# ParentStay Short Application.



UniMed

Complete and return to us, along with Immigration New Zealand medical assessments, at applicationsparentstay@unimed.co.nz.

# 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 If your visa application is declined, withdrawn, or expires, your policy will no longer be valid.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.

# Section B: Application details

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

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

Male Female

**Email**

**Mobile phone**

**Home phone**

**New Zealand postal address**

Street

Town/ city

Postcode

**Country of origin**

This is the country listed as your last country of residence in your visa application or immigration records at the time of entry to New Zealand.

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

### Partner/ Spouse:

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

Male Female

**Email**

**Mobile phone**

**Home phone**

**Country of origin**

This is the country listed as your last country of residence in your visa application or immigration records at the time of entry to New Zealand.

## 3. Policy options

**Policy start date** (dd/mm/yy)

This must align with the date you enter New Zealand on your Parent Boost Visitor Visa.

## 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 your cover and any applicable restrictions.

## 5. Adviser details

Provide your 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/ Spouse |
|---|---|---|
| **1. Heart conditions**<br>Have you, 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? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| **2. Cancer**<br>Have you, 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 conditions including skin cancer? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| **3. Change to health**<br>Since your Immigration New Zealand medical assessment, have you, or any other person to be insured, experienced any changes in your health, including the onset of new symptoms, diagnoses, treatments, or any changes to existing medical conditions? | ◯ Yes ◯ No | ◯ Yes ◯ No |

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

Continue on next page ▸

# Section D: Declaration and authorisation

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

1. 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.
2. I understand that I need to include in this Application all information requested, even if I have already shared this information with a representative of UniMed or with my Adviser.
3. 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.
4. I understand that this Application is not a guarantee of cover and cover will not commence until the policy start date listed on the Membership Certificate issued by UniMed.
5. 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.
6. I understand that this Application and any policy issued is subject to the UniMed Terms and Conditions or the Terms and Conditions contained within the Health Plan document, and to the UniMed Rules.
7. 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.
8. 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.
9. I confirm 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.

The personal and health information about you and those covered under your Health Plan is collected for the purpose of evaluating your Application.

If your Application is approved then this information will be used by us to help you access our products and services, including administering your policy and associated claims.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – unimed.co.nz/privacy.

☐ **I/We have read and agree to the Declaration.**

☐ **I am authorised by all persons listed in this Application to submit this Application on their behalf and I confirm that they are aware the information I provide will be disclosed to UniMed.**

☐ **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.**

**Primary Member**

Full name

Signature

Date (dd/mm/yy)

**Partner/ Spouse**

Full name

Signature

Date (dd/mm/yy)

### Financial strength rating

UniMed has an **A (Excellent)** Financial Strength Rating from AM Best.

The 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), S (Suspended).

**IT IS IMPORTANT THAT YOU RETURN THIS FORM WITHIN 30 DAYS OF YOU SIGNING OR IT MAY BECOME INVALID.**

# ParentStay Authority to Act.



UniMed

Complete and return to us at applicationsparentstay@unimed.co.nz if you wish to nominate someone to act on your behalf regarding your policy. You can opt to give them Full or Partial Authority to Act.

## Definitions

### Full Authority to Act

Act on the instructions of my nominated person and share my personal and health information (including claims history) with them. This includes submitting claims and prior approvals on my behalf, changing policy details including excesses, adding and removing Members or modules to my policy, or suspending my policy.

- Full Authority to Act **does not** give your nominated person the authority to cancel your policy or change your bank account details for reimbursements.
- Your nominated person with Full Authority to Act **will not** be able to access the claims history of, or submit claims for, any other person on your policy.

### Partial Authority to Act

Share my personal and health information (including claims history) with my nominated person.

- Partial Authority to Act **does not** give your nominated person the authority to transact on your policy in any way.
- Your nominated person with Partial Authority to Act **will not** be able to access the claims history of any other person on your policy.

## 1. Primary Member details

**Title**

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Mx ◯ Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Membership/ Policy number**

**Address**

Street

Town/ city

Postcode

**Mobile phone number**

**Home phone number**

**Email**

## 2. Your nominated person 1

**I authorise UniMed to give the below nominated person**

◯ Full Authority to Act ◯ Partial Authority to Act

**Title**

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Mx ◯ Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Relationship to Primary Member** (optional)

**Address**

Street

Town/ city

Postcode

**Mobile phone number**

**Home phone number**

**Email**

## 3. Your nominated person 2

**I authorise UniMed to give the below nominated person**

◯ Full Authority to Act ◯ Partial Authority to Act

**Title**

◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Mx ◯ Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Relationship to Primary Member** (optional)

**Address**

Street

Town/ city

Postcode

**Mobile phone number**

**Home phone number**

**Email**

# 4. Declaration and authorisation

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

**I understand that:**

1. My nominated person will have access to my claims history and all policy and premium information for everyone covered by the policy. It is my responsibility to ensure that everyone on my policy is aware of and consents to this.
2. UniMed is not responsible for any actions of my nominated person using this authority.
3. This authority comes into effect from the date UniMed receives this form.
4. I am giving my nominated person access to my information by phone, email, and letter.
5. My nominated person or I can contact UniMed at any time to cancel this authority. Cancellation will not be effective until it is confirmed by UniMed.

**Personal information**

The personal information about you and your nominated person is collected for the purposes of administering your policy.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices and your associated rights – unimed.co.nz/privacy. It is your responsibility to ensure your nominated person is aware of our Privacy Statement.

☐ **I have read and agree to the Declaration.**

☐ **I am authorised by all persons listed in this form to submit this form to UniMed and I confirm they are aware the information I provide will be disclosed to UniMed.**

**Primary Member's full name**

**Signature**

**Date signed** (dd/mm/yy)