Your insurance plan

Primary Care

Effective 1 April 2026

HealthCare
It's good to belong

UniMed

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TEU | TE HAUTŪ KAHURANGI
TERTIARY EDUCATION UNION

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And Affiliate Unions

Welcome to Primary Care a HealthCarePlus product underwritten by Union Medical Benefits Society Ltd (UniMed)

Thank you for choosing Primary Care from HealthCarePlus underwritten by UniMed. We are sure that you will find that it's good to belong.

This is your Health Plan document. Please take the time to read it carefully and if you have any questions please contact UniMed at 0800 600 666.

See unimed.co.nz/contact for when we're available.

What is Primary Care?

This Health Plan covers day-to-day healthcare costs. This includes a wide range of healthcare treatment and other benefits from optical and GP visits to complementary medical provider visits and healthcare screening.

Primary Care is exclusively available to members of participating unions[1] and their families.[2] It's one of the key benefits of belonging to these unions. Primary Care is underwritten by UniMed. Only UniMed can approve and accept your policy and UniMed will be responsible for all claims and other matters relating to your policy.

Terms used in this document

We have included terms in the Definitions section on Page 15.

1. Members of Unions that are either Primary Members or admitted to membership of the Education Benevolent Society as an Affiliate Member in accordance with the Society's Constitution.
2. See definition of "Family/Whānau" on page 15.

Who is HealthCarePlus?

HealthCarePlus is the trading name for the Education Benevolent Society Incorporated (EBS). Established and owned by like-minded unions, HealthCarePlus is a not-for-profit/charitable society that has been supporting the union movement for over 60 years by providing services and member benefits to all eligible union members and their whānau.

HealthCarePlus manages a Member Benefits Program on behalf of their member unions, called Better Off Together. It aims to add value to their union membership by giving members access to everyday discounts and supporting their physical, mental and financial wellbeing through education, services, and trusted advice.

HealthCarePlus is committed to working with Member Unions to:

- Add value to your union membership by offering everyday discounts & offers
- Improve members health & wellbeing through education and access to services
- Help members' become more financially resilient through education and access to advice & solutions
- Improve educational outcomes by offering annual individual learning grants and bigger group initiative grants

Since 2019 UniMed has been a key partner of HealthCarePlus. UniMed offers, manages and underwrites exclusive Health Plans for HealthCarePlus members.

HealthCare
It's good to belong

Who is UniMed?

UniMed is the trading name for Union Medical Benefits Society Limited established in 1979. UniMed provides a comprehensive range of health insurance plans. Like HealthCarePlus, UniMed was established by Unions to provide its Members with health insurance benefits. UniMed is a New Zealand licensed insurer.

UniMed is a not-for-profit incorporated society. This means UniMed is owned by you, its Members, and any profits (called surpluses) are applied for the benefit of those Members. Unlike a company, there are no dividends paid to shareholders.

When you have health insurance policy underwritten by UniMed, you also become a Member of UniMed.

UniMed

Primary Care Coverage Table

The following tables describe the benefits covered by your Primary Care policy. It includes the healthcare service or benefit covered, reimbursement level, benefit maximums, no-claiming periods and other terms and conditions applicable to the cover. The benefit maximums apply as a total (i.e. aggregate) sum for all of the services outlined in the benefit section (unless otherwise indicated i.e. where sub-limits apply).

