KidSmart

APPLICATION FORM

accuro
HEALTH INSURANCE

At Accuro Health Insurance, we actively look for ways to add value and support members, not just if things go wrong, but to keep things going right.

As a co-operative that is 100% owned and managed in New Zealand, we are always working for members, not shareholders.

Accuro is a brand owned, operated and underwritten by Union Medical Benefits Society Limited (UniMed). When you take out an Accuro policy, you become a member of UniMed.

Eligibility

To qualify for a KidSmart policy, the child must be a New Zealand citizen, permanent resident or be covered under New Zealand's public health system.

Medical history

Health insurance only covers your child(ren) for the things that happen after cover is provided. Don't be concerned if they already have a medical condition, just make sure you give us as much information as possible so we can fairly assess their medical history.

If they have a condition – or have had a condition or symptoms in the past that might result in further issues – we may exclude coverage for that condition in the first instance. We're happy to review any exclusions if you can provide further medical information. We will assess all the information you provide and make a decision based on the level of risk involved. Excluding coverage for pre-existing conditions enables us to minimise our costs and keep premiums low.

We're here to help

If you have questions or need help, either talk to your adviser or call us on **0800 222 876**.

accuro
HEALTH INSURANCE

SECTION A

Type of application

1 Is this a new application? ◯ Yes ◯ No (go to Q4)

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

3 Choose your KidSmart plan

Hospital and Surgical base plan excess	◉ $0 excess or ◯ $250 excess
Please tick if you would like to add the Specialist plan	◯ Specialist plan
When would you like this policy to start?	DAY / MONTH / YEAR or ◯ as soon as possible

4 Are you making a change to an existing KidSmart policy? ◯ Yes ◯ No (go to Q5)

Do you want to add a child to an existing KidSmart policy?	◯ Yes ◯ No
Do you want to add the Specialist plan to an existing KidSmart policy?	◯ Yes ◯ No Name(s) of child(ren) to have the Specialist plan

5 Do you wish to add an adviser on your policy? ◯ Yes ◯ No (go to Q6)

Your adviser's name and company	

FOR OFFICE USE ONLY Membership number: Agent name/number:

SECTION B

Personal details

6 Please complete the details for the guardian who will be the policy owner

The guardian on the policy must be the legal guardian for all children listed in this application, and they must complete the application form on behalf of all children.

Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other _____
First name(s)	
Surname	
Date of birth	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female
Postal address	Street
	Town/city Postcode
Telephone	Home ( ) Mobile
Email	Home
	Business
Industry	◯ Agriculture, forestry and fishing ◯ Mining ◯ Manufacturing ◯ Electricity, gas, water and waste services ◯ Construction ◯ Wholesale trade ◯ Retail trade and accommodation ◯ Transport, postal and warehousing ◯ Information media and telecommunications ◯ Financial and insurance services ◯ Rental, hiring and real estate services ◯ Professional, scientific, technical, administrative and support services ◯ Public administration and safety ◯ Education and training ◯ Healthcare and social assistance ◯ Arts, recreation and other services
How did you hear about us?	◯ Search engine ◯ Social media ◯ District Health Board or NZNO ◯ Online advertisement ◯ Print advertisement ◯ Radio ◯ Event ◯ Adviser ◯ FreeStart Plan ◯ From a current member (please provide the member's name and membership number if available) _____ ◯ Other (please provide details) _____

7 Children (under the age of 18) to be insured on the policy

	Child 1:	Child 2:	Child 3:	Child 4:	Child 5:
Relationship to guardian					
Title	◯ Mr ◯ Master ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Master ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Master ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Master ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Master ◯ Miss ◯ Ms ◯ Other (please specify):
First name(s)					
Surname					
Date of birth	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female
Name of child's usual GP and medical practice	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____
Name of child's usual dentist and dental practice	Dentist _____ Practice _____ _____ Fax _____	Dentist _____ Practice _____ _____ Fax _____	Dentist _____ Practice _____ _____ Fax _____	Dentist _____ Practice _____ _____ Fax _____	Dentist _____ Practice _____ _____ Fax _____

HOW TO PROVIDE A CHILD'S MEDICAL INFORMATION

Please complete one of the two following options:

OPTION 1

OR

OPTION 2

SECTION C
Full medical history

If you elect this option, simply answer questions 8–10 and attach the full medical history for each child (from their date of birth to today). This gives you peace of mind that you have given us all the medical information you can for the child and will not need to provide us with an additional medical report for any child's claims.

