

# ParentStay Health Plan Application Form

October 2025 v1

## Section A: Important information before you start your application

The ParentStay Health Plan has been designed specifically for people applying for or holding a Parent Boost Visitor Visa for New Zealand.

Before you begin, please make sure you meet the eligibility requirements below.

### Eligibility overview

#### You can apply for ParentStay if:

- **You** hold a valid Parent Boost Visitor Visa, or **you** are in the process of obtaining one; and
- **You** meet Immigration New Zealand's Acceptable Standard of Health and all other visa requirements.

#### To remain covered under your policy:

1. **You** must hold a valid Parent Boost Visitor Visa at the **start date** of **your policy** and continue to hold this visa for the entire duration of **your** cover.
2. **Your** cover will only begin from **your policy start date**, which will be after **your** Parent Boost Visitor Visa has been approved and **you** have entered New Zealand.
3. If **your** visa application is declined, withdrawn, or expires, **your policy** will no longer be valid.

#### You're not eligible for this policy if any of the following apply to you:

- **You** are travelling against the advice of **your specialist** or **GP**
- **You** have ever been diagnosed with **metastatic cancer**
- **You** have been diagnosed with a **terminal illness** with a life expectancy of less than 24 months
- **You** have been diagnosed with congestive heart failure
- **You** have ever had a valve replacement
- **You** have ever had an organ transplant
- **You** are using home oxygen for any medical **condition**
- **You** require full-time assistance in order to undertake any **activities of daily living**.

If **you** apply and do not meet these criteria then **you** will not be eligible for cover under this **Health Plan**. If **you** provide incorrect information **your policy** may be cancelled from the beginning and any related **claims** may not be paid.

Defined terms used in this Application are in bold and have the same meanings as those set out in the ParentStay **Health Plan** document available on our website [unimed.co.nz](https://unimed.co.nz). Please refer to that document if **you** need to check the meaning of any defined term.

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## Section B: Application details

### 1. Personal details - Primary Member (please print clearly in block letters throughout form)

Title		Sex assigned at birth		Date of birth DD/MM/YYYY			
<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	<input type="radio"/> Mx	<input type="radio"/> Male	<input type="radio"/> Female	<input type="text"/>
First name(s)				Last name			
<input type="text"/>				<input type="text"/>			
New Zealand postal address - Street / Suburb / City / Postcode							
<input type="text"/>							
Mobile phone				Home phone			
<input type="text"/>				<input type="text"/>			
Email							
<input type="text"/>							
Country of origin				This is the country listed as <b>your</b> last country of residence in <b>your</b> visa application or immigration records at the time of entry to New Zealand.			
<input type="text"/>							

### 2. Additional family member to be covered under this policy

#### Partner/Spouse:

Title		Sex assigned at birth		Date of birth DD/MM/YYYY			
<input type="radio"/> Mr	<input type="radio"/> Mrs	<input type="radio"/> Miss	<input type="radio"/> Ms	<input type="radio"/> Mx	<input type="radio"/> Male	<input type="radio"/> Female	<input type="text"/>
First name(s)				Last name			
<input type="text"/>				<input type="text"/>			
Mobile phone				Home phone			
<input type="text"/>				<input type="text"/>			
Email							
<input type="text"/>							
Country of origin				This is the country listed as <b>your</b> last country of residence in <b>your</b> visa application or immigration records at the time of entry to New Zealand.			
<input type="text"/>							

### 3. Policy options

#### Policy start date

DD/MM/YYYY	This must align with the date <b>you</b> enter New Zealand on <b>your</b> Parent Boost Visitor Visa.
<input type="text"/>	

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## 4. Current insurance

Do **you** currently have health and/ or travel insurance with another provider?

☐ Yes ☐ No

Name of current provider and insurance plan

**Please note:** This Application is not a guarantee of cover. Do not cancel **your** existing health or travel insurance **policy** until **you** have received **your UniMed Membership Certificate**, which will confirm any restrictions in cover.

## 5. Financial Adviser details

Provide **your** Financial Adviser's name and company:

Adviser's Full Name

Adviser's Company

## 6. Payment details

**Your premium** is payable annually in advance. Please indicate **your** preferred payment method:

- ☐ Direct debit (from a New Zealand bank account)
- ☐ Credit card
- ☐ Invoice (to be paid by bank transfer or online payment)

Once **your** application has been processed, **we'll** contact **you** with instructions on how to make payment and confirm **your policy** has been set up.

## Section C: Health declaration

Please answer all questions below and [attach the Immigration New Zealand medical assessment](#) for each person to be insured, completed within the last 12 months.