UniMed reserves the right to interpret, alter or amend the conditions for payment of benefits generally as it deems necessary. Further details about the terms and conditions are outlined in this Health Plan document, within UniMed Terms and Conditions, in the UniMed Rules, and at unimed.co.nz/important-documents. Please also refer to your Membership Certificate for any personal terms, conditions and exclusions.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Optical			
Optometrist eye examinations and glasses, contact lenses	50% reimbursement of actual costs incurred up to $250 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	6 months	Covers the cost, up to the maximum cover for this benefit, of: • Optometrist eye examinations • Prescription glasses or contact lenses. Documentation specifying the date of the eye examination must be provided to claim for prescription glasses or contact lenses. Receipted itemised accounts must be provided, clearly stating the date of the prescribing eye examination. Optical coatings, eye drops, solutions, cases and prescribed medicines are not included.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Medical, specialists & tests (including health screening)			
General Practitioner fees, **Prescription medicines,** **Laboratory tests,** **Specialist consultations,** **Diagnostic tests and health screening,** including mammography, prostate checks and skin checks (excluding mole mapping – dermatologist consultations only), **Ambulance fees**	50% reimbursement of actual costs incurred up to $750 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of: • Registered Medical Practitioner consultations, • Registered Medical Specialist consultations, • Medicines or laboratory tests prescribed or referred by a Registered Medical Practitioner or Registered Medical Specialist up to a maximum of $10 per prescription item or laboratory test, • Flu vaccinations (all other vaccinations excluded), • Diagnostic tests, x-rays and ultrasounds (non obstetric) on referral from a Registered Medical Practitioner or Registered Medical Specialist. This benefit excludes treatment covered by the Complementary Medical Benefit even if this treatment is provided by a Registered Medical Practitioner. If you have an Approved Hospital Cover policy, please refer to the Approved Hospital Cover Policy benefit.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Complementary Medical			
Physiotherapy, Chiropractic, Osteopathy, Podiatry, **Acupuncture, Naturopathy, Homeopathy, Rongoā Māori, Chinese Medicine,** **Drug and Alcohol therapy,** **Dietitian and Nutritionist,** **Lymphoedema Therapy, Allergy Testing and Chelation Therapy,** **Audiology, Occupational Therapy, Speech-Language Therapy,** **Infertility/Sterilisation**	50% reimbursement of actual costs incurred up to $400 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of treatment and consultations provided by/or x-rays on referral from persons registered with: • The Physiotherapy Board of New Zealand; • New Zealand Chiropractic Board; • Osteopathic Council of New Zealand; • Podiatrists Board of New Zealand; • Acupuncture NZ; • New Zealand Acupuncture Standards Authority Inc (NZASA); • The Physiotherapy Acupuncture Association of New Zealand Inc (PAANZ); • Naturopaths & Medical Herbalists of New Zealand Inc – **Naturopaths only;** • New Zealand Council of Homeopaths Inc (NZCH); • Te Aka Whai Ora: Māori Health Authority; • Chinese Medicine Council of New Zealand; • The Addiction Practitioners Association of Aotearoa – New Zealand Inc (DAPAANZ); • Dietitians Board; • Nutritionist Society of New Zealand; • Lymphoedema NZ; • New Zealand Audiological Society (MNZAS); • Occupational Therapy Board of NZ (OTBNZ); • New Zealand Speech-Language Therapists Association (NZSTA). Treatment outlined above is also covered if performed by a Registered Medical Practitioner. Fertility treatment or sterilisation procedures are covered. Dietitian or Nutritionist consultations are covered if referred by a Registered Medical Practitioner. Chelation therapy, allergy testing or consultations and treatment related to allergies are covered if performed by a Registered Medical Practitioner. Medications, remedies, aids, food supplements or other items relating to treatment by the providers listed above are not included.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Mental Health			
Psychologist, Psychotherapist, Counsellor, Psychologist	50% reimbursement of actual costs incurred up to $1,000 per claiming year for each insured adult or for all insured children collectively	No claiming period does not apply	Covers the costs for consultations provided by persons registered with: • New Zealand Psychologists Board • New Zealand Association of Counsellors • Psychotherapist Board of Aotearoa New Zealand • Registered under the psychiatry scope with the medical council of New Zealand

