Day to Day application

New member

accuro HEALTH INSURANCE

If you have questions or need help to complete this form, call us on 0800 222 876.

1 Start date for your Day to Day plan

DAY / MONTH / YEAR or ◯ as soon as possible

2 If you have a promotional code, please enter it here _____

3 Please confirm the details for the main member who will be the policy owner

Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other _____	Gender assigned at birth ◯ Male ◯ Female
First name(s)		
Surname		Date of birth DAY / MONTH / YEAR
Postal address	Street	
	Town/city	Postcode
Telephone	Home ( )	Mobile
Email	◯ I would like to receive all correspondence via email Home	Business
How did you hear about us?		

4 Details of other family members to be added on to this policy

	Participant 1:	Participant 2:	Participant 3:
Relationship to main member			
Title	◯ Mr ◯ Mrs ◯ Master ◯ Miss ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Master ◯ Miss ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Master ◯ Miss ◯ Other (please specify):
First name(s)			
Surname			
Date of birth	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female
Email Not required for participants under the age of 16 years.			

5 Do you wish to add an adviser on your policy? ◯ Yes ◯ No

Your adviser's name and company	

7 Declaration

Declaration and authorisation to obtain and use information

Accuro Health Insurance (Accuro) is a brand owned, operated and underwritten by Union Medical Benefits Society Ltd trading as UniMed.

I/We, the person(s) applying for this health insurance, confirm that I/we:

1. Agree that this application and any other information obtained/provided about persons to be included on my/our plan forms the basis of the contract.
2. Declare that the information I/we have given is correct and complete and that no material fact has been omitted. I/We undertake to advise UniMed of any health condition or event that may affect me/us or any of the other people named in this application or any relevant information that may affect the policy between the date I/we sign this application and the date the policy commences.
3. Declare that any information supplied in this application, whether written by me/us or not, is true and accurate and that I am/we are authorised, where any person insured is less than 18 years of age, to act on their behalf.
4. Have read and understand this declaration and authorisation and its applicability to the Privacy Act 2020 and Health Information Privacy Code 2020 (see below for further information).
5. Understand the nature of the plan(s) chosen and believe they meet my/our requirements.
6. Understand that, upon issuance of the membership certificate, I/we have fourteen (14) days to cancel my/our plan(s) (14-day free-look period) and that, subject to no claims having been made, I/we will receive a full refund.
7. Understand that, if the application is approved, cover will start from the date stated on the membership certificate issued by UniMed.
8. For the purpose of assessing this application and any future claims, authorise UniMed to request and obtain information and records about me/us and any other people in this application.
9. I/We authorise the following people to give you any such information and records:
   - Any doctor, medical specialist, health agency, hospital, the Accident Compensation Corporation or other relevant person, including another insurer or person relating to any other insurance held by me/us.

Privacy Act 2020 and the Health Information Privacy Code 2020

Each person applying for this health insurance should please note the following:

1. This proposal collects personal information about you and each other member named in this policy in connection with the insurance that is sought.
2. The intended recipient of that personal information is UniMed.
3. You have the right to access and request corrections subject to the provisions of the Privacy Act 2020. The information you provide us is stored with our trusted third party cloud storage providers located inside and outside New Zealand.
4. While UniMed intends to treat this information as confidential, there are some situations where we may need to disclose your personal information to a trusted third party to help us undertake the purposes detailed in our Privacy Policy.
5. By signing this declaration, you authorise the disclosure of the personal information of each member named in this policy (including any dependants) to third parties and any other member named in the policy:
   a) for statistical purposes (where not individually identified)
   b) for evaluation and assessment of claims under the policy that results from this application
   c) for providing on-going client service and information
   d) for any other matter related to the policy.
6. By signing this declaration, you also authorise UniMed or any agency authorised by UniMed to give and obtain your personal information, including your medical records, from other insurers and from medical practitioners. You agree this may include information relating to any other insurance applied for or obtained or claims previously made by you.

For more information, please refer to the Accuro Privacy Policy, available on our website.

Important information

1. This form represents an application by each person named below to become a member of UniMed and relates only to the plan(s) indicated.
2. Anything in this declaration purporting to the singular may, by inference, include the plural.
3. Accuro Health Insurance is a brand owned, operated and underwritten by Union Medical Benefits Society Ltd trading as UniMed (as registered under the Industrial and Provident Societies Act 1908). By making this application, you are accepting the rules of the Society, including obligations therein, and understand that the rules may subsequently be changed. If you would like a copy of the current rules before making this application, please do not hesitate to ask.
4. UniMed is also a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 and a licenced insurer under the Insurance (Prudential Supervision) Act 2010.
5. The Board of Directors of the Society reserves the right, at all times, to vary the terms and conditions and benefits of plans however it deems appropriate.
6. This application forms the basis of any contract that eventuates and must be filled in truthfully and accurately. All information requested as part of this application is voluntary but any non-disclosure may lead to underwriting when the information becomes known and claims relating to the non-disclosure being declined. If you have doubts, you should disclose the information to UniMed for determination of significance.
7. Premiums are subject to change on 21 days' notice.
8. Changes to Direct Debit payments normally require 10 days' notice. However, you may authorise a Direct Debit to occur earlier so that a payment can occur prior to this.