SECTION D
Health declaration

You will need to answer questions 11-30 in relation to the child's medical history. This information is then used to underwrite the application and again at claim time.

An additional medical report may be required to be completed by the child's GP for any claims for the child within the first five years of the policy.

Please note that we will still require either a copy of the GP's referral letter or a letter from the specialist confirming why the consultation or procedure is required for each claim submitted.

Is the child under six months of age?

If you are wanting to apply for a child under six months of age, you do not need to complete either of the health sections for them (Sections C and D). Please make sure that they are listed as a child under question 7 and then proceed to the declaration page (Section E).

SECTION C

OPTION 1

Full medical history

If you select this option, you must attach the full medical history from their date of birth to today for each child included in this application. In addition, you must answer questions 8, 9 and 10.

Important: Please complete this section for each applicant. If you need more space, please see our website for suplementary pages.

8 Dental problems

Has any child ever had oral surgery or experienced, had symptoms of, been treated for or been advised to seek testing or treatment for wisdom teeth, impacted or unerupted teeth, cysts or gum disease?

◯ Yes ◯ No (go to Q9) ◯ Yes ◯ No (go to Q9)

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
If wisdom teeth have been removed, please confirm how many.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

9 Other conditions

Has any child:

- ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for any other illness, accident, injury, condition, complaint, disability, medication or disorder not already stated in the medical notes?
- been hospitalised or had any tests, medical treatment or investigations in the last five years (or since birth if the child is less than five years of age) or be intending to for **any condition not already stated**, including but not limited to blood and/or urine test, X-ray, ultrasound, CT scan, mammogram, MRI, gastroscopy, colonoscopy, endoscopy, hysteroscopy or laparoscopy?
- had more than five consecutive days off school or paid childcare in the past five years (or since birth if the child is less than five years of age) due to **any condition not already stated in the medical notes**?
- ever had elective surgery for any reason?

	◯ Yes ◯ No (go to Q10)	◯ Yes ◯ No (go to Q10)
	Name of child:	**Name of child:**
Please advise the name of the medical condition, treatment and/or surgery. If elective surgery, when did you first receive treatment?		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

10 Family history

Have any of the participants to be insured, ever undertaken testing or treatment, or been advised to seek testing or treatment in relation to family history?

◯ Yes ◯ No (go to the question below) ◯ Yes ◯ No (go to the question below)

	Name of participant:	Name of participant:
Please advise the name of the medical condition tested, the reason why the testing was required and the outcome		

Have any of the child's grandparents, parents, brothers or sisters (living or dead) had or been diagnosed with any of the following: cancer, stroke, heart disease, diabetes, kidney disease, Huntington's chorea, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, bowel and/or colon polyps, multiple sclerosis, inherited neurological or blood disease or any familial and/or congenital disease or disorder?

◯ Yes ◯ Yes ◯ Yes ◯ Yes
◯ No (go to Section E) ◯ No (go to Section E) ◯ No (go to Section E) ◯ No (go to Section E)

	Name of child:	Name of child:	Name of child:	Name of child:
Medical condition (If cancer, specify type and site)				
Family member affected				
Age(s) at diagnosis				
Current age(s)				
Age at death (if applicable)				

Once you have completed this section for each child and attached each child's full medical history, please go to Section E.

If you require more space to write, please use page 31

SECTION D

OPTION 2

Health declaration

These questions need to be answered by everyone who is:

- applying for a new policy, or
- making changes to an existing policy, or
- adding a child aged six months or older to the policy. If the child is under six months of age, go to Section E.

Important: Please complete this section for each applicant. If you need more space, please see our website for suplementary pages.

11 Heart

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for abnormal heart beat, arrhythmia, heart murmur or rheumatic fever?

◯ Yes ◯ No (go to Q12) ◯ Yes ◯ No (go to Q12)

	Name of child:	Name of child:
Please provide details of the cardiac disorder.		
When did the child first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did the child last experience symptoms of this condition?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Has the child been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child ever undergone or been advised to undergo any investigations and/or treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child experienced any residual effects?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Does the child require any on-going treatment, medication and/or monitoring?	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:

If you require more space to write, please use page 29.

12 Breathing or respiratory disorders

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis or sleep disorders?

