HealthCare
It's good to belong

# Primary Care Application

**MOE Employee Number** (if applicable)

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

☐ I am a current Member ☐ I am a new Member
☐ I am a Family/Whanau non union Member

**UniMed Ref :** (For office use only)

Union: _____

☐ Linked through (name): _____ at non union rate. His/Her UniMed Ref: _____

**UniMed 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 Advisor.**

Hospital Cover Provider: _____ Specialist & Tests Y / N

Policy Name: _____ Monument Financial Advisor (if known): _____

**MEMBER & FAMILY MEMBER DETAILS (children must be under 21 years)**

| | Title | Surname | Given Names | Sex | DOB | Plan Type HCP ✓ | Plan Type Hos |
|---|---|---|---|---|---|---|---|
| **Member** | | | | | / / | | |
| **Partner** | | | | | / / | | |
| **Child 1** | | | | | / / | | |
| **Child 2** | | | | | / / | | |
| **Child 3** | | | | | / / | | |
| **Child 4** | | | | | / / | | |

**MEMBER: ADDITIONAL DETAILS**

Postal Address: _____

_____ Postcode: _____

Home Phone: (0 ) _____ Work Phone: (0 ) _____ Mobile: (0 ) _____

Preferred Email: _____

Alternative Email: _____

Place of Work: _____

**DECLARATION & COMMENCEMENT OF COVER** (tick as appropriate)

☐ The rate/new rate will be $_____ which I understand is subject to review in accordance with the Primary Care Policy wording. ☐ I understand my/our **UniMed Primary Care** cover will commence from the date of my first fortnightly salary deduction of premium. (n/a PSA members)

☐ I understand my/our **UniMed Primary Care** cover will commence from the date of the first direct debit of premium from my bank.

☐ I have attached my completed direct debit form.
**(Direct debit forms can be downloaded at unimed.co.nz/important-documents or Freephone 0800 600 666.)**

☐ I declare that I am a full financial member of the above named union.

☐ I declare 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 contained in the UniMed/HealthCarePlus Conditions of Membership. I also consent to the collection, disclosure and use of my/our information for the purposes of the Integrity Register.

☐ I declare that the information provided in this form is true and correct. This application is for cover under the Primary Care Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

**Member's Signature:** **Date**: ____/____/____

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

Surname: _____ Given Names: _____

Worksite: _____ ☐ This is a new authority ☐ This replaces an existing authority

I authorise you to deduct $_____ (or such other amount from time to time determined by UniMed) from my salary

**Financial Strength Rating:** Union Medical Benefits Society Limited (UniMed) has been given an A (Excellent) Financial Strength Rating by AM Best. AM Best's ratings are as follows:
Secure: A++, A+ (Superior); A, A- (Excellent); B++, B+ (Good)
*Vulnerable*: B, B- (Fair); C++, C+ (Marginal); C, C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Suspended)

**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 Document for full conditions applicable to each benefit at www.healthcareplus.org.nz

**Optical**: 50% of the net 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) - providing subscriptions have been paid for six months prior to the date of the optical examination.

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 net 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 net 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 net 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 net cost of CAT & MRI scans and Angiograms to a maximum of $600 a yeareach for Member, partner and children (maximum total of $1,800) - providing subscriptions have been paid forsix months prior to the date of the procedure.

**Medical Appliance**: 50% of the net 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 percent 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 2024

| | Single | | | Couple | | | One Parent Family | | | Two Parent Family | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | Fortnight | Month | Annual | Fortnight | Month | Annual | Fortnight | Month | Annual | Fortnight | Month | Annual |
| 00-45 | $8.04 | $17.42 | $208.99 | $18.06 | $39.14 | $469.69 | $17.11 | $37.08 | $444.96 | $24.16 | $52.35 | $628.17 |
| 46-60 | $9.32 | $20.20 | $242.43 | $22.38 | $48.49 | $581.85 | $18.70 | $40.51 | $486.08 | $29.50 | $63.91 | $766.88 |
| 61-65 | $11.75 | $25.46 | $305.49 | $27.44 | $59.46 | $713.51 | $19.29 | $41.78 | $501.42 | $31.85 | $69.00 | $828.00 |
| 66-99 | $14.36 | $31.11 | $373.35 | $32.31 | $70.00 | $839.96 | $21.60 | $46.80 | $561.64 | $36.52 | $79.13 | $949.51 |

## Primary Care Non Union rates (conditions apply) – effective 1 April 2024

| | Single | | | Couple | | | One Parent Family | | | Two Parent Family | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | Fortnight | Month | Annual | Fortnight | Month | Annual | Fortnight | Month | Annual | Fortnight | Month | Annual |
| 00-45 | $8.84 | $19.16 | $229.89 | $19.87 | $43.05 | $516.66 | $18.83 | $40.79 | $489.46 | $26.58 | $57.58 | $690.99 |
| 46-60 | $10.26 | $22.22 | $266.67 | $24.62 | $53.34 | $640.04 | $20.56 | $44.56 | $534.69 | $32.44 | $70.30 | $843.57 |
| 61-65 | $12.92 | $28.00 | $336.04 | $30.19 | $65.40 | $784.86 | $21.21 | $45.96 | $551.56 | $35.03 | $75.90 | $910.80 |
| 66-99 | $15.80 | $34.22 | $410.69 | $35.54 | $77.00 | $923.96 | $23.76 | $51.48 | $617.80 | $40.17 | $87.04 | $1,044.46 |