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|---|--|
| Safety Link Promotion Code (if applicable): |  |
| Name:                                       |  |
| Organisation (if applicable):               |  |
| Contact Phone Number:                       |  |
| Email:                                      |  |

## 1. CLIENT DETAILS

First Name: (Mr/Mrs/Miss/Ms)  Surname:

Residential Address:

Suburb/Town:  State:  Postcode:

Date of Birth:  /  /  Telephone No: Home (  )  Mobile

Postal Address (if different from above):

Is a Key Safe in place? Yes  No  Location and Combination No:

## 2. EMERGENCY DETAILS

### Emergency Contact 1

Name: (Mr/Mrs/Miss/Ms)  Relationship to Client:

Is this person Next of Kin? Yes  No  Does this person have a spare key? Yes  No

Address:

State:  Postcode:  Approx. travel time to Client's home:

Telephone No: Home (  )  Business (  )  Mobile

### Emergency Contact 2

Name: (Mr/Mrs/Miss/Ms)  Relationship to Client:

Is this person Next of Kin? Yes  No  Does this person have a spare key? Yes  No

Address:

State:  Postcode:  Approx. travel time to Client's home:

Telephone No: Home (  )  Business (  )  Mobile

### Emergency Contact 3

Name: (Mr/Mrs/Miss/Ms)  Relationship to Client:

Is this person Next of Kin? Yes  No  Does this person have a spare key? Yes  No

Address:

State:  Postcode:  Approx. travel time to Client's home:

Telephone No: Home (  )  Business (  )  Mobile

**Note:** Following an alarm call, an ambulance will be called to provide assistance if none of the above Contacts are available, or if an emergency occurs. Please note, if you are not a member, ambulance service charges may apply.

## 3. IMPORTANT MEDICAL INFORMATION

Significant Medical Conditions (including allergies):

Does client have problems with? Eyesight  Hearing  Speech  Mobility

Doctor's Name:  Doctor's Telephone No: (  )

## 4. PERSON TO BE CONTACTED REGARDING INSTALLATION OR OTHER ENQUIRIES

Name: (Mr/Mrs/Miss/Ms)  Relationship to Client:

Telephone No: Home (  )  Business (  )  Mobile

Does this person wish to be present at the time of installation? Yes  No

## 5. INSTALLATION INFORMATION

Is there a power point available for the alarm? Yes  No

Is your service connected to the National Broadband Network (NBN)? Yes  No

## 6. OTHER OPTIONS AVAILABLE\*

Daily Call  Additional Pendant  Customised Triggering Device  Key Safe  Fall Detector Pendant

Safety Link has additional options that promote independence in the home. Please indicate which option/s you are interested in and a Safety Link representative will contact you to discuss.

**\*Additional fees will apply.**

## 7. ACCOUNT REQUIREMENTS

Payment to be made: Monthly  Quarterly  Half Yearly  Yearly

Account to be paid by: Direct Debit  Credit Card  EFT  Other

**If Direct Debit or Credit Card, an authorisation form will be sent to you which must be completed and returned to Safety Link.**

If accounts are to be forwarded to a person other than the Client, please give details below:

Name: (Mr/Mrs/Miss/Ms)  Relationship to Client:

Address:

Suburb/Town:  State:  Postcode:

Telephone No: Home (  ) Business (  ) Mobile

I/we agree to be responsible for the payment of: All accounts  Establishment Fee only

Monthly Service Fee only  Additional options  on behalf of this client.

Signed:  Date:  /  /

## 8. CLIENT AGREEMENT

I have read, understand, and agree to all information in this document and Safety Link's **Terms and Conditions\*** brochure including:

- The installation of a Safety Link Personal Response System
- Notifying Safety Link prior to any alterations being made to my current telecommunication services
- Informing Safety Link between 8.30am and 5pm Monday to Friday (AEST) prior to **any** relocation of the alarm unit
- Payment of any additional charges that apply to the relocation of the alarm unit
- Returning the alarm unit to Safety Link when no longer required. I understand that failure to do so will require the replacement cost of the alarm unit to be paid
- Service Fees still apply if away from home (e.g. holidays etc.).

\*Please call Safety Link to request the **Terms and Conditions** brochure if required.

Name:  Signed:

Comments:

**Please forward the completed Application Form to:**

Safety Link, 16 Eastwood Street Ballarat Central Vic 3350

T: 1800 813 617 F: 1800 193 233

E: info@safetylink.org.au

**www.safetylink.org.au**

Safety Link is a division of Ballarat Health Services

ABN 39089584391