◯ Yes ◯ No (go to Q13) ◯ Yes ◯ No (go to Q13)

	Name of child:	Name of child:
Please provide details of the breathing disorder (e.g. asthma, bronchitis).		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did the child last experience symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
What treatment and/or medication has the child been prescribed?		
How frequent are/were the symptoms?	_____ per month/per year (delete one)	_____ per month/per year (delete one)
Does the child consider their breathing disorder to be:	◯ Mild ◯ Moderate ◯ Severe ◯ Other	◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child been hospitalised and/or been on a nebuliser in the last two years (or since birth if the child is less than two years of age)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child been prescribed steroids (e.g. prednisone) in the last two years (or since birth if the child is less than two years of age)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child been referred to a specialist for investigations and/or treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use page 29.

13 Digestive disorders; stomach, intestine, liver or gall bladder problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for gastritis, ulcers, reflux, irritable bowel, Crohn's disease, colitis, coeliac disease, bowel polyps, abdominal pain, pancreatitis, liver inflammation, gallstones or hernias?

◯ Yes ◯ No (go to Q14) ◯ Yes ◯ No (go to Q14)

	Name of child:	Name of child:
Please provide details of the type of digestive disorders and/ or stomach, intestine, liver or gall bladder problems.		
When did the child first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Does the child still experience symptoms of this condition?	◯ Yes ◯ No If **no**, when did the child last experience symptoms? If **yes**, how many times per year?	◯ Yes ◯ No If **no**, when did the child last experience symptoms? If **yes**, how many times per year?
Has the child been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child ever undergone or been advised to undergo any investigations of the gastrointestinal tract (e.g. gastroscopy, endoscopy, colonoscopy)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child ever undergone or been advised to undergo any treatment (including surgery) for this condition?	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome:	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome.
Has the child in the past taken or is currently taking any medication for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use page 31

14 Cancer, cysts, tumours or growths

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for polyps, benign growths, any cancers or pre-cancerous condition, suspicious moles, cysts, abscesses, ganglion, basal cell carcinoma or melanoma?

◯ Yes ◯ No (go to Q15) ◯ Yes ◯ No (go to Q15)

	Name of child:	Name of child:
Please provide details of the condition.		
What is the medical name of this condition?		
When did the child first experience symptoms or become aware of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment was undertaken or advised? If surgical removal, please provide date.		
If no treatment was undertaken, is the condition still present?	◯ Yes ◯ No	◯ Yes ◯ No
Do you know if the child's condition was:	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure
Has there been any recurrence?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child seen a specialist, does the child require any on-going follow-up, treatment or monitoring or has any follow-up/further treatment been recommended?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use page 31

15 Muscle or skeletal problems (including cartilage, tendon or ligament problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for arthritis, back pain, neck/shoulder problems, whiplash, sciatica, scoliosis, ankylosing spondylitis, OOS, RSI, carpal tunnel, joint replacements, fractures, osteoporosis, gout or inflammatory conditions; any disorders of the hips, knees, ankles, feet, toes, shoulders, arms, elbows, wrists, hands or fingers?

◯ Yes ◯ No (go to Q16) ◯ Yes ◯ No (go to Q16)

	Name of child:	Name of child:
What is the name of the condition/ complaint/injury?		
What body part is affected? Please indicate if left or right limb.		
When did the child first suffer from this condition/complaint/injury, and how did it occur?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
How long did the symptoms last?		
When did the child last suffer from symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Has this condition occurred more than once?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child had any investigations for the condition?	◯ Yes ◯ No If **yes**, please provide details of type, date and results:	◯ Yes ◯ No If **yes**, please provide details of type, date and results:
Has the child had any treatment (including surgery) for the condition?	◯ Yes ◯ No If **yes**, please provide details including date:	◯ Yes ◯ No If **yes**, please provide details including date:

If you require more space to write, please use page 31

Muscle or skeletal problems (continued)

	Name of child:	Name of child:
Has the child had any time off school or paid childcare as a result of this condition?	◯ Yes ◯ No ◯ The child has not returned to school/ childcare If **yes**, please provide date and duration: DAY / MONTH / YEAR	◯ Yes ◯ No ◯ The child has not returned to school/ childcare If **yes**, please provide date and duration: DAY / MONTH / YEAR
Has the child made a claim to ACC in respect of this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Is the child currently receiving treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Is the child awaiting investigations, treatment or surgery, or has the child been advised that treatment or surgery will be required for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Has the child experienced any pain or discomfort since the last episode/ symptoms?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you aware of any arthritis or degeneration in the child's affected body part(s)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use page 31

16 Blood, immune or circulatory disorders

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for abnormal blood tests, anaemia, hepatitis, HIV, haemochromatosis, vitamin B12 deficiency, haemophilia, lupus or any autoimmune disorder or blood clots?

