Application.

Primary Care, Primary Care Extra, Primary Care Max

UniMed

This form is for eligible members of HealthCarePlus. Complete and return to us at sales@unimed.co.nz.

Union

MOE Employee Number (if applicable)

◯ I am a current union member ◯ I am a new union member

◯ I am a family/ whānau/ non-union member linked at non-union rate through:

Union member or Affiliate union name

Their UniMed membership number

1. Choose a Health Plan

◯ Primary Care ◯ Primary Care Extra ◯ Primary Care Max

Who is the application for?

◯ Member ◯ Member & Partner ◯ Member & Children ◯ Member, Partner & Children

2. 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)

Sex at birth

◯ Male ◯ Female

Address

Street

Town/city

Postcode

Mobile phone number

Home phone number

Personal email

Alternative email

Place of work

3. Additional Members to be insured

Note: To be included on your policy, your children must be under 21 years of age.

Additional Member – Spouse/ partner

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** **Email**

Male Female

Additional Member – Child 1

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** **Email**[+]

Male Female

Additional Member – Child 2

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** **Email**[+]

Male Female

Additional Member – Child 3

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** **Email**[+]

Male Female

[+] Email not required for dependants under the age of 16 (dependant means a Member's child (including any stepchild or adopted child).

Additional Member – Child 4

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** **Email***

Male Female

Additional Member – Child 5

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** **Email***

Male Female

Additional Member – Child 6

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** **Email***

Male Female

4. Premium payment method

Please select one:

Direct debit or recurring credit card

I have attached a completed Payment Authority form (available at unimed.co.nz/important-documents).

Salary/ wage deduction (not available to PSA members)

I authorise my employer to deduct regular premium instalments from my salary/ wage and provided I am first notified by UniMed, to alter the amount of such instalments as required. I authorise my employer to hold a copy of this page.

Name of employee

Name of employer

Date (dd/mm/yy)

5. Declaration and authorisation

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

1. 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.
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 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.
4. 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.
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.

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 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 they are aware the information I provide will be disclosed to UniMed.

I declare that I am a full financial member of the above-named union or that I am linked as family/ whānau/non-union.

Primary Member's full name

Signature

Date signed (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).