Cancer Care Plus Application

UniMed
YOUR HEALTH INSURER

Title

☐ Mrs ☐ Ms ☐ Miss ☐ Mr ☐ Mx ☐ Dr

Membership Number | **Date of birth** DD/MM/YYYY | **Gender at birth**

☐ Female ☐ Male

Full name

First name(s) | Surname

Postal Address

Street | Suburb

City | Postcode

Contact information

Email | Home phone | Cellphone

Additional family members to be covered under this plan

	Surname	First name(s)	Gender at birth		Date of birth DD/MM/YYYY
Spouse/Partner			☐ M	☐ F	
Child 1			☐ M	☐ F	
Child 2			☐ M	☐ F	
Child 3			☐ M	☐ F	
Child 4			☐ M	☐ F	
Child 5			☐ M	☐ F	

1. Have you or any person named on this application ever been diagnosed with, received or intend to receive medical advise, or had signs or symptoms that could suggest cancer or malignancy including, Hodgkin's disease, blood cancer (leukemia, lymphoma, or myeloma), melanoma, or metastasised skin lesion?

☐ Yes ☐ No

Name	Description of symptoms/ Treatment/Investigation/Diagnosis	Date/Year

2. Have you or any person named on this application ever had signs or symptoms of, or been tested, treated, or diagnosed with any disease or disorder of any of the following?

- ☐ Yes ☐ No Cervix, uterus, vagina, including abnormal smears, pre-cancerous cells, polyps
- ☐ Yes ☐ No Prostate including blood in urine or change in urination habits
- ☐ Yes ☐ No Bowel, including change in bowel habits, polyps
- ☐ Yes ☐ No Breast, including breast lumps
- ☐ Yes ☐ No Skin disorders, including BCC's, SCC's and skin lesions

Name	Description of symptoms/Treatment/Investigation/Diagnosis	Date/Year

3. Have you or any person named on this application had a parent or sibling (blood relative) diagnosed with any type of cancer or malignancy before the age of 55?

☐ Yes ☐ No

Name	Relationship to person	Type of cancer	Date/Year

4. Are you or any person named on this application aware that they have a genetic predisposition for developing cancer?

☐ Yes ☐ No

Name	Type of cancer

5. Are you or any person named on this application waiting for the completion or results of any medical investigation?

☐ Yes ☐ No

Name	Symptoms for investigation

6. Are you or any person named on this application intending to seek or currently seek any medical advice, examination or procedure?

☐ Yes ☐ No

Name	Symptoms for investigation

7. In the last 12 months have you or any person named on this application smoked tobacco or any other substance and /or used smoking alternatives (e.g. e-cigarettes, vapes, nicotine gum or patches)

☐ Yes ☐ No

Name	Please give details of each substance including date started (or stopped) and quantity/nicotine strength

THIS DECLARATION IS VERY IMPORTANT. PLEASE ENSURE YOU READ IT CAREFULLY

1. I declare all statements made for the purpose of this application to be true and complete (i.e, includes all medical history requested for all persons listed on the application).
2. I confirm that I have authority to submit this application on behalf of all persons listed in this application.
3. I understand that the information provided in this application forms the basis of the contract with UniMed and will be used to assess eligibility for cover and any special terms (including exclusions or restrictions of cover) to administer the policy and to assess any future claims.
4. I understand that not providing complete or correct information for all persons listed in this application (or added at a later date) or failing to answer truthfully, may result in this application being rejected, any claim declined, the policy being cancelled, or the policy being void (cancelled from the beginning).
5. I understand that UniMed will confirm cover and any special conditions, (including specific exclusions or restrictions) by issuing a (Membership Certificate) and that cover will not commence until the effective date stated on the (Membership Certificate).
6. I understand that the continuation of cover is conditional upon payment of all premiums as they fall due and that premiums may change over time. I understand that UniMed will provide me notice of any change in premiums at least 30 days in advance of this taking effect.
7. I authorise UniMed to collect relevant health information from any health service provider or insurer who holds health records relating to me or any other person listed in my application (or added at a later date), which is reasonably required in order to process this application or to assess future claims submitted under this policy. I agree to do all things reasonably requested to facilitate UniMed obtaining such information (i.e completing or signing any necessary consents or authorities).
8. I agree to the terms and conditions of Membership and the rules of UniMed.
9. I acknowledge that my electronic acceptance of this declaration is equivalent to my signing this application.

The Privacy Act 2020 provides you with certain rights relating to the information which we collect in this application. We recommend that you read the Privacy Statement on our webpage unimed.co.nz

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 agree to the above terms and conditions and have disclosed fully about the applicant on my/their behalf.

Signed **Date**

Full name Signature

UniMed
YOUR HEALTH INSURER

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

Union Medical Benefits Society Limited
165 Gloucester Street, Christchurch
PO Box 1721, Christchurch 8140
unimed.co.nz