	◯ Yes ◯ No (go to Q17)	◯ Yes ◯ No (go to Q17)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

17 Endocrine (glandular) disorders

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for diabetes (type 1 or type 2), thyroid problems, Graves' disease, abnormal thyroid function tests, pituitary problems or abnormal blood sugar and/or glucose tolerance tests?

	◯ Yes ◯ No (go to Q18)	◯ Yes ◯ No (go to Q18)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

18 Urinary or kidney disorders

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for kidney or bladder problems, incontinence, urinary difficulties, kidney stones or kidney infections, kidney failure or recent and/or recurrent UTIs?

	◯ Yes ◯ No (go to Q19)	◯ Yes ◯ No (go to Q19)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

19 Anal/rectal problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for change in bowel habit, anal bleeding or pilonidal sinus?

	◯ Yes ◯ No (go to Q20)	◯ Yes ◯ No (go to Q20)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

20 Skin problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for eczema, dermatitis, rashes, psoriasis, acne or allergic conditions?

	◯ Yes ◯ No (go to Q21)	◯ Yes ◯ No (go to Q21)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

21 Brain or nervous system disorders

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for migraine, repeated headaches, vertigo, fainting, dizziness, multiple sclerosis, epilepsy/seizures, paralysis, motor neuron disease, nerve pain or meningitis?

	◯ Yes ◯ No (go to Q22)	◯ Yes ◯ No (go to Q22)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

22 Fatigue or pain syndromes

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for chronic fatigue, fibromyalgia or chronic pain syndrome?

	◯ Yes ◯ No (go to Q23)	◯ Yes ◯ No (go to Q23)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

23 Eye, ear and throat problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for visual impairment, hearing loss, tinnitus, recent and/or recurrent ear infections, grommets, enlargement of adenoids, tonsillitis or recent and/or recurrent throat infections?

◯ Yes ◯ No (go to Q24) ◯ Yes ◯ No (go to Q24)

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

24 Allergies, nasal and/or sinus problems

Has any child ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for anaphylaxis, nasal obstruction, hay fever, sinusitis or recent and/or recurrent sinus infections?

	◯ Yes ◯ No (go to Q25)	◯ Yes ◯ No (go to Q25)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Have these symptoms completely resolved?	◯ Yes ◯ No	◯ Yes ◯ No
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

25 Dental problems

Has any child ever had oral surgery or experienced, had symptoms of, been treated for or been advised to seek testing or treatment for wisdom teeth, impacted or unerupted teeth, cysts or gum disease?

	◯ Yes ◯ No (go to Q26)	◯ Yes ◯ No (go to Q26)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
If wisdom teeth have been removed, please confirm how many.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

26 Mental health

Has any child ever experienced any signs or symptoms of or is currently receiving or has ever received counselling, investigations or treatment for any psychiatric or psychological condition, including anxiety, stress or depression?

◯ Yes ◯ No (go to Q27 for males or Q28 for females)

◯ Yes ◯ No (go to Q27 for males or Q28 for females)

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

27 To be completed for male children only

Has any child ever experienced any signs or symptoms of or is currently receiving or has ever received counselling, investigations or treatment from a health professional for any of the following: blood in the urine, slow urinary stream, problems with passing urine or disease or disorder of the testicles, bladder, urethra or prostate?

	◯ Yes ◯ No (go to Q29)	◯ Yes ◯ No (go to Q29)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

28 To be completed for female children only

Has any child ever experienced any signs or symptoms of or is currently receiving or has ever received counselling, investigations or treatment from a health professional for any of the following: breast lumps, gynaecological disorder of any kind, endometriosis, polycystic ovarian syndrome, irregular, heavy or painful menstrual bleeding or ovarian or hormonal problems?

	◯ Yes ◯ No (go to Q29)	◯ Yes ◯ No (go to Q29)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

29 Other conditions

Has any child:

- ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for any other illness, accident, injury, condition, complaint, disability, medication or disorder not already stated?
- been hospitalised or had any tests, medical treatment or investigations in the last five years (or since birth if the child is less than five years of age) or be intending to for **any condition not already stated**, including but not limited to blood and/or urine test, X-ray, ultrasound, CT scan, mammogram, MRI, gastroscopy, colonoscopy, endoscopy, hysteroscopy or laparoscopy?
- had more than five consecutive days off school or paid childcare in the past five years (or since birth if the child is less than five years of age) due to **any condition not already stated**?
- ever had elective surgery for any reason?

