UniMed
YOUR HEALTH INSURER

Health Positive Plan

It's the security of knowing we're there

Effective 1 August 2023

Benefit Schedule

DENTAL BENEFITS	Stand Down Period	Annual Limit
Routine examinations, scale and polish, fillings, extractions, X-rays.	2 Months	$500
Wisdom teeth extraction.	12 Months	$500
Treatment by a registered orthodontist.	36 Months	$600

OPTICAL BENEFITS	Stand Down Period	Annual Limit
Prescription glasses or contact lenses.	12 Months	$350
Routine eye test.	12 Months	$50

HEALTH MAINTENANCE BENEFIT	Stand Down Period	Annual Limit
Physiotherapy. Treatment by a Registered Physiotherapist.	3 Months	$300 per service per annum, up to $600 total benefit per annum
Chiropractic. Treatment by a Registered Chiropractor.	3 Months	
Osteopath. Treatment by an Osteopath with NZ Registration.	3 Months	
Podiatry. Treatment by a Registered Podiatrist. Excludes orthotics and other devices.	3 Months	

HEALTH MAINTENANCE BENEFIT CONTINUED		
Rongoa Māori Practitioner as per Ministry of Health list of Practitioners (excluding food and food stubstitutes).	3 Months	See prior page for benefit limit
Homeopathy. Treatment by a Registered Homeopath including the cost of any medication.	3 Months	
Acupuncture. Treatment by a Registered Acupuncture Practitioner.	3 Months	
Remedial massage therapy. Treatment by a Registered Massage Therapist.	3 Months	
Dietician. Treatment by a Registered Dietician. Excludes food/ food substitutes.	3 Months	

GP BENEFITS	Stand Down Period	Annual Limit
GP consultations. Consultations with a Registered Medical Practitioner, Registered Practice Nurse and Independent Nurse Practitioner.	3 Months	$300
Prescriptions. User part charges for prescription items on the New Zealand Pharmaceutical Schedule and prescribed by a Registered Medical Practitioner; including psychiatric medications.	3 Months	
Non-Pharmac Subsidised Pharmaceuticals. Pharmaceuticals prescribed by a Registered Medical Practitioner in General Practice which have been approved by Medsafe and are not fully or partially subsidised by Pharmac through the New Zealand Pharmaceutical Schedule.	3 Months	
Surgery performed by a Registered Medical Practitioner in GP rooms.	3 Months	$200 per procedure up to $500 total benefit per annum

SPECIALIST CONSULTATIONS	Stand Down Period	Annual Limit
Consultations with a Specialist Registered Medical Practitioner, on referral from a GP (Registered Medical Practitioner).	3 Months	$5,000
Diagnostic investigations on referral from a specialist, excluding healthcare services performed in the specialists' rooms. Limited to X-rays, ultrasound, ECG, EEG, CT scans, MRI scans and diagnostic blood tests.	3 Months	

LOYALTY BENEFITS	Stand Down Period	Annual Limit
Loyalty benefit for screening services. Limited to smear and prostate tests, mammogram, mole checking, bone density scan, colonoscopy.	3 Years	$750
Childbirth grant (where both parents qualify then the grant is increased by 50%).	12 Months	$300 grant per per child
Psychiatric Consultations. Consultation with a psychiatrist who is vocationally registered in New Zealand.	5 Years	$150 per consultation Max 3 consultations per year

Although the UniMed Health Positive Plan includes registered specialist consultations on referral from a GP and diagnostic investigations on referral from a specialist, it excludes major surgery, hospital visits or healthcare services performed in the specialists' rooms. If you are interested in cover for surgery and related costs our qualified staff can discuss our other plans with you; call 0800 600 666.

Cover options explained

You can choose from two levels of reimbursement – 50% or 80% of actual costs up to the benefit limits. Your premium will reflect the level of cover you choose.

If you choose the 50% plan and wish to upgrade to the 80% plan in the future, please note that the stand down periods will start again and the higher level of cover will apply at the end of the stand down period. During the new stand down period, you will remain covered at the 50% level.

Cover for pre-existing conditions is included so we do not require you to provide details of your medical history.

If you choose to upgrade to a UniMed surgical plan, you will need to complete a full medical declaration relating to your medical conditions at the time of upgrade.

Application Form.

Title (please tick)

- ☐ Mrs
- ☐ Ms
- ☐ Miss
- ☐ Mr
- ☐ Mx
- ☐ Dr

Gender at birth (please tick)

- ☐ Female
- ☐ Male

DOB of applicant

DD/MM/YYYY

Full name of applicant*

First name | Middle name | Surname

Address of applicant

Street | Suburb

City | Postcode

*Please use another form for each additional family member

Contact information

Contact Phone | Cellphone | Email

Nature of plan: Level of reimbursement (please tick)

- ☐ 50%
- ☐ 80%

Premium payment options

I wish to pay my premium:

- ☐ Annually
- ☐ Monthly
- ☐ Fortnightly

And by the following method

- ☐ Direct debit
- ☐ Recurring credit card payment

Important information

- This form is your application to become a member of the Union Medical Benefits Society Limited (UniMed), which administers health insurance for Members.
- You have a 30 day free look period to review all Health Plan information provided to you. If for any reason you do not want to proceed with your selected Health Plan you can cancel for free within the 30 Day period. If you decide to cancel within 30 days but have already made a claim UniMed will not process any claim you are waiting on and you will need to return any money to UniMed for any claim you have been paid out for under this Health Plan.
- 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 or view these on our website.