	Primary Member	Partner
<b>1. Heart conditions</b> Have <b>you</b> , or any other person to be insured, ever experienced, had symptoms of, been treated for, or been advised to seek testing or treatment for: angina or chest pain, heart attack (myocardial infarction), heart failure, irregular heartbeat (arrhythmia), heart murmur or rheumatic fever?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>2. Cancer</b> Have <b>you</b> , or any other person to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for: polyps, any cancers or pre-cancerous <b>conditions</b> including skin cancer?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<b>3. Change to health</b> Since <b>your</b> Immigration New Zealand medical assessment, have <b>you</b> , or any other person to be insured, experienced any changes in <b>your</b> health, including the onset of new symptoms, diagnoses, treatments, or any changes to existing medical <b>conditions</b> ?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

Once **we** have reviewed **your** Application, **we** may get in touch if **we** need more details or clarification about **your** health information.

# Section D: Declaration

This declaration is very important. Please ensure you read it carefully.

1. I am authorised by all persons listed in this Application to submit this Application on their behalf.

2. I declare that all the information provided in this Application is true, correct and complete and that I have not omitted or misrepresented any information.

3. I declare that I have read and understood the eligibility criteria for the ParentStay **Health Plan** and confirm that I and all persons listed in this Application meet those criteria.

4. If, between the date this Application is signed and the **policy start date**, I become aware of any health **condition** or **event**, or other relevant information concerning any person listed in this Application, that has not been included in this Application, I agree to inform **UniMed** immediately.

5. I understand that if I have provided information in this Application that is untrue, incomplete or misleading, or if I have failed to disclose any information asked for (including complete and true medical and health information), this may result in my Application being rejected, any **claims** made declined, additional terms applied to the **policy** and/ or the cancellation of the **policy**, in accordance with its terms and New Zealand law.

6. I understand that if I have provided information that is fraudulent, that **UniMed** may take legal action, and/or notify Government agencies or departments such as the New Zealand Police and/or Immigration New Zealand.

7. I understand that the information provided in this Application forms the basis of my contract with **UniMed** and will be treated as one of the documents that make up the **policy**.

8. I understand that this Application is not a guarantee of cover and cover will not commence until the **start date** listed on the **Membership Certificate** issued by **UniMed**.

9. I understand and agree that my **membership** and **policy** cover with **UniMed** is conditional upon the continual payment of all **premiums** as they fall due.

10. I understand that any restrictions of cover in relation to my declared existing **conditions** (**personal exclusions**) will be shown on my **Membership Certificate**.
11. I authorise **UniMed** to obtain from any person or organisation any further information required to assess this Application or future **claims**, and I authorise those persons or organisations to disclose such information to **UniMed**. This may include, but is not limited to, obtaining details regarding previous medical history and previous health insurance. I understand this authorisation is ongoing and I agree to do anything necessary to assist **UniMed** in obtaining such information, including completing or signing any necessary consents or authorities.

12. I authorise **UniMed** to share information about my **policy** and **membership** with relevant government departments or agencies, where necessary to confirm eligibility, validate cover, or comply with legal or regulatory requirements.

13. I understand that the information collected in this Application is for the purpose of evaluating my **membership** application, future **claims** and otherwise in accordance with **UniMed's** Privacy Statement. The intended recipient of this information is **UniMed**.

14. I declare that if I am incapacitated or otherwise unable, due to serious medical reasons or death, to communicate with **UniMed** regarding my **policy**, I authorise my **sponsoring child** to act on my behalf in all discussions with **UniMed** concerning this **policy**.

15. I understand that this Application and any **policy** issued is subject to the terms and conditions within the ParentStay **Health Plan** document and the **Rules of UniMed**.

16. If this Application has been completed online, I acknowledge and agree that my electronic acceptance of this declaration makes it fully binding on me and any other persons listed in the Application.
- The Privacy Act 2020 requires **UniMed** to inform **you** about certain rights and obligations relating to the information which **we** collect in this application. Please read the [Privacy Statement](#) on **our** website.

For further information about **UniMed**, including **our** Financial Strength Rating (FSR) please visit [unimed.co.nz](#)

## Primary Member

Full name

Signature

Date (dd/mm/yy)

## Partner

Full name

Signature

Date (dd/mm/yy)

It is important that **we** receive **your** Application within 30 days of **you** signing this form or **your** Application may become invalid. Please email all Application forms and Immigration New Zealand medical assessments to [applicationsparentstay@unimed.co.nz](mailto:applicationsparentstay@unimed.co.nz).