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Hospital Treatment			
A contribution towards the cost of private hospital treatment. Includes reimbursement of excess on eligible hospital cover policies ($500 Maximum applies per calendar year or claiming year).	50% reimbursement of actual costs incurred up to $700 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of: Surgery provided by a Registered Medical Specialist • Surgeon's fees, Anaesthetist's fees, Hospital charges • This benefit covers endoscopy procedures (where a theatre/facility fee applies) i.e. gastroscopy and colonoscopy procedures. Cover commences from the date of hospitalisation or treatment and continues through to post operative consultations (up to 6 months after hospitalisation). Consultations prior to admission to hospital may be claimed under the Medical Benefit. Documentation for all parts of the procedure must be submitted with the application even if they are not being claimed at that time. Travel, newspapers, television, telephone and any extras are excluded. Oral surgery is not included under this benefit. If you have an Approved Hospital Cover policy, please refer to the Approved Hospital Cover Policy benefit. An Excess reimbursement may apply.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Major Diagnostic Imaging			
A contribution towards the cost of CT/CAT, MRI and Angiograms.	50% reimbursement of actual costs incurred up to $600 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	6 months	Covers the cost, up to the maximum cover for this benefit, of: • CT/CAT scans • MRI scans • Angiograms If you have an Approved Hospital Cover policy, please refer to the Approved Hospital Cover Policy benefit.

Approved Hospital Cover Policy
Members may be eligible for a full or partial reimbursement of hospital treatment, diagnostic tests or specialist consultations included in this policy if they have a HealthCarePlus linked and Approved Hospital Cover policy.

Excess Reimbursement – Hospital Treatment
If Members claim under an Approved Hospital Cover policy for hospital treatment (as outlined in the Hospital Treatment section) and an Excess applies, then they may submit a claim for the Excess reimbursement available under this policy. Excess reimbursement related to oral surgery is not available under this policy. The Excess reimbursement is calculated based upon the value of the claims submitted to the Hospital Cover provider. For Hospital Cover claims submitted which are greater than $1,000, the Excess reimbursable is the actual Excess paid up to a maximum of $500. For example; a Member has a hip operation in a private hospital. It costs $25,000 and they claim this from their Hospital Cover provider and pay their Excess of $500. They then claim their Excess from their HealthCarePlus policy and are reimbursed $500. For Hospital Cover claims of less than $1,000 the reimbursement will be 50% of the actual claim submitted, provided that this amount is not greater than the Excess paid (in which case the Excess reimbursement will be the actual Excess paid). For example a Member requires a minor operation performed by a dermatologist, which costs $800. Their Hospital Cover provider deducts their Excess of $500 from the amount charged, paying the Member $300. The Member claims their $500 Excess from their HealthCarePlus policy and are reimbursed $400 (i.e. 50% of $800).

