



# HOSPITAL SELECT INSURANCE APPLICATION FORM

Union Medical Benefits Society Ltd

Head Office: PO Box 1721, Christchurch 8140.  
Tollfree 0800 600 666, Telephone 03 365 4048. www.unimed.co.nz

Please print clearly in BLOCK LETTERS

## Applicant - Personal Details

Mr/Mrs/Miss/Ms  Surname  First Names

Mailing Address

Residential Address *(If different from mailing address)*

Telephone: Home     Date of Birth  /  /

Work   Fax

Email

## Additional Family Members To Be Covered

	<small>Surname</small>	<small>First Names</small>	<small>Gender</small>	<small>Date Of Birth</small>
Spouse/Partner	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 1	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 2	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 3	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 4	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 5	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>
Child 6	<input type="text"/>	<input type="text"/>	M / F	<input type="text"/>

## This Application Is For

New Membership
  Addition of dependant(s) to existing policy as listed above

Upgrade existing  plan Membership No. *(where known)*

Other

Scheme Eligibility Date  Cover Start Date

## Plan Applied For

Select 1 Base Plan only:

- Hospital Select Base No Excess
- Hospital Select Base \$1,000 Excess
- Hospital Select Base \$2,000 Excess
- Hospital Select Base \$3,000 Excess

Select as many Modules as you wish:

- Module "S" (Specialists and Tests)
- Select 1 Only  No Excess  \$100 Excess  \$200 Excess  \$300 Excess
- Module "G" (Day to Day)
- Module "N" (Natural Health)
- Module "D" (Dental & Vision)

## Employment Details

Employer *(full company name)*

Your occupation

Employer Address

## Important Information

1. This form is your application to become a member of the Union Medical Benefits Society Limited (UniMed), which administers health insurance plans for members.
2. "Acceptance" by UniMed will not have immediate binding effect. You will be afforded a period in which to consider the extent of the cover UniMed is prepared to provide, any exclusions, the Conditions of Membership, and the like.
3. UniMed is registered under the Industrial and Provident Societies Act 1908. Like all societies, it has rules which will bind you. The Rules govern the way UniMed is run and the Health Insurance Plans it administers. The Rules are subject to change. If you want a copy of the current rules before making this application, please feel free to request a copy.
4. Because the information contained in this application will form the basis of any contract of insurance which eventuates, it is essential that it be completed accurately and truthfully. Applicants for insurance cover are also under an obligation to volunteer information not specifically asked for which would be material to an insurer in deciding whether to offer cover.
5. If in any doubt therefore, disclose the information, and leave it for UniMed to determine the significance of what you have disclosed.
6. The same applies for any additional persons for whom you are seeking cover. Be aware that what you state about them can affect their entitlement, so it is better that you inform them of that and ensure the comprehensiveness of what is provided.

I acknowledge having read and understood the above:  Yes  No

### Residency

Do you and all named applicants have New Zealand citizenship or hold a Residents Work Permit with a duration exceeding two years?  Yes  No – please contact UniMed immediately

## Health Information

### A. Hospital Admissions (other than for childbirth)

Have you or any named applicant at any time been admitted to a hospital, private surgical centre or day surgery unit?

No  Yes *If Yes please provide details*

Name of person	Treatment/Investigation/Operation	Year of Admission	Hospital/Doctor

### B. Injury/Employment Related Conditions (including details of all claims you have lodged with the ACC, or other approved insurers, or successors)

Have you or any named applicant undergone diagnostic tests, required medical treatment or undergone surgery for any injury or employment related conditions?

No  Yes *If Yes please provide details*

Name of person	Treatment/Investigation/Operation	Side	ACC approved	Date of Treatment	Hospital/Doctor
		L / R	Yes / No		
		L / R	Yes / No		
		L / R	Yes / No		
		L / R	Yes / No		
		L / R	Yes / No		

### C. Future Treatment/Diagnosis/Surgery

Have you or any named applicant been advised that you may require, or you have an expectation you may need, diagnostic tests/treatment/surgery in the future?

No  Yes *If Yes please provide details*

Name of person	Treatment/Nature of Investigation/Operation	Approximate Date of Future Treatment	Doctor

**D. General Health Questionnaire**

Have you or any named applicant: a. suffered from and/or  
b. had diagnostic tests relating to and/or  
c. had consultations or received medical advice/treatment for symptoms relating to:

	No	Yes	Name of person(s) to whom answer applies
<b>1. General</b>			
a) Accidents or injuries which have required, or could require treatment (state left or right side)	<input type="radio"/>	<input type="radio"/>	
b) Allergic condition including hay fever	<input type="radio"/>	<input type="radio"/>	
c) Jaw, mouth or teeth condition including wisdom teeth and/or over or under bite	<input type="radio"/>	<input type="radio"/>	
d) Asthma, chronic bronchitis or any other disease or disorder of the lungs	<input type="radio"/>	<input type="radio"/>	
e) Congenital conditions and/or developmental disorders	<input type="radio"/>	<input type="radio"/>	
f) Hernia - if yes, what type?	<input type="radio"/>	<input type="radio"/>	
g) Do you smoke?	<input type="radio"/>	<input type="radio"/>	
<b>2. Digestive</b>			
a) Stomach, bowel, or digestive disorders including ulcers, polyps, irritable bowel syndrome or gastric reflux	<input type="radio"/>	<input type="radio"/>	
b) Rectal or anal condition including haemorrhoids, or bleeding from the bowel or rectum	<input type="radio"/>	<input type="radio"/>	
c) Abdominal or pelvic pain	<input type="radio"/>	<input type="radio"/>	
<b>3. Skeletal</b>			
a) Back pain or condition including neck/cervical, thoracic, lumbar and sacral spine	<input type="radio"/>	<input type="radio"/>	
b) Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis and bunions	<input type="radio"/>	<input type="radio"/>	
<b>4. Cardiac and Circulatory</b>			
a) Heart disease or disorder including chest pain, angina, coronary artery disease, dysrhythmias, aneurysms and heart valve impairments	<input type="radio"/>	<input type="radio"/>	
b) High blood pressure and/or high cholesterol	<input type="radio"/>	<input type="radio"/>	
c) Blood or bleeding disorder including anaemia or B12 deficiency	<input type="radio"/>	<input type="radio"/>	
d) Disorder of veins and or arteries including varicose veins	<input type="radio"/>	<input type="radio"/>	
<b>5. Endocrine</b>			
a) Diabetes, gout, thyroid or other glandular disorders	<input type="radio"/>	<input type="radio"/>	
b) Disorders of the liver or gall bladder including hepatitis	<input type="radio"/>	<input type="radio"/>	
c) Female: Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, or endometriosis	<input type="radio"/>	<input type="radio"/>	
<b>6. Eyes, Ears, Nose and Throat</b>			
a) Impairment of the eyes including long/short sightedness, cataracts and glaucoma	<input type="radio"/>	<input type="radio"/>	
b) Recurrent upper respiratory tract infections including sore throat, tonsillitis, blocked nose and rhinitis within the last 2 years	<input type="radio"/>	<input type="radio"/>	
<b>7. Urinary</b>			
a) Kidney or bladder disorders including stones, incontinence or pelvic floor disorder and prolaps	<input type="radio"/>	<input type="radio"/>	
<b>8. Skin, Cysts and Tumors</b>			
a) Moles, cysts, skin lesions, lipomas, including treatment for melanoma	<input type="radio"/>	<input type="radio"/>	
<b>9. Other Conditions</b>			
a) Neurological or nerve conditions including headaches, migraines, epilepsy and stroke	<input type="radio"/>	<input type="radio"/>	
b) Any mental illness, stress or depression	<input type="radio"/>	<input type="radio"/>	
c) Female: Recurrent miscarriage(s) and infertility	<input type="radio"/>	<input type="radio"/>	





## Declaration – Privacy Statement

Pursuant to the Privacy Act 1993 (and the Health Information Privacy code 1994) the following is brought to your attention:

- i. Your application collects personal information about you and other named applicants to enable Union Medical Benefits Society Limited to evaluate and administer the Member's application and future claims.
- ii. You are required by law to disclose information that is relevant to the cover you require. Failure to provide this information may result in your application for cover being declined or your cover being void.
- iii. This information will be held securely by the Union Medical Benefits Society Limited whose Head Office is 165 Gloucester Street, Christchurch and any agency involved in completing your application. UniMed endeavour to protect your information from loss and unauthorised access.
- iv. You have the right to access and to request correction of this information, subject to the provisions of the Privacy Act 1993.
- v. UniMed will, in the main, be able to treat the information you supply as confidential between you and us. There are situations however where this will not be possible. These are:
  - a. To offer the best acceptance terms, we may need to share the information with reinsurers.
  - b. Statistical purposes (you will not be identified) and marketing purposes.

## Agent's Declaration

1. I,  the Sales Representative, confirm that I have advised   
the Applicant at  fully on the benefits and Conditions of Membership as outlined in the brochure of the Health Plan selected by him/her.
2. I further confirm that I have given no advice that breaches the Rules of the Society and that I have fully explained the provisions of the policy to the Applicant. I have only given advice on which I have authority and am competent, and have referred all other queries to the Society in writing and they accompany this Application Form.

Agent's Code

Signature of Sales Representative

## Applicant's Declaration

1. I acknowledge having read and understood the significance of the 'Important Information' contained in this Application Form.
2. I declare all entries made on this form to be true and correct and that I am not aware of any other circumstance which might affect the risk of insurance on my health or that of any other person listed on my application. I acknowledge that failure to make this declaration truthfully may invalidate my insurance.
3. Pursuant to the Privacy Act 1993 and the Health Information Privacy Code 1994. The information provided in this application form collects personal information for the purpose of evaluating your Membership Application and future claims. UniMed may disclose information related to this application and future claims to the Integrity Register\* for the purposes of the detection and prevention of fraudulent and suspicious conduct.
4. I understand that the Society's Membership/Sales Representative does not have authority to advise me upon such disclosure and that the said Representative has explained the terms and conditions of the Society.
5. I understand that the written declaration in the Application Form constitutes the basis of the contract with the Society. No oral representations, inducements, statements or promises made by or on behalf of either party, including the Sales Representative, and not contained in the Application Form or the brochure for the Health Plan selected shall be relied upon or binding.
6. I agree that any payment accompanying this application shall be a deposit only and I understand that any coverage will not commence until the Society has issued a Membership Certificate.
7. I understand that any special joining concessions or restrictions of cover in relation to my declared existing conditions will be shown on my Membership Certificate.
8. I authorise the obtaining of any personal medical information the Society may require in respect of this application or future claims as submitted by me, from any doctor who has attended or examined me or my listed dependants.
9. I agree to be bound by the Rules of the Society and the Conditions of Membership including limitations and exclusions.
10. I authorise my employer to deduct regular premium instalments from my wages/salary and provided I am first notified, to alter the amount of such instalments as required.

Signature

Date

## PRIVACY ACT

The Privacy Act 1993 requires UniMed to inform you about certain rights and obligations relating to the information which we collect on this form. In this regard we recommend that you read the declaration at the top of this page.\* The Integrity Register is a register of health insurance claims and administered by PwC (on behalf of HFANZ) for the purposes of the prevention and detection of fraudulent and suspicious conduct. The collection of information complies with the Privacy Act 1993 and the Health Information Privacy Code 1994.