I/We acknowledge the information provided in this declaration, including in relation to my/our privacy, and accept the terms and conditions (including the limitations and exclusions) of the policy, including UniMed general policy terms and conditions.

Main member's name in full

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Financial strength rating

UniMed has an **A (Excellent)** Financial Strength Rating.

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).

For information on UniMed's current Financial Strength Rating and the scale used by AM Best, please visit our website at: **www.unimed.co.nz/about-unimed/financial/strength**

It is important that we receive your application within 45 days of you signing this form or your application may become invalid.

accuro
HEALTH INSURANCE
0800 222 876

Payment method form

For information on discounts available at Accuro, visit accuro.co.nz/about/discounts

Policy number	Main member name
Preferred first date of payment	Date DAY / MONTH / YEAR or ◯ as soon as possible

Invoice

Please fill in the details below if you would like to pay by Invoice.

Recurring payment frequency ◯ Monthly ◯ Annually

Credit/Debit card

Please fill in the details below if you would like to pay by Credit/ Debit Card.

Recurring payment frequency

◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Annually

Please note that we only accept Visa or Mastercard.
We do not accept other cards such as American Express or Diners Club.

For security reasons, please do not provide your credit card number. Once we receive this form, we will contact you with a secure link to provide these details. This link will be valid for 48 hours. Please remember, when your credit/debit card expires, you will need to contact us to update your credit/debit card details.

Accuro Health Insurance (Accuro) is a brand owned, operated and underwritten by Union Medical Benefits Society Ltd trading as UniMed.

I/We authorise Union Medical Benefits Society Limited (trading as UniMed), until further notice in writing, to charge my/our credit/debit card account with all amounts due on my/our UniMed account from time to time, on or after the payment due date.

Cardholder signature Date DAY / MONTH / YEAR

Direct Debit authority

Please fill in the details below if you would like to pay by Direct Debit.

Recurring payment frequency ◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Annually

Name of account

Account number

To the manager:

Bank name

I/We authorise the bank to debit my account with the amounts of direct debits from Union Medical Benefits Society Ltd. (trading as UniMed) with the authorisation code specified on this authority in accordance with this authority until further notice. I/we agree that this authority is subject to the bank's terms and conditions that relate to my account, and the specific terms and conditions listed below.

The following information will appear on your bank statement:

Payer particulars:	UniMed
Payer code:	Health insurance
Payer reference:	Your policy number

Authorised signatures Date signed: DAY / MONTH / YEAR

AUTHORITY
TO ACCEPT
DIRECT DEBITS

(not to operate as an assignment or agreement)
Authorisation Code

0	3	4	3	6	0	4

(User number)

For bank use only

Approved		Date received	Recorded by	Checked by	Bank stamp
4360					
05	2024				

Original
Retain at branch

Copy
Forward to Initiator if requested

Accuro Health Insurance (Accuro) is a brand owned, operated and underwritten by Union Medical Benefits Society Ltd trading as UniMed.

Conditions of this authority to accept direct debit

1) The Initiator:

a) Undertakes to give notice of the commencement date, frequency and net amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months). This notice will be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

Where the Direct Debit system is used for the collection of payments which are regular as to frequency, but variable as to amount, the Initiator undertakes to provide the Customer with a schedule detailing each payment amount and each payment date.

In the event of any subsequent change to the frequency or amount of the Direct Debit, the Initiator has agreed to give advance notice of at least 30 days before the change comes into effect. This notice must be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

b) May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.

c) May, upon receiving written notice (dated after the date of this Authority) from a bank to which I/we have transferred my/our account, initiate Direct Debits in reliance of that written notice and this Authority from the account identified in the written notice.

2) The Customer may:

a) At any time, terminate this Authority as to future payments by giving notice of termination to the Bank and to the Initiator by the means agreed by me/us, the Bank and the Initiator.

b) Stop payment of any Direct Debit to be initiated under this Authority by the Initiator by giving written notice to the Bank prior to the Direct Debit being paid by the Bank.

c) Where a variation to the amount agreed between the Initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1(a) above, request the Bank to reverse or alter any such Direct Debit initiated by the Initiator by debiting the amount of the reversal of alteration of Direct Debit back to the Initiator through the Initiator's Bank, PROVIDED such request is made not more than 120 days from the date when the Direct Debit was debited to my/our account.

3) The Customer acknowledges that:

a) This Authority will remain in full force and effect in respect of all Direct Debits passed to my/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this Authority until actual notice of such event is received by the Bank.

b) In any event this Authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.

c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the Direct Debit has not been paid in accordance with this Authority. Any other dispute lies between me/us and the Initiator.

d) Where the Bank has used reasonable care and skill in acting in accordance with this Authority, the Bank accepts no responsibility or liability in respect of:

- The accuracy of information about Direct Debits on Bank statements; and
- Any variations between notices given by the Initiator and the amounts of Direct Debit.

e) The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with 1(a), nor for the non-receipt, or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.

f) Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.

4) The Bank may;

a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other Authority, cheque or draft properly signed by me/us and given to or drawn on the Bank.