

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

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) _____

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				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Partner				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Child 1				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Child 2				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Child 3				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Child 4				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>
Child 5				<input type="radio"/> M <input type="radio"/> F		<input type="checkbox"/> <input type="checkbox"/>

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

#care4U Benefits: #care4U offers reimbursements towards day-to-day health care costs. The following is a brief outline of the benefits #care4U has to offer. Please refer to our online Policy Document for full terms and conditions applicable to each benefit at unimed.co.nz

Dental: 50% of the actual cost of dental consultations and minor treatment to a maximum of \$250 a year each for Member, partner and children (maximum total \$750).

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 \$250 a year each for Member, partner and children (maximum total \$750).

Complementary Medical: (e.g., homeopathic, fertility treatment) 50% of the actual cost of specified expenses to a maximum of \$250 a year each for Member, partner and children (maximum total \$750).

*UniMed #care4U 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 #care4U rates and are available on request, please call 0800 268 3763.

#care4U rates - effective 1 April 2025

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
0-45	\$9.33	\$20.21	\$242.51	\$20.18	\$43.72	\$524.61	\$19.50	\$42.25	\$507.03	\$28.26	\$61.24	\$734.83
46-60	\$10.26	\$22.24	\$266.88	\$23.32	\$50.52	\$606.25	\$20.69	\$44.83	\$537.92	\$32.17	\$69.70	\$836.45
61-65	\$11.86	\$25.69	\$308.33	\$26.65	\$57.74	\$692.86	\$20.91	\$45.31	\$543.68	\$33.53	\$72.64	\$871.71
66-99	\$13.49	\$29.22	\$350.67	\$29.64	\$64.22	\$770.59	\$22.25	\$48.21	\$578.55	\$36.34	\$78.73	\$944.82

#care4U non union rates (conditions apply - effective 1 April 2025)

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
0-45	\$10.26	\$22.23	\$266.76	\$22.19	\$48.09	\$577.07	\$21.45	\$46.48	\$557.73	\$31.09	\$67.36	\$808.31
46-60	\$11.29	\$24.46	\$293.57	\$25.65	\$55.57	\$666.88	\$22.76	\$49.31	\$591.71	\$35.39	\$76.67	\$920.10
61-65	\$13.04	\$28.26	\$339.16	\$29.31	\$63.51	\$762.15	\$23.00	\$49.84	\$598.05	\$36.88	\$79.91	\$958.88
66-99	\$14.84	\$32.14	\$385.74	\$32.60	\$70.64	\$847.65	\$24.48	\$53.03	\$636.41	\$39.97	\$86.61	\$1,039.30

#care4U 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.