Privacy declaration

Pursuant to the Privacy Act 2020 (and the Health Information Privacy code 2020) 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 cover you seek.
ii. You are required by law to disclose information that is revelant to the cover you require. Failure to provide this information may result in your application for cover rejected, any claim declined or your cover being cancelled from your Health Plan start date.
iii. This information will be held by Union Medical Benefits Society Limited whose Head Office is 165 Gloucester Street, Christchurch, and any agency involved in completing your application.
iv. You have the right to access and to request correction of this information, subject to the provisions of the Privacy Act 2020.
v. Your information and privacy is important to us. Please check unimed.co.nz to view our privacy sytatement.

Applicant's declaration

- I acknowledge having read and understood the significance of the 'Important Information' contained in this Application Form.
- I declare all entries made on this form to be true and correct and that I am not aware of any other circumstance which may impact the terms or acceptance of my Health Plan. I acknowledge that failure to make this declaration truthfully may invalidate my insurance.
- I understand that the declaration in the Application Form constitutes the basis of the contract with UniMed. 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.
- I agree that any payment accompanying this application shall be a deposit only and I understand that any coverage will not commence until UniMed has issued a Membership Certificate.
- 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 personal medical information UniMed may require in respect of this application or future claims as submitted by me, from any healthcare professional who has attended or examined me or my listed dependants.
- I agree to be bound by the Rules of UniMed and the Conditions of Membership.

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)

I am filling this form on behalf of:

☐ Myself (proceed to signature)

☐ Dependant/applicant ☐ I have the authority/delegation to apply for the applicant Your relationship to applicant

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☐ I agree to the above terms and conditions

Signed **Date**

Full name Signature

Payment Authority

Membership Number (if known)

Full name

First name

Surname

I would like to pay by:

☐ Direct Debit (Complete direct debit authority section **A ONLY**)

☐ Credit Card (Complete credit card authority section **B ONLY**)

Payment frequency

☐ Annually ☐ Monthly ☐ Fortnightly

Deduction date

A. Direct debit authority:

Authority to accept Direct Debits
(Not to operate as an assignment or agreement)

Authorisation code: 0201319

Complete this section if you have chosen **direct debit** as your payment type or skip to section (B) for credit card authority.

Account name

Name of bank account e.g. JP Smith

Bank

Bank name e.g. ANZ

Bank account from which payments are to be made

I/We (hereinafter referred to as the Customer) authorise you until further notice, to debit my/our account with all amounts which Union Medical Benefits Society Limited (referred to as the Initiator in this form) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit. I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed overleaf.

Signature(s)

Date

☐ I agree to the conditions of this authority as stated overleaf

B. Authority to accept recurring card payments:

Card type

☐ Mastercard ☐ Visa

Card expiry date

☐ I agree to the conditions of this authority as stated overleaf

Card number

I/We (hereinafter referred to as the Customer) authorise Union Medical Benefits Society Limited (referred to as the Initiator in this form), until further notice in writing, to debit my card number as detailed above (the "Nominated Card"). I acknowledge and accept that the initiator accepts this Authority only upon the conditions listed overleaf.

Signed

Date

Cardholder's full name

Cardholder's signature

Payment Authority

Conditions of this authority to accept Direct Debits

1. The Initiator

(a) Has agreed to give advance Notice of the net amount of each direct debit and the due date of debiting at least 10 calendar days before (but not more than 2 calendar months) the date the direct debit will be initiated. This notice will be provided either:

(i) in writing; or

(ii) by electronic mail where the Customer has provided prior written consent to the Initiator

The advance notice will include the following message:
"Unless advice to the contrary is received from you by (*date), the amount of $..... will be directly debited to our Bank account on (initiating date)."
* This date will be at least two days prior to the due date to allow for amendment of direct debits

(b) May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

2. The Customer may:

(a) At any time, terminate this Authority as to future payments by giving written notice of termination to the Bank and to the Initiator.

(b) Stop payment of any direct debit to be initiated under this authority by the Initiator by giving written notice to the Bank prior to the direct debit being paid by the Bank.

3. The Customer acknowledges that:

(a) This authority will remain in full force and effect in respect of all direct debits made from me/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.

(b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

(c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the Initiator.

(d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:

(i) the accuracy of information about Direct Debits on Bank statements

(ii) any variations between notices given by the Initiator and the amounts of Direct Debits

(e) The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

4. The Bank may:

(a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.

(b) At any time terminate this authority as to future payments by notice in writing to me/us.

(c) Charge its current fees for this service in force from time-to-time.

Conditions of this authority to accept recurring card payments

1. The Initiator agrees:

(a) To give advance written notice (including by electronic means) to the Customer in the form of a schedule of payment dates and the net amounts to be debited to the Nominated Card.

(b) In the event of any subsequent change to the frequency or amount of the debits to the Nominated Card, the Initiator has agreed to give advance written notice of at least 10 days to the Customer before the changes comes into effect.

2. The Customer may:

(a) At any time, terminate this Authority by giving written notice of termination to the Initiator.

3. The Customer acknowledges that:

(a) This Authority will remain in full force and effect in respect of all amounts to be debited to my Nominated Card in good faith notwithstanding my death, bankruptcy or other revocation of this authority.

Need to know more before making your choice?

Phone UniMed's friendly, helpful staff now and secure your future. If calling from Christchurch please phone 03 365 4048.

Freephone: **0800 600 666**

Head Office

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