Primary Care Application

Please complete all the details of the mandatory sections relevant to you.

MOE Employee Number: (if applicable)

UniMed Ref: (office use only)

Union: ____________________

☐ I am a current Member ☐ I am a new Member

☐ I am a Family/Whanau non union Member linked at non union rate through:
(Union Member name) ____________________

Their UniMed Ref: ____________________

HealthCarePlus policy required: (tick as appropriate)

◯ Member ◯ Member & Partner ◯ Member & Children ◯ Member, Partner & Children

Plus 'Hospital Cover' – There are separate forms required for Hospital Cover. Please ask your Monument financial adviser.

Hospital Cover Provider: ____________________ **Specialist & Tests** ◯ Yes ◯ No

Policy Name: ____________________ **Monument financial adviser (if known):** ____________________

Member & Family Member Details (children must be under 21 years)

	Title	Last name	First name(s)	Sex at birth		Date of birth DD/MM/YYYY	Plan type HCP	HOS
Member				◯ M	◯ F		☐	☐
Partner				◯ M	◯ F		☐	☐
Child 1				◯ M	◯ F		☐	☐
Child 2				◯ M	◯ F		☐	☐
Child 3				◯ M	◯ F		☐	☐
Child 4				◯ M	◯ F		☐	☐
Child 5				◯ M	◯ F		☐	☐

Member Additional Details

Postal Address ____________________

Postcode ____________________

Home Phone ____________________ **Work Phone** ____________________ **Mobile Phone** ____________________

Preferred Email ____________________ **Alternative Email** ____________________

Place of work ____________________

Declaration and Commencement of Cover (tick as appropriate)

☐ I have attached my completed Payment Authority form. (These can be downloaded at unimed.co.nz or Freephone 0800 600 666.)

☐ I declare that I am a full financial member of the above named union or that I am linked as Family/Whanau/non union.

☐ I confirm that I am authorised by each person named in this application form to complete and sign on their behalf.

☐ I consent to receiving all documentation in electronic form and I consent to receiving communications to me via the preferred email address specified in this application form.

☐ In completing and submitting this form I consent to the collection, disclosure and use of my/our information in accordance with the Privacy Act 2020, the Health Information Privacy Code and the Privacy Statement on UniMed's Website.

☐ I declare that the information provided in this form is true and correct.

Member's Signature: ____________________ **Date:** ____________________

Authority to make HealthCarePlus deductions from salary (n/a PSA members)

Last name ____________________ First name(s) ____________________

Worksite ____________________ ☐ This is a new authority ☐ This replaces an existing authority

I authorise you to deduct $ ____________ Or such other amount from time to time to determined by UniMed) from my salary

Financial Strength Rating

UniMed has been given an A (Excellent) Financial Strength Rating by AM Best.

A (Excellent) Rating
AM Best's ratings are as follows:

Secure ratings						Vulnerable Ratings						
A++	A+	A	A-	B++	B+	B	B-	C++	C+	C	C-	D
Superior		Excellent		Good		Fair		Marginal		Weak		Poor

Primary Care Benefits: Primary Care offers reimbursements towards day-to-day health care costs. The following is a brief outline of the benefits Primary Care has to offer. Please refer to our online Policy Documentfor full conditions applicable to each benefit at unimed.co.nz

Optical: 50% of the actual cost of an eye examination, glasses/lenses due to a change in vision, to a maximum of $250 a year each for Member, partner and children (maximum total $750).

Please Note - The effective date for the optical benefit is the date of the eye examination, NOT the date the lenses/glasses are purchased or supplied.

Medical Treatment: 50% of the actual cost of doctors' fees and prescription charges ($10 per item limit applies) to a maximum of $750 a year each for Member, partner and children (maximum total$2250).

Complementary Medical: (e.g., homeopathic, fertility treatment) 50% of the actual cost of specified expenses to a maximum of $400 a year each for Member, partner and children (maximum total$1200).

Hospital Expenses: 50% of the actual cost to a maximum of $700 a year each for Member, partner andchildren (maximum total $2100).

Standard $500 Excess Reimbursement:* is available to HealthCarePlus linked and approved Hospital Cover policies only (dental related oral surgery is excluded).

Major Diagnostic: 50% of the actual cost of CAT & MRI scans and Angiograms to a maximum of $600 a yeareach for Member, partner and children (maximum total of $1,800).

Medical Appliance: 50% of the actual cost of specified items (e.g. hearing aids) to a maximum of $400 a year each for Member, partner and children (maximum total $1200).

Orthodontic: 30% of orthodontic and associated fees to a maximum of $750 per registered child. The maximum benefit payable for the duration of the Membership is $1,500.

Sick Leave Without Pay: $50 per week plus $5 for each child to a maximum of $60 per week for 26 weeks.

Birth: $200 for each live child born to a Member or partner.

Bereavement: $1000 on the death of a Member, registered partner or child (including still birth).

*Entitlements cannot be aggregated to allow more than the annual maximum per adult or child. *Hospital Cover excess is available to HealthCarePlus linked and approved Hospital Cover policies only.*

*UniMed Primary Care rates are based on the age of the Member. **Please note that rates may change from time to time.** Hospital Cover rates are additional to the Primary Care rates and are available on request, please call 0800 268 3763.

Primary Care rates – effective 1 April 2025

	Single			Couple			One Parent Family			Two Parent Family		
Age	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
0-45	$8.50	$18.42	$221.01	$19.10	$41.39	$496.70	$18.10	$39.21	$470.55	$25.55	$55.36	$664.29
46-60	$9.86	$21.36	$256.37	$23.67	$51.28	$615.31	$19.77	$42.84	$514.03	$31.19	$67.58	$810.98
61-65	$12.43	$26.92	$323.06	$29.02	$62.88	$754.54	$20.39	$44.19	$530.25	$33.68	$72.97	$875.61
66-99	$15.19	$32.90	$394.82	$34.16	$74.02	$888.26	$22.84	$49.49	$593.93	$38.62	$83.68	$1,004.11

Primary Care non union rates (conditions apply – effective 1 April 2025)

	Single			Couple			One Parent Family			Two Parent Family		
Age	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
0-45	$9.35	$20.26	$243.11	$21.01	$45.53	$546.37	$19.91	$43.13	$517.61	$28.10	$60.89	$730.72
46-60	$10.85	$23.50	$282.01	$26.03	$56.40	$676.84	$21.75	$47.12	$565.43	$34.31	$74.34	$892.08
61-65	$13.67	$29.61	$355.37	$31.92	$69.17	$829.99	$22.43	$48.61	$583.28	$37.04	$80.26	$963.17
66-99	$16.70	$36.19	$434.30	$37.58	$81.42	$977.09	$25.13	$54.44	$653.32	$42.48	$92.04	$1,104.52

Primary Care is administered and underwritten by Union Medical Benefits Society Ltd (UniMed). Any cover issued in response to this application is subject to the terms and conditions contained in the relevant policy documentation and UniMed/HealthCarePlus Conditions of Membership. UniMed, PO Box 1721, Christchurch 8140. Level 3, 165 Gloucester Street, Christchurch 8011.

P 03 365 4048 **FP** 0800 600 666 **F** 03 365 4066 **E** sales@unimed.co.nz **W** unimed.co.nz

01 April 2025