Cancer Care Plus or Medsafe Approved Application.

UniMed

You can only add Cancer Care Plus or Medsafe Approved to Hospital Select, Major Surgical or a specialised surgical health plan through your employer. If added it needs to apply to all Members on that plan, at the same level of cover — it can't be selected for just some Members.

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

1. Plan applied for

◯ Cancer Care Plus **or** ◯ Medsafe Approved $100,000 ◯ Medsafe Approved $250,000

2. Please complete the details for the Primary Member

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

Membership/ Policy number

Address

Street

Town/city | Postcode

Home phone number

Mobile phone number

Email

We recommend using a personal email address.

3. Additional Members to be insured

Additional Member – 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

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

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

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

Note: Please provide all relevant information even if you have completed a health declaration before.

4. Health questions

4.1 Have you or any person named on this application ever been diagnosed with, received or intend to receive medical advice, or had signs or symptoms that could suggest cancer or malignancy including, Hodgkin's disease, blood cancer (leukaemia, lymphoma, or myeloma), melanoma, or metastasised skin lesion?

◯ Yes ◯ No

Name	Description of symptoms/ treatment/ investigation/ diagnosis	Date/ year

4.2 Have you or any person named on this application ever had signs or symptoms of, or been tested, treated, or diagnosed with any disease or disorder of any of the following?

a. Cervix, uterus, vagina, including abnormal smears, pre-cancerous cells, polyps	◯ Yes ◯ No
b. Prostate including blood in urine or change in urination habits	◯ Yes ◯ No
c. Bowel, including change in bowel habits, polyps	◯ Yes ◯ No
d. Breast, including breast lumps	◯ Yes ◯ No
e. Skin disorders, including BCCs, SCCs and skin lesions	◯ Yes ◯ No

Name	Description of symptoms/ treatment/ investigation/ diagnosis	Date/ year

4.3 Have you or any person named on this application had a parent or sibling (blood relative) diagnosed with any type of cancer or malignancy before the age of 55?

◯ Yes ◯ No

Applicant name	Relative (e.g. 'father')	Type of cancer	Age diagnosed

4.4 Are you or any person named on this application aware that they have a genetic predisposition for developing cancer?

◯ Yes ◯ No

Name	Type of cancer

4.5 Are you or any person named on this application waiting for the completion or results of any medical investigation?

◯ Yes ◯ No

Name	Symptoms for investigation

4.6 Are you or any person named on this application intending to seek or currently seeking any medical advice, examination or procedure?

◯ Yes ◯ No

Name	Symptoms for investigation

4.7 In the last 12 months have you or any person named on this application smoked tobacco or any other substance and/ or used smoking alternatives (e.g. e-cigarettes, vapes, nicotine gum or patches)?

◯ Yes ◯ No

Name	Please give details of each substance including date started (or stopped) and quantity/ nicotine strength

5. 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 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.**

☐ If required, I have attached my completed Payment Authority form (available at unimed.co.nz/important-documents).

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).