Critical Diagnosis Application

UniMed
YOUR HEALTH INSURER

Plan applied for

☐ Critical Diagnosis $10,000 ☐ Critical Diagnosis $25,000 ☐ Critical Diagnosis $50,000

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:

Yes	No	
☐	☐	**a.** Angina, rheumatic fever, aneurysms, high blood pressure and/or high cholesterol or any other vascular, blood or heart conditions?
☐	☐	**b.** Gynaecological disorders including abnormal smears?
☐	☐	**c.** Cancer or any type of malignancy including, Hodgkin's disease, leukemia, lymphoma, melanoma, metastasised skin lesion or breast lumps?
☐	☐	**d.** Any injury or disorder of the nervous system (brain, spinal cord or nerves), including: Stroke, multiple sclerosis, dementia, Alzheimer's disease, Parkinsons disease, motor neurone disease, muscular dystrophy or paralysis?
☐	☐	**e.** Any condition of the bladder or kidney?
☐	☐	**f.** Any condition of the liver including hepatitis?
☐	☐	**g.** Respiratory or lung disorders including cystic fibrosis and chronic obstructive pulmonary disorder (not including asthma)?
☐	☐	**h.** Failure of the heart, liver, lung, kidney, pancreas, small bowel or bone marrow or been advised by a medical specialist that an organ transplant would be an appropriate procedure?
☐	☐	**i.** Inflammatory joint disorders, including rheumatoid arthritis or ankylosing spondylitis (not including osteo-arthritis)?
☐	☐	**j.** Diabetes or high blood sugar (not including gestational)?
☐	☐	**k.** Digestive tract disorders, including crohn's disease and ulcerative colitis?

If you answered Yes to any questions above, please complete full details:

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

2. Have you or any person named on this application had a parent or sibling (blood relative) diagnosed with any of the following: Motor neurone disease, Parkinson's disease, Dementia, Heart disease, Polycystic kidney disease, Stroke, Diabetes, Muscular dystrophy, Cancer before the age of 55?

☐ Yes ☐ No

Name	Condition	Treatment	Date

3. Have you or any person named on this application ever been diagnosed with or received treatment for any congenital, hereditary conditions and/or developmental disorders?

☐ Yes ☐ No

Name	Condition	Treatment	Date

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
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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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