

# APPLICATION FORM



UniMed is assessed by AM Best Company Inc. to have a Financial Strength Rating of: A (Excellent)

To help interpret the rating the AM Best's Financial Strength Rating scale is;

A++, A+ (Superior), A, A- (Excellent), B++, B+ (Good), B, B- (Fair), C++, C+ (Marginal), C, C- (Weak), D (Poor), E (Under Regulatory Supervision), F (In liquidation)

- RESIDENCY: Are you and all family members named in this application New Zealand citizens, holders of a resident visa or holders of a work visa for a minimum of two years or otherwise entitled to free public healthcare for all services as determined by the Ministry of Health? If not, please do not proceed. Contact your UniMed Representative or UniMed Head Office on 0800 600 666.

## PERSONAL DETAILS - PRIMARY MEMBER

Mr/Mrs/Miss/Ms Surname \_\_\_\_\_ First name(s) \_\_\_\_\_

Postal address \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Mobile \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender at birth  M / F

Email \_\_\_\_\_  I agree to receive all correspondence from UniMed via email

## ADDITIONAL FAMILY MEMBERS TO BE COVERED UNDER THIS POLICY

	Surname	First Name(s)	Gender at Birth		Date of Birth	
Spouse/Partner			M	F	/	/
Child 1			M	F	/	/
Child 2			M	F	/	/
Child 3			M	F	/	/
Child 4			M	F	/	/

## THIS APPLICATION IS FOR Tick appropriate box

- New membership  Addition of family to existing policy  Upgrade of existing policy  Other

Plan applied for \_\_\_\_\_ Membership No. \_\_\_\_\_ Cover Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## PREMIUM PAYMENT OPTIONS Tick appropriate box

- I have completed my direct debit/credit card authority and it is attached.
- Group Schemes Only - If your scheme is wage deduction** - I authorise my employer to deduct regular premium instalments from my salary and provided I am first notified, to alter the amount of such instalments as required. I authorise my employer to hold a copy of this page.

Name of Employer \_\_\_\_\_

## APPLICANT'S DECLARATION

### THIS DECLARATION IS VERY IMPORTANT. PLEASE ENSURE YOU READ IT CAREFULLY

- I declare that all statements made for the purposes of this application to be true, correct and complete and that I have not omitted, and I am not aware, of any other medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application. If, after submitting this application, I become aware of any such medical information or circumstances, I agree to inform the Society immediately of such information or circumstances.
- I acknowledge that failure to make any statements truthfully, or to omit any medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application, may mean my application is rejected, or any claim made is declined, or the policy becoming void. I further acknowledge that if this application is accepted by the Society, there is no cover for any health conditions I have not declared, but only for those conditions I have declared which are accepted by the Society.
- I understand that the written declaration in the Application Form constitutes the basis of the contract with the Society. No oral representation, inducement, statements and 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.
- Where other persons are listed in my application, I confirm that I have full authority and consent to submit this application on behalf of all such persons. I understand that any statements made concerning such persons (or persons added to the policy at a later date) may affect whether this application is accepted or their entitlements to cover.
- 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. I further agree that the maintenance of membership and cover is conditional upon the continual payment of all premiums as they fall due.

- 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.
- I authorise the obtaining of any medical information the Society may require in relation to this application or future claims as submitted by me from any medical practitioner who has attended or examined me or any other person listed in my application. I agree to do anything necessary to facilitate the Society obtaining such information, including completing or signing any necessary consents or authorities.
- I authorise the Society to obtain details regarding my previous medical insurance.
- Pursuant to the Privacy Act 1993 and the Health Information Privacy Code 1994 (incorporating amendments), in this application form the Society collects personal information for the purpose of evaluating your membership application and future claims. The Society 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.
- I agree to the terms and conditions of Membership and the rules of the Society.
- If this application has been completed online, I acknowledge and agree that my electronic acceptance of this declaration (whether by electronic signature or otherwise) makes it fully binding on me and any other persons listed in the application.
- 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 Privacy Statement on our webpage <https://www.unimed.co.nz/about-unimed/privacy-statement/>*
- \*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.*

Signature of Applicant

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of UniMed Representative (where applicable)

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_



Have any named applicants been advised that they may require any diagnostics, medical or surgical treatment in the future?

✓ Yes  No

Name	Medical Condition	Treatment

✓ Have any named applicants suffered an accident or injury? Yes  No

Name	Medical Condition	Side?	ACC Covered?	Workplace Injury?
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No

✓ Have any named applicants taken in the past, or are currently taking, any medication on a regular basis? Yes  No

Name	Medication	Reason	Time Period

✓ Are any named applicants currently suffering from, or have suffered from in the past, any condition/ailment or received treatment not already disclosed? Yes  No

Name	Medical Condition	Treatment	Year

**CURRENTLY INSURED?**

✓ Are you currently insured elsewhere? Yes  No

Name of current Provider and Plan type \_\_\_\_\_

Please provide a copy of your current medical insurance certificate, so we may confirm your \*like with like plan and special joining concessions.  
\*Only available in certain Groups.

**Union Medical Benefits Society Ltd**

**Head Office**

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**TOLL FREE 0800 600 666**