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Medical Appliance			
Specified items prescribed by a GP, specialist or hospital.	50% reimbursement of actual costs incurred up to $400 per Calendar Year, or Claiming Year for each Insured Adult or for all Insured Children collectively.	3 months	Covers the cost, up to the maximum cover for this benefit, of medical appliances prescribed by a Registered Medical Practitioner, Registered Medical Specialist or provided by an approved hospital facility, including: • Prosthesis (not related to surgery), • Hearing aids, • Toric and Irlen lenses, • Aids for the control of diabetes or lung-related disease, • Epipens, • Mirena, • CPAP Machine/Mask, • Specially made footwear (excluding inserts for shoes provided by a podiatrist), • Compression Stockings/Sleeves, • Baby monitor or any equipment essential for the disabled. Any subsidy payable or assistance available from any other source must be claimed first and disclosed on the claim form with supporting documentation. A medical referral or supporting letter from a Registered Medical Practitioner must be provided with your claim. Hire costs are included.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Orthodontic Treatment			
A contribution towards the cost of Orthodontic treatment for insured children	30% reimbursement of actual costs incurred up to $750 for each Insured Child, up to a policy maximum of $1500 for the duration of the Member's Membership	12 months	Covers the cost, up to the maximum cover for this benefit, of orthodontic treatment to straighten dental arches or crooked teeth, to improve breathing, eating or speaking difficulties. This benefit covers Insured Children only. A treatment plan and estimate of the expected total cost is required from the orthodontist with the first application for the Orthodontic Benefit. Preliminary consultation and extraction costs will be considered only when a brace or appliance for the straightening of the dental arch(es) has been fitted. Permanent fixtures or devices for other purposes e.g. dentures, thumb crib are excluded. Where a consultation or treatment occurred prior to the end of the No-Claiming Period for eligibility (12 months) for this benefit, all subsequent orthodontic expenses in relation to that child are ineligible. Full orthodontic guidelines may be viewed on unimed.co.nz/important-documents.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Sick Leave Without Pay Grant			
Due to sickness of the Member	$50 per week plus $5 for each Insured Child up to a maximum of $60 per week for 26 weeks for the Member.	12 months	The period may be extended by up to 26 weeks provided a full sickness benefit is being received from Work and Income and the Primary Care benefit does not prejudice the right to additional assistance from Work and Income benefits. The minimum recognised period, which can be claimed, is 5 consecutive working days' approved sick leave without pay. A medical certificate must be supplied stating the nature of the illness and specifying the period of absence from work. A letter from the Member's pay office, or employer stating the start date of approved sick leave without pay and proposed finish date must be supplied. Once the Member resigns or retires, this benefit is no longer claimable. A Member absent from duty on approved sick leave without pay is not required to pay premiums in respect of any complete fortnight of absence for which a salary payment is not received. Persons in receipt of this benefit may continue to apply for other mandatory benefits for up to 12 months from the start of the period of approved sick leave without pay. This benefit is not applicable to employees who have sick leave with pay available. Members who return to work on reduced hours cannot claim this benefit. A Member receiving payments under the Accident Compensation Act 2001 (ACC) is not entitled to this benefit, except for the first week of a non-work related accident if salary is not received. Members on maternity or parental leave, teacher trainees, relieving teachers and Members who are free to take up other employment cannot apply for this benefit.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Birth Grant			
	$200 for each live child born to a Member or their partner/ $200 for each child adopted by a Member or their partner.	12 months	An adoptive parent may claim this benefit. Claims must be supported by an original or certified copy of the child's birth certificate or a statement of adoption issued by the adoption agency or solicitor.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Bereavement Grant			
	$1,000 on the death of an Insured Adult or Child (including still birth).	3 months	Where the Member dies, the benefit is payable to the surviving partner or to the person who is the accredited next of kin. In the event that the deceased has no accredited next of kin a discretionary application may be made by the person responsible for the funeral expenses and arrangements (a supporting letter is required from the solicitor). It should be noted that the benefit is not payable to an estate. All applications must be supported by the original or a certified copy of the death certificate or an original newspaper notice.

Healthcare Service or Benefit	Benefit Maximums	No-Claiming Periods	Other Terms and Conditions
Bowel screening kit			
At home bowel screening kit	One kit every three years	36 months	Children do not qualify for this benefit. Visit the Members section of UniMed's website for terms and conditions and information on how to access them.

Considerations applying to particular claims

Sick leave without pay
Members receiving the Sick Leave Without Pay Grant are eligible for all benefits until premiums resume, up to a maximum of 12 months from the start of approved sick leave without pay.

Parental leave
Members on maternity or parental leave who do not pay premiums in advance may apply for the Birth Grant (and Bereavement Grant if the child dies) but eligibility for all other benefits ceases until premium payments start again.

Claims from outside New Zealand
Costs incurred outside New Zealand are ineligible except if you are on approved overseas exchange or study leave, continue to have NZD salary paid to you, and continue to make contributions for your policy. Costs within the country of exchange only are eligible. Claims must be supported by a letter from your pay office confirming the country of exchange and the start and finish date of approved overseas exchange or study leave.

Events claimable from any other source
Reimbursement must be claimed from other sources first including ACC. Copies of receipts/accounts must support claims. All claims must be accompanied by evidence of the amount received from from any other source - you don't need to repeat the same details on your HealthCarePlus claim form.

Claims subject to the Accident Compensation Corporation (ACC), Work and Income, Ministry of Health, Ministry of Social Development, Ministry of Justice, other government refunds or assistance must be settled before applying to UniMed. In these cases a maximum of 50% of the balance less other medical insurance refunds will be paid.

In no circumstance are you entitled to receive an aggregated refund of more than 100% of original costs.

