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

Surname *First Names*

Mr/Mrs/Miss/Ms

Mailing Address

Residential Address *(If different from mailing address)*

Telephone: Home

Work

Email

Date of Birth / /

Fax

Additional Family Members To Be Covered

	Surname	*First Names*	*Gender*	*Date Of Birth*
Spouse/Partner			M / F	
Child 1			M / F	
Child 2			M / F	
Child 3			M / F	
Child 4			M / F	
Child 5			M / F	
Child 6			M / F	

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
1.	**General**			
a)	Accidents or injuries which have required, or could require treatment (state left or right side)	◯	◯	
b)	Allergic condition including hay fever	◯	◯	
c)	Jaw, mouth or teeth condition including wisdom teeth and/or over or under bite	◯	◯	
d)	Asthma, chronic bronchitis or any other disease or disorder of the lungs	◯	◯	
e)	Congenital conditions and/or developmental disorders	◯	◯	
f)	Hernia - if yes, what type?	◯	◯	
g)	Do you smoke?	◯	◯	
2.	**Digestive**			
a)	Stomach, bowel, or digestive disorders including ulcers, polyps, irritable bowel syndrome or gastric reflux	◯	◯	
b)	Rectal or anal condition including haemorrhoids, or bleeding from the bowel or rectum	◯	◯	
c)	Abdominal or pelvic pain	◯	◯	
3.	**Skeletal**			
a)	Back pain or condition including neck/cervical, thoracic, lumbar and sacral spine	◯	◯	
b)	Bone, muscle or Joint disorder, disease or injury including rheumatism or arthritis and bunions	◯	◯	
4.	**Cardiac and Circulatory**			
a)	Heart disease or disorder including chest pain angina, coronary artery disease, dysrhythmias, aneurysms and heart valve impairments	◯	◯	
b)	High blood pressure and/or high cholesterol	◯	◯	
c)	Blood or bleeding disorder including anaemia or B12 deficiency	◯	◯	
d)	Disorder of veins and or arteries including varicose veins	◯	◯	
5.	**Endocrine**			
a)	Diabetes, gout, thyroid or other glandular disorders	◯	◯	
b)	Disorders of the liver or gall bladder including hepatitis	◯	◯	
c)	Female: Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, or endometriosis	◯	◯	
6.	**Eyes, Ears, Nose and Throat**			
a)	Impairment of the eyes including long/short sightedness, cataracts and glucoma	◯	◯	
b)	Recurrent upper respiratory tract infections including sore throat, tonsillitis, blocked nose and rhinitis within the last 2 years	◯	◯	
7.	**Urinary**			
a)	Kidney or bladder disorders including stones, incontinence or pelvic floor disorder and prolaps	◯	◯	
8.	**Skin, Cysts and Tumors**			
a)	Moles, cysts, skin lesions, lipomas, including treatment for melanoma	◯	◯	
9.	**Other Conditions**			
a)	Neurological or nerve conditions including headaches, migraines, epilepsy and stroke	◯	◯	
b)	Any mental illness, stress or depression	◯	◯	
c)	Female: Recurrent miscarriage(s) and infertility	◯	◯	

Supplementary Information For General Health Questionnaire (Section D)

Please provide the following details for all questions ticked "Yes" in Section D

Question No.	*Name*	*Date of Visit*	*Description of Symptoms/Treatment/Investigation/Operation*	*Name of Doctor/Specialist*

E. Regular Medication

Have you or any named applicant taken in the past, or are currently taking, any form of medication on a regular basis?

○ No ○ Yes *If Yes please provide details*

Name of person	*Name of Medication*	*Duration of Medications: From - To*	*Doctor*

F. Dental Questionnaire (complete only if applying for dental options)

Please provide the following details in respect to your most recent dental consultation(s) for yourself or any named applicant

Name	*Most Recent Visit Date*	*Dental Treatment Completed*	*Was **All Required** Treatment Completed*	*Dental Practitioner*
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	
			Yes / No	

Note: If a dental consultation has not occurred within the past twelve (12) months a Certificate of Good Oral Health may be required.

G. Other Past Medical Treatment

Have you or any named applicant, in the past:

a. Had symptoms/diagnostic tests relating to, and/or

b. Had consultations or received medical advice relating to:

Any illness, disability or condition not already disclosed? ◯ No ◯ Yes *If Yes please provide details*

Name	*Date of Visit*	*Reason for Visit*	*Name of Health Professional*

If You Are Currently Insured Elsewhere

◯ Yes ◯ No *Please tick the appropriate box*

Plan covered under

*We must request a copy of your current medical insurance certificate, so that we may confirm your Loyalty Benefits under the *Special Joining Concessions.*

**Only available to certain groups.*

Claim Payment Options

I wish to have my claim payments —

◯ Direct credited to my bank account

Bank & Branch

Account Number

(Where possible please attach your bank deposit slip)

◯ Posted to me as a cheque

Premium Payment Options

I wish to pay my premium by:

◯ Monthly direct debit from my bank ◯ I have completed my direct debit authority and it is attached

◯ Six monthly invoice

◯ Annual invoice

◯ Weekly/Fortnightly/Monthly deductions from my wages

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. Persuant 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.