Making changes to your policy

accuro HEALTH INSURANCE

This form is to make changes to an existing Accuro policy that does not require underwriting. If you have questions or need help to complete this form, either talk to your adviser or call us on 0800 222 876.

Existing membership number	

1 Purpose: What would you like to do? (please select one):

◯ **Transfer to a new policy** Please ask us for a payment method form.	◯ I would like the same level of cover as my previous policy ◯ I would like to change my level of cover (please specify the change below)
◯ **Increase the excess that applies to your policy** If you'd like to decrease your excess, you will need to complete an Accuro Health Insurance application form.	◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $4,000 ◯ $6,000 ◯ $8,000 ◯ $10,000
◯ **Add an additional plan or plans to your policy**	**SmartCare** ◯ Natural Health plan ◯ GP plan ◯ Dental and Optical plan **SmartCare+** ◯ Natural Health+ plan ◯ GP+ plan ◯ Dental and Optical+ plan **SmartStay** ◯ GP plan ◯ **Day to Day**
◯ **Add a dependant under the age of 6 months to your policy**	◯ Yes ◯ No

2 Please complete the details for the main member

Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):	
First name(s)		Date of birth DAY / MONTH / YEAR
Surname		Gender ◯ Male ◯ Female
Postal address	Street	
	Town/city	Postcode
Telephone	Home ( ) Business ( )	Mobile
Email*	◯ I would like to receive all correspondence from Accuro Health Insurance via email Home Business	
Adviser	If there is an adviser listed on your policy, do you authorise all information under the policy to be released to your adviser, including all details in relation to any claim or pre-approval submitted for any participant under this policy?	◯ Yes ◯ No

3 Additional participants to be insured

Participant 1	First name(s)		Date of birth DD / MM / YY
	Surname		Gender ◯ Male ◯ Female
	Relationship to main member	Email*	
Participant 2	First name(s)		Date of birth DD / MM / YY
	Surname		Gender ◯ Male ◯ Female
	Relationship to main member	Email*	
Participant 3	First name(s)		Date of birth DD / MM / YY
	Surname		Gender ◯ Male ◯ Female
	Relationship to main member	Email*	

* Not required for dependants under the age of 16 (dependant means a member's child (including any stepchild or adopted child) who has been accepted as a participant in the member's plan).

4 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 the 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.