Other conditions for the Orthodontic Benefit
Please refer to the orthodontic guidelines available on unimed.co.nz/important-documents.

Exclusions – what you are not covered for

These are expenses or items that are not covered and will not be reimbursed by your policy.

The following items are excluded from coverage:

- Excesses charged from other insurers (apart from reimbursement of Excesses on HealthCarePlus Approved Hospital Cover policies linked to a HealthCarePlus Primary Care or Primary Care Extra policy).

Please refer to UniMed's Terms and Conditions for further general exclusions along with the List of Approved HealthCare Services and Unapproved HealthCare Services.

Eligibility

To be eligible to take out a HealthCarePlus policy underwritten by UniMed, you must be a financial member of, or be employed by, one of the following participating unions:

Primary Unions:

- **TEU:** Tertiary Institutes Allied Staff Association Incorporated
- **NZEI:** New Zealand Educational Institute Incorporated Te Riu Roa Incorporated
- **PPTA:** New Zealand Post Primary Teachers' Association Incorporated
- **TIASA:** Tertiary Institutes Allied Staff Association Incorporated
- **PSA:** NZ Public Service Association Te Pukenga Here Tikanga Mahi Incorporated
- **ISEA:** The Independent Schools Education Association

Members of Primary unions are eligible for union rates.

Affiliate Unions:

- Other unions that are approved to join EBS in accordance with the EBS Constitution.

Members of Affiliate unions are eligible for Affiliate/ non-union rates.

A former employee of a participating union who is a financial member of a participating union is eligible to take out a HealthCarePlus policy.

An applicant who is linked through 'Family/ Whānau' Membership* is eligible to take out a HealthCarePlus policy.

Once the applicant is accepted and has their policy issued by UniMed, the Member must advise UniMed of any change to union status.

Honorary/Associate or Retired Member
You can continue your health insurance provided you either:

- become an Honorary or Associate member of a Primary union and pay the union premium rate; or
- pay the Affiliate/non-union premium rate.

Adding family/whānau

You're able to add your partner and/or children to your policy - you must include them in your policy application (or add them later) and pay the appropriate premium.

A parent or other adult who is not recognised as the Member's partner cannot be included in the policy as a partner for the purpose of obtaining benefits as a family.

Dependent children included in a policy are eligible for benefits up to the end of the year in which they become 21 to 31 December in any year.

Note: students, although living with a parent, may be eligible for the Community Services Card and this should be used where appropriate before claiming Primary Care benefits.

Over 21 year olds may continue to enjoy Primary Care policy benefits by moving to the Affiliate/ non-union premium rate.

To discuss these options contact UniMed.

Special eligibility categories

You may also be eligible to take out a health insurance policy if the following applies:

Trainee Teachers

- If you're a trainee teacher and a member of a participating union, you qualify for union premium rates.
- You must advise UniMed if you no longer meet the eligibility requirements of your qualifying union.

***Family/Whānau**

- A family/whānau member can pay for a policy under their own name at the Affiliate/ non-union rate provided that they:
  - are living in the same house as you; or
  - are your ex-partner; or
  - are your child aged 21 years or older.

Managing your policy

Continuing your policy when circumstances change

Life can be unpredictable so it's good to know that there are options that enable you and your family to maintain your health insurance when your circumstances change.

These life events can include:

- Starting a family
- A change in career
- Travelling overseas for an extended period
- Relationship break-ups and new relationships
- Children reaching 21
- Retirement.

If your change of circumstances means you are no longer a member of a qualifying union, you will move to the Affiliate/non-union premium rate.

In order to continue to enjoy lower premiums some Members may elect to remain in their union, through associate union membership.

Relieving Teacher/Support Staff
Irregular salary payments may make it difficult to keep up with premium payments. To ensure continous cover, premiums can be paid in advance or by regular monthly direct debits.

Suspending your policy

You may ask us to suspend your policy (put it on hold and not pay premium) for a period of time. You must provide the reason(s) for your request, and we will advise if we need supporting information.

