Health Positive Application.

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. Plan options

Select level of Health Positive reimbursement

◯ 50% ◯ 80%

3. 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

4. Additional Members to be insured

Yes No (go to Q5)

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

* 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

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

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

Yes No (go to section B)

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.

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 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.**

☐ 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).