KidSmart short application form

accuro HEALTH INSURANCE

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

1 This application is to (please select one):

- ◯ **add a child under six months of age to a new policy.** Please complete the attached payment method form.
- ◉ **add a child under six months of age to an existing policy.** Please advise your existing membership number _____

2 Choose your KidSmart plan(s)

Choose the excess for your Hospital & Surgical base plan	◯ $0 excess ◯ $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 ◯ To be advised

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

4 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 _____	Gender ◯ Male ◯ Female
First name(s)		
Surname		Date of birth DAY / MONTH / YEAR
Postal address	Street	
	Town/city	Postcode
Telephone	Home ( )	Mobile
Email	Primary	Alternative
How did you hear about us?		

5 Children (under the age of six months) to be insured on this policy

	Child 1:	Child 2:	Child 3:
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):
First name(s)			
Surname			
Date of birth	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female
Name of child's usual GP and medical practice	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____	GP _____ Practice _____ _____ Fax _____

6 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, 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 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.

accuro
HEALTH INSURANCE
0800 222 876

Payment method form

You don't need to complete this section if you are adding a child to an existing policy.

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.

Specific conditions relating to notices and disputes

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.