We will not pay any claims for you or any additional Members for medical treatment or procedures that occur while your policy is suspended. You are unable to access Active Benefits/Care while your policy is suspended.

You must be a Member for a minimum of 12 months before your policy can be suspended.

There is a minimum of 12 months between suspension periods. This 12-month period starts from the end date of the last suspension.

Reasons to request a policy suspension may include:

- taking parental leave
- suffering financial hardship
- travelling overseas for an extended period
- being seconded overseas for work if you are part of a group insurance scheme.

There are specific terms and conditions for each suspension type, such as minimum and maximum periods. These terms and conditions, and further information about suspension options are on our website at unimed.co.nz/important-documents.

Changing your policy

You can change from one plan to another, provided that:

- All family members are covered in the same policy and
- The appropriate premium is paid.

Members who elect to change their Health Plan will serve the No-Claiming Period applicable for all benefits that are not included in their current Health Plan. These additional No-Claiming Periods apply over and above the standard No-Claiming Periods for their current Health Plan and from the date of the first payment on the new premium rate.

For details on the No-Claiming Periods refer to the Table of Coverage for the respective Health Plan. All Health Plan documents may be viewed and downloaded from unimed.co.nz.

Cancelling your policy

If you are not satisfied with the policy during the first 30 days after the date you have received your Health Plan document and your Membership Certificate, you can cancel the policy and UniMed will provide a full refund of all premiums paid. You can only do this if no claim has been made under the policy during this period by you anyone else on your policy. If you wish to cancel the policy within the 30 day period please contact us.

You can cancel your policy at any other time after the first 30 days but if you do so any refund of premium will be according to the UniMed Terms and Conditions. Cover will be provided until the date the policy is paid to.

Definitions

These are terms used in this Policy Wording that are defined to provide clarity.

Benefit Maximum or Entitlement The maximum, total (or aggregate) sum that will be reimbursed for the specified period relating to the healthcare services or benefit outlined in the Benefit Section. Note: in some cases Sub-limits will apply.

Benefit Section This is a category of healthcare services or benefits that have a common Benefit Maximum. For example, Optical.

Calendar Year A 12-month period starting 1 January and ending 31 December.

Claiming Year means the 12 month period following the start date of your policy and each successive 12 month period. 'Claiming Year' applies to all policies that were purchased after 1 January 2019.

Family/Whānau Family or Whānau is defined as a family member residing in your household, your ex-partner, or your child over 21 years of age.

HealthCarePlus The trading name for The Education Benevolent Society Incorporated.

Insured Adult A Member who is aged 18 (and over) and not registered as an Insured Child on the policy.

Insured Child A registered dependent child who is aged under 21 and 21 year olds up until the end of the year in which they turn 21 years of age, i.e. 31 December.

Member All persons insured under a HealthCarePlus policy underwritten by UniMed (unless specifically referring to member or membership of HealthCarePlus or a qualifying organisation).

No-Claiming Period This is the minimum period that all Members on a policy must have been continuously insured (with premiums fully paid) before they are eligible to claim. Benefits may be claimed for events that occur after the No-Claiming Period has been completed in full. It was previously referred to as 'Waiting Period'.

Participating Unions Primary and Affiliate unions that are admitted to become members of EBS in accordance with the EBS constitution.

Sub-limit This is a limit that applies to a specific healthcare service or benefit within a Benefit Section. For example a prescription limit of $10 per item.

The Board The Board of Directors of Union Medical Benefits Society referred to as UniMed.

Trainee Teacher Is a student that is; registered with and studying at a tertiary education institution, to become a teacher, and who is a current and eligible member of a participating union.

"We" or "Us" Refers to Union Medical Benefits Society referred to as UniMed.

"You", "your" or "yourself" means the Primary Member and any additional Members on your policy.

Primary Care services and claims:

Ph: 0800 600 666

Queries:
members@unimed.co.nz

Claims:
Submit in the UniMed Member Portal or email:
claims@unimed.co.nz

Download forms at:
unimed.co.nz/important-documents

Remember, the sooner you join, the sooner we can help you pay for your day-to-day health costs.

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