	◯ Yes ◯ No (go to Q30)	◯ Yes ◯ No (go to Q30)
	Name of child:	**Name of child:**
Please advise the name of the medical condition.		
When did the child first experience symptoms? If elective surgery, when did they first receive treatment?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did the child last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Has the child had any investigations and/or received any treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Has the child been referred to a specialist for this condition?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use page 31

30 Family history

Have you, or any of the participants to be insured, ever undertaken testing or treatment, or been advised to seek testing or treatment in relation to family history?

	◯ Yes ◯ No (go to the question below)	◯ Yes ◯ No (go to the question below)
	Name of participant:	**Name of participant:**
Please advise the name of the medical condition tested, the reason why the testing was required and the outcome		

Have any of the child's grandparents, parents, brothers or sisters (living or dead) had or been diagnosed with any of the following: cancer, stroke, heart disease, diabetes, kidney disease, Huntington's chorea, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, bowel and/or colon polyps, multiple sclerosis, inherited neurological or blood disease or any familial and/or congenital disease or disorder?

	◯ Yes ◯ No (go to Section E)	◯ Yes ◯ No (go to Section E)	◯ Yes ◯ No (go to Section E)	◯ Yes ◯ No (go to Section E)
	Name of child:	**Name of child:**	**Name of child:**	**Name of child:**
Medical condition (If cancer, specify type and site)				
Family member affected				
Age(s) at diagnosis				
Current age(s)				
Age at death (if applicable)				

Once you have completed this section for each child, please go to Section E.

If you require more space to write, please use page 31

Please use this page if you require more space to answer any of the questions. Make sure you include the question number (e.g. Q8) and the child's name.

SECTION E

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, the person applying for this health insurance policy, confirm that I:

1. Agree that this application and any other information obtained/provided about persons to be included on my plan forms the basis of the contract.
2. Declare that the information I have given is correct and complete and that no material fact has been omitted. I undertake to advise UniMed of any health condition or event that may affect any of the people named in this application or any relevant information that may affect the policy between the date I sign this application and the date the policy commences.
3. Am legally responsible for the named children and declare that any information supplied in this application, whether written by me or not, is true and accurate.
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 have fourteen (14) days to cancel my/our plan(s) ('14-day free-look' period) and that, subject to no claims having been made, the person who paid the premium 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 named children and any other people in this application.
9. I 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 any other insurance held in respect to a named child.

Privacy Act 2020 and the Health Information Privacy Code 2020

Each person applying for this health insurance plan 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 any personal information, including any child's 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 Privacy Policy, available on our website.

Important information

1. This form represents an application by the guardian signing this declaration to become an associate 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.
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 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 general policy terms and conditions.

Guardian's name in full

Signature Click to add your signature Date signed: DD / MM / YY

Please be aware that you are required to advise us of any new signs/symptoms or health condition for any applicant that arises between the date you sign the application form and the date the policy commences.

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.

SECTION F

Payment method form

accuro HEALTH INSURANCE
0800 222 876

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

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 Click to add 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 Click to add signature **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					
06	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. I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:
    - I don't receive written notice of the amount and date of each direct debit from the initiator, or
    - I receive written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.
2. The initiator is required to give me written notice of the amount and date of each direct debit in a series of direct debits no less than 10 calendar days before the date of the first direct debit in the series. The notice is to include:
    - the dates of the debits, and
    - the amount of each direct debit.
3. If the bank dishonours a direct debit but the initiator sends the direct debit a second time within 5 business days of the original direct debit, the initiator is not required to notify me a second time of the amount and date of the direct debit.
4. If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give me notice:
    - no less than 30 calendar days before the change, or
    - if the initiator bank agrees, no less than 10 calendar days before the change.

Checklist

Please check:

- ◯ You have answered all the questions.
- ◯ You have provided additional information in the appropriate questionnaire if a question required you to provide more detail.
- ◯ You have read and signed the declaration in Section E. (This must be signed by the guardian listed on the application form.)

Payment details

- ◯ If paying by direct debit, please complete the form on page 33.
- ◯ If paying by credit/debit card, please complete the form on page 33.
- ◯ If a child is being added to an existing policy, do not fill out Section F.
- ◯ If a non-guardian is wanting to pay for this policy, the guardian will still need to complete the application form, and the non-guardian will need to complete Section F Payment details.

Attachments

- ◯ If you have completed Section C Full medical history, please ensure that you have attached each child's full medical history (from their date of birth to today) to this application.
- ◯ If you are providing any supporting documentation, please ensure it has been attached to this application.

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