

MOE Employee Number (if applicable)

UniMed Ref : (For office use only)

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

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 / 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 #care4U Policy wording.  I understand my/our **UniMed #care4U** cover will commence from the date of my first fortnightly salary deduction of premium. (n/a PSA members or a non Novopay payroll)
- I understand my/our **UniMed #care4U** 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 #care4U Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

**Member's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

\*\*\*\*\*  
**Authority to make HealthCarePlus deductions from salary (n/a PSA members or a non Novopay payroll)**

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)



**#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 [www.healthcareplus.org.nz](http://www.healthcareplus.org.nz)

**Dental:** 50% of the net 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 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 \$250 a year each for Member, partner and children (maximum total \$750).

**Complementary Medical:** (e.g., homeopathic, fertility treatment) 50% of the net 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 2024**

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	\$8.84	\$19.16	\$229.87	\$19.13	\$41.44	\$497.26	\$18.48	\$40.05	\$480.60	\$26.79	\$58.04	\$696.52
46-60	\$9.73	\$21.08	\$252.97	\$22.10	\$47.89	\$574.64	\$19.61	\$42.49	\$509.88	\$30.49	\$66.07	\$792.84
61-65	\$11.24	\$24.35	\$292.26	\$25.26	\$54.73	\$656.74	\$19.82	\$42.94	\$515.34	\$31.78	\$68.86	\$826.27
66-99	\$12.78	\$27.70	\$332.39	\$28.09	\$60.87	\$730.42	\$21.09	\$45.70	\$548.39	\$34.44	\$74.63	\$895.56

**#care4U non union rates (conditions apply) – effective 1 April 2024**

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	\$9.73	\$21.07	\$252.86	\$21.04	\$45.58	\$546.99	\$20.33	\$44.05	\$528.66	\$29.47	\$63.85	\$766.17
46-60	\$10.70	\$23.19	\$278.27	\$24.31	\$52.67	\$632.10	\$21.57	\$46.74	\$560.87	\$33.54	\$72.68	\$872.12
61-65	\$12.36	\$26.79	\$321.49	\$27.78	\$60.20	\$722.41	\$21.80	\$47.24	\$566.87	\$34.96	\$75.74	\$908.90
66-99	\$14.06	\$30.47	\$365.63	\$30.90	\$66.95	\$803.46	\$23.20	\$50.27	\$603.23	\$37.89	\$82.09	\$985.12

#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.

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01 April 2024