CONTINUATION FORM

UniMed
YOUR HEALTH INSURER
UNION MEDICAL BENEFITS SOCIETY LTD

TYPE OF CONTINUATION ✓*Tick appropriate box*

☐ Group Scheme Leaver ☐ Policy Split ☐ Child over 19 moving to own policy

Current Membership No _____ Start Date of Continuation _____

PERSONAL DETAILS - PRIMARY MEMBER

Mr/Mrs/Miss/Ms Surname _____ First name(s) _____

Postal address _____

Telephone: Home _____ Work _____ Mobile _____

Date of birth ___/___/___ Gender at birth M / F

Email _____ ☐ I agree to receive all correspondence from UniMed via email

FAMILY MEMBERS TO ALSO CONTINUE COVER

	Surname	First Name(s)	Gender at Birth		Date of Birth
Spouse/Partner			M	F	/ /
Child 1			M	F	/ /
Child 2			M	F	/ /
Child 3			M	F	/ /
Child 4			M	F	/ /

I WISH TO CONTINUE COVER WITH UNIMED

Chosen Plan _____

PREMIUM PAYMENT OPTIONS

☐ I have completed my direct debit/credit card authority and it is attached

APPLICANT'S DECLARATION

I confirm I have read the declaration overleaf

Signature of Applicant _____ Date ___/___/___

Union Medical Benefits Society Ltd

Head Office
PO Box 1721, Christchurch 8140, www.unimed.co.nz
Phone: 03 365 4048 Fax: 03 365 4066 Email: sales@unimed.co.nz

TOLL FREE 0800 600 666

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

1. I declare that all statements made for the purposes of this application to be true, correct and complete and that I have not omitted, and I am not aware, of any other medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application. If, after submitting this application, I become aware of any such medical information or circumstances, I agree to inform the Society immediately of such information or circumstances.

2. I acknowledge that failure to make any statements truthfully, or to omit any medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application, may mean my application is rejected, or any claim made is declined, or the policy becoming void. I further acknowledge that if this application is accepted by the Society, there is no cover for any health conditions I have not declared, but only for those conditions I have declared which are accepted by the Society.

3. I understand that the written declaration in the Application Form constitutes the basis of the contract with the Society. No oral representation, inducement, statements and promises made by or on behalf of either party, including the Sales Representative, and not contained in the Application Form or the brochure for the Health Plan selected, shall be relied upon or binding.

4. Where other persons are listed in my application, I confirm that I have full authority and consent to submit this application on behalf of all such persons. I understand that any statements made concerning such persons (or persons added to the policy at a later date) may affect whether this application is accepted or their entitlements to cover.

5. I agree that any payment accompanying this application shall be a deposit only and I understand that any coverage will not commence until the Society has issued a Membership Certificate. I further agree that the maintenance of membership and cover is conditional upon the continual payment of all premiums as they fall due.

6. I understand that any special joining concessions or restrictions of cover in relation to my declared existing conditions will be shown on my Membership Certificate.

7. I authorise the obtaining of any medical information the Society may require in relation to this application or future claims as submitted by me from any medical practitioner who has attended or examined me or any other person listed in my application. I agree to do anything necessary to facilitate the Society obtaining such information, including completing or signing any necessary consents or authorities.

8. I authorise the Society to obtain details regarding my previous medical insurance.

9. Pursuant to the Privacy Act 2020 and the Health Information Privacy Code (incorporating amendments), in this application form the Society collects personal information for the purpose of evaluating your membership application and future claims. The Society may disclose information related to this application and future claims to the Integrity Register* for the purposes of the detection and prevention of fraudulent and suspicious conduct.

10. I agree to the terms and conditions of Membership and the rules of the Society.

11. If this application has been completed online, I acknowledge and agree that my electronic acceptance of this declaration (whether by electronic signature or otherwise) makes it fully binding on me and any other persons listed in the application.

For policies within an Employer Scheme

If your scheme is wage deduction – I authorise my employer to deduct regular premium instalments from my salary and provided I am first notified, to alter the amount of such instalments as required.

If your scheme is direct debit – I authorise UniMed to debit my/our account or process recurring credit deductions from my nominated card should any portion of my premium be payable directly to UniMed. I have completed the direct debit / recurring credit card authorisation form enclosed.

The Privacy Act 2020 requires UniMed to inform you about certain rights and obligations relating to the information which we collect on this form. In this regard, we recommend that you read the Privacy Statement on our webpage https://www.unimed.co.nz/about-unimed/privacy-statement/

**The Integrity Register is a register of health insurance claims and administered by PwC (on behalf of the Financial Service Council) for the purposes of the prevention and detection of fraudulent and suspicious conduct.*