing My Health Record
- cancelled a My Health Record
- opted out of getting a My Health Record.

For more information about My Health Record, or to find out how to access and manage your record online, go to **digitalhealth.gov.au** or call the My Health Record help line on 1800 723 471.

You (applicant or cardholder)

1 Are you enrolling yourself in Medicare on this form?

No ☐ ***Go to 3***

Yes ☐ *Go to next question*

2 Do you want a My Health Record?

No – **Do not** give me a My Health Record ☐

Yes – Give me a My Health Record ☐

3 Are you using this form to enrol other people in Medicare?

No ☐ ***Go to Privacy notice and Declaration***

Yes ☐ *Go to Other people*

Other people

4 **Read** this information before completing the questions for other people.

You must provide the name(s) of all other people enrolling in Medicare on this form.

If you included more than 2 people at **Section 7**, print or photocopy this page and return it with this form.
You can also write the required details on a piece of paper and return it.

If the other person is 14 years or older, they must complete the My Health Record question, read the **Privacy notice** and sign their declaration.

Other person – Name (as stated in **Section 7**)

First name | Second name

Family name

5 Do you want us to give this person a My Health Record?
If this person is 14 years or older, they must complete this question, read the **Privacy notice** and sign below.

No – **Do not** give this person a My Health Record ☐

Yes – Give this person a My Health Record ☐

6 Other person declaration (if 14 years or older)
I declare that:

- I have read and understood the **Privacy notice** in **Section 8**
- the information I have provided at **question 5** is complete and correct.

Signature: On completion, print and sign by hand.

Date (DD MM YYYY)

7 Are there other people listed in **Section 7** of this form?

No ☐ ***Go to Privacy notice and Declaration***

Yes ☐ *Go to next question*

8 Other person – Name (as stated in **Section 7**)

First name | Second name

Family name

9 Do you want us to give this person a My Health Record?
If this person is 14 years or older, they must complete this question, read the **Privacy notice** and sign below.

No – **Do not** give this person a My Health Record ☐

Yes – Give this person a My Health Record ☐

10 Other person declaration (if 14 years or older)

I declare that:

- I have read and understood the **Privacy notice** in **Section 8**
- the information I have provided at **question 9** is complete and correct.

Signature: On completion, print and sign by hand.

Date (DD MM YYYY)

11 Privacy notice – The My Health Record System Operator will collect personal information in this form from Services Australia for the purpose of the My Health Record system and may also use and disclose this information as required or authorised by law, only within Australia, including the *My Health Records Act 2012* and *Privacy Act 1988*.

For more information, see the My Health Record System Operator's privacy policy at **digitalhealth.gov.au/privacy**

Declaration

12 I declare that:

- I have parental responsibility for the other people under 14 years or older that I have completed My Health Record questions for
- I have read and understood the privacy information
- the information I have provided in **Section 9** is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Applicant's or cardholder's signature: On completion, print and sign by hand.

Date (DD MM YYYY)

Section 10 Returning this form

Return this form and any supporting documents by:

- **email** to **mes@servicesaustralia.gov.au**
  There may be risks with sending personal information through unsecured networks or email channels.

  Make sure your documents are:
  - in PDF, JPG, PNG, GIF or BMP format
  - not password protected, or in a WinZip or RAR file
  - no larger than 5MB for each document
  - no larger than 10MB in total for all the documents.

  To help us process your request, include **Enrolment** in the email subject line.
- in person at one of our service centres
- post to
  Services Australia
  Medicare
  PO Box 7856
  CANBERRA BC ACT 2610

Reset form