Application – with health questions.

UniMed

Complete and return to us at sales@unimed.co.nz.

Personal details

SECTION A

1. Eligibility

☐ I confirm that I and all applicants are New Zealand citizens or permanent residents, hold a New Zealand work visa valid for two years or more, or are otherwise covered under New Zealand's public health system.

2. Please complete the details for the Primary Member to be insured

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

Postal address

Street/ PO Box number

Town/ city

Postcode

Residential address (if different from above)

Street

Town/ city

Postcode

Mobile phone number

Alternative phone number

Personal email

Alternative email

Type of application

3. Is this a new application?

◯ Yes ◯ No (go to Q5)

4. Choose a health plan

Please choose a base plan	Please choose the excess for your base plan (does not apply to modules) The excess is the amount you agree to pay towards the cost of specified claims on your Health Plan. The higher the excess, the lower your premium.	Options to add to your base plan
◯ Hospital Select	◯ $0 ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $3,000 ◯ $4,000 ◯ $6,000 ◯ $8,000 ◯ $10,000	Modules: ☐ Specialists module ☐ Day to Day module ☐ Natural Health module ☐ Dental and Vision module This module can only be added if one or more of the above modules are also added. Optional plans: (note, you'll need to complete a separate application) ◯ Cancer Care Plus or ◯ Medsafe Approved
◯ UniCare Advantage	Excesses are not part of this Health Plan	Modules are not part of this Health Plan
◯ Other (please list name of base plan and any additional modules, if available with that plan) _____		

When would you like this policy to start?

Note: this date can only be in the future and may depend on your payment method. We will confirm the start date with you.

DD/MM/YY or ☐ as soon as possible

5. Are you applying as part of a group insurance scheme?

◯ Yes ◯ No (go to Q6)

Name of group/ employer

Date employed (dd/mm/yy)

Employee number (if applicable)

6. Are you making a change to an existing policy?

◯ Yes (please fill in the below) ◯ No (go to Q7)

Existing membership/ policy number

Please choose the change to your policy

☐ **Add a Member to an existing policy**

Please ensure you complete Q9 and answer the health questions in Section C for all new Members.

☐ **Upgrade to an existing policy/ reduce your current excess**

Please state the new base plan, module/s and excess (if available with that plan), or new reduced excess amount.

Note: to increase your excess, we just require confirmation by email or in writing from the Primary Member.

Please ensure you answer the health questions in Section C for all Members.

7. Do you wish to add an Adviser on your policy?

◯ Yes ◯ No (go to Q8)

Your Adviser's name and company

Full name

Company

Note: if you are part of a group insurance scheme that has an Adviser, they will be automatically linked to your policy.

8. Additional Members to be insured

Yes No (go Q9)

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 is 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

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

Health declaration

These questions need to be answered for everyone who is:

- applying for a new policy, or
- making changes to an existing policy.

IMPORTANT: You must complete this section for each applicant.

NOTE: PRE-EXISTING MEDICAL CONDITIONS NOT DECLARED ARE AUTOMATICALLY EXCLUDED FROM COVER

9. Pre-existing conditions

Have you, or any other person named in this Application, ever experienced, had symptoms of, been treated for, or been advised to seek testing or treatment for, any of the following?:

a.	Congenital conditions and/or developmental disorders	◯ Yes ◯ No
b.	Stomach, bowel, rectal or digestive disorders including haemorrhoids	◯ Yes ◯ No
c.	Back pain, or any condition including neck/cervical, thoracic, lumbar and sacral spine	◯ Yes ◯ No
d.	Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis, gout and bunions.	◯ Yes ◯ No
e.	Heart disease or disorder including chest pain, angina, coronary artery disease, dysrhythmias, aneurysms, heart valve replacements or rheumatic fever	◯ Yes ◯ No
f.	High blood pressure and/or high cholesterol	◯ Yes ◯ No
g.	Blood or bleeding disorders including anaemia or B12 deficiency	◯ Yes ◯ No
h.	Vascular or arterial disorders including varicose veins	◯ Yes ◯ No
i.	Diabetes, thyroid or other glandular disorders	◯ Yes ◯ No
j.	Liver or gall bladder disorders including hepatitis	◯ Yes ◯ No
k.	Gynaecological or menstrual disorders including irregular, heavy or painful periods, any abnormal smears, or endometriosis	◯ Yes ◯ No
l.	Eye disease including cataracts or glaucoma	◯ Yes ◯ No
m.	Upper respiratory tract infections, adenoids, sore throat, ear infections, tonsillitis and sinusitis	◯ Yes ◯ No
n.	Kidney or bladder disorders including stones, hernia, incontinence or pelvic floor disorder and prolapse	◯ Yes ◯ No
o.	Suspicious moles, cysts, skin lesions, lipomas, including treatment for melanoma	◯ Yes ◯ No
p.	Neurological or nerve conditions including migraines, epilepsy, paralysis or stroke	◯ Yes ◯ No
q.	Cancerous and pre-cancerous conditions or tumours	◯ Yes ◯ No

If you answered Yes to any questions above, please complete full details (if you require more space to write, please use pages 10-11).

Question No.	Name	Date/year	Description of symptoms/treatments/investigation/operation

Question No.	Name	Date/year	Description of symptoms/treatments/investigation/operation

10. Future diagnostics or treatment

Have any named applicants been advised that they may require any diagnostics, medical or surgical treatment in the future?

◯ Yes ◯ No (go to Q11)

Name	Medical condition	Treatment

11. Accident or injury

Have any named applicants suffered an accident or injury?

◯ Yes ◯ No (go to Q12)

Name	Injury or condition and body part affected	Side? (leave blank if not applicable)	ACC covered?	Date/year
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	
		◯ Left ◯ Right	◯ Yes ◯ No	

12 . Medication

Have any named applicants taken in the past, or are currently taking, any medication on a regular basis?

◯ Yes ◯ No (go to Q13)

Name	Medication	Reason	Time period

13. Other conditions

Are any named applicants currently suffering from, or have suffered from in the past, any condition/ailment or received treatment not already disclosed?

◯ Yes ◯ No (go to Q14)

Name	Medical condition	Treatment	Date/year

14. Are you currently insured elsewhere?

Do you currently have health insurance in New Zealand with another provider?

◯ Yes ◯ No (go to Q15)

If Yes, name of current provider and plan:

PLEASE NOTE: DO NOT CANCEL YOUR EXISTING HEALTH INSURANCE POLICY UNTIL YOU RECEIVE YOUR MEMBERSHIP CERTIFICATE AS PERSONAL EXCLUSIONS AND UNDERWRITING CONDITIONS MAY APPLY.

Once you have completed all health questions, please go to Section D (page 12).

Please use the next two pages if you require more space to answer any of the health questions.
Make sure you include the question number (e.g. Q8) and the Member's name.

15. Premium payment method

Please select one:

○ **Direct debit or recurring credit card**

I have an existing authority in place, or have attached a completed Payment Authority form (available at unimed.co.nz/important-documents).

○ **Salary/ wage deduction** (only for a group insurance scheme offering this method)

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)

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.

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.**

Primary Member 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).