

# HEALTH INSURANCE

APPLICATION FORM

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 SmartCare or SmartCare+ policy, you need to be a New Zealand citizen or permanent resident, hold a work visa valid in New Zealand for two years or more or be covered under New Zealand's public health system. The same applies to the other participants included in this application.

To qualify for a SmartStay policy, the main member needs to hold a work visa valid in New Zealand for less than two years and not have cover under New Zealand's public health system. Your family can also be covered under SmartStay as long as they have a visitor visa valid in New Zealand.

## **Your medical history**

Health insurance only covers you for the things that happen after you take out cover. Don't be concerned if you already have a medical condition – just make sure you give us as much information as possible so we can fairly assess your medical history.

If you 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**.

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 Are you applying as an individual or part of a group scheme?

☐ Individual (please fill in the below) ☐ Group scheme (go to Q6)

<p>Please choose a base plan</p>	<p>If you are a New Zealand citizen or resident, hold a work visa valid for two years or more or are covered by the New Zealand public health system, you can select:</p> <p><input type="radio"/> SmartCare Hospital and Surgical base plan</p> <p><input type="radio"/> SmartCare+ Hospital and Surgical base plan</p> <p><input type="radio"/> Other _____</p>	<p>If you are <b>not</b> a New Zealand citizen or resident but hold a work visa valid for at least one month or a visitor visa valid for at least three months, you can select:</p> <p><input type="radio"/> SmartStay Hospital and Surgical base plan</p>
<p>Please choose your excess</p> <p>The excess is the amount you agree to pay towards the cost of any claims on your plan. The higher the excess, the lower your premium.</p>	<p><input type="radio"/> \$0 <input type="radio"/> \$4,000</p> <p><input type="radio"/> \$250 <input type="radio"/> \$6,000</p> <p><input type="radio"/> \$500 <input type="radio"/> \$8,000</p> <p><input type="radio"/> \$1,000 <input type="radio"/> \$10,000</p> <p><input type="radio"/> \$2,000</p>	<p><input type="radio"/> \$0 <input type="radio"/> \$1,000</p> <p><input type="radio"/> \$250 <input type="radio"/> \$2,000</p> <p><input type="radio"/> \$500 <input type="radio"/> \$4,000</p>
<p>Once you have chosen your base plan, you can add other plans</p>	<p><input type="radio"/> Specialist plan (Excess: <input type="radio"/> \$0 <input type="radio"/> \$250)</p> <p><input type="radio"/> GP plan</p> <p><input type="radio"/> Natural Health plan</p> <p><input type="radio"/> Dental and Optical plan</p>	<p><input type="radio"/> Specialist plan</p> <p><input type="radio"/> GP plan</p>
<p>When would you like this policy to start?</p>	<p>DAY / MONTH / YEAR or <input type="radio"/> as soon as possible</p>	

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

<p><input type="radio"/> Add a participant to an existing policy</p>	<p>All new participant(s) need to complete Section B, answer the health questions in Section C and sign the declaration under Section D.</p> <p>The payment details section (Section E) does not need to be completed for any new participant that is added to an existing policy.</p>
<p><input type="radio"/> Add a new plan to an existing policy</p>	<p>Please state the new plan(s) to be added _____</p> <p>Please include excess option if applicable</p>
<p><input type="radio"/> Decrease the excess that applies to an existing policy</p> <p>If you'd like to increase your excess, just send us a letter signed by the main member.</p>	<p><input type="radio"/> \$0 <input type="radio"/> \$500 <input type="radio"/> \$2,000 <input type="radio"/> \$6,000</p> <p><input type="radio"/> \$250 <input type="radio"/> \$1,000 <input type="radio"/> \$4,000 <input type="radio"/> \$8,000</p>

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

<p>Your adviser's name and company</p>	
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Membership number:

Agent name/number:

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Are you applying for a group scheme? ☐ Yes ☐ No (go to Q7)

Name of company/association/ organisation/partnership		
Date employed	DAY / MONTH / YEAR	Employee number (if applicable):
Please choose a base plan	<div><input type="radio"/> StaffCare Hospital and Surgical base plan</div> <div><input type="radio"/> StaffStay Hospital and Surgical base plan</div> <div><input type="radio"/> StaffCare+ Hospital and Surgical+ base plan</div>	
<div>Please choose your excess</div> <div>The excess is the amount you agree to pay towards the cost of any claims on your plan. The higher the excess, the lower your premium.</div>	<div><input type="radio"/> \$0</div> <div><input type="radio"/> \$1,000</div> <div><input type="radio"/> \$250</div> <div><input type="radio"/> \$2,000</div> <div><input type="radio"/> \$500</div>	
Once you have chosen your base plan, you can add other plans	StaffCare additional plans: <div><input type="radio"/> Specialist plan (Excess: <input type="radio"/> \$0 <input type="radio"/> \$250)</div> <div><input type="radio"/> GP plan</div>	
	StaffCare+ additional plans: <div><input type="radio"/> Specialist+ plan (Excess: <input type="radio"/> \$0 <input type="radio"/> \$250)</div> <div><input type="radio"/> GP+ plan</div> <div><input type="radio"/> Dental and Optical+ plan</div> <div><input type="radio"/> Natural Health+ plan</div>	
	StaffStay additional plans: <div><input type="radio"/> Specialist plan</div> <div><input type="radio"/> GP plan</div>	

SECTION B

Personal details

7 Please complete the details for the main member to be insured

Title	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):	
First name(s)		
Surname		
Date of birth	DAY / MONTH / YEAR	
Gender at birth	<input type="radio"/> Male <input type="radio"/> Female	
Residential address	Street	
	Town/city	Postcode
Postal address <small>(if different from above)</small>	Street	
	Town/city	Postcode
Telephone	Mobile (    )	Alternative (    )
Email	Primary	Secondary
Industry of work	<div><div><input type="radio"/> Agriculture, forestry and fishing</div><div><input type="radio"/> Mining</div><div><input type="radio"/> Manufacturing</div><div><input type="radio"/> Electricity, gas, water and waste services</div><div><input type="radio"/> Construction</div><div><input type="radio"/> Wholesale trade</div><div><input type="radio"/> Retail trade and accommodation</div><div><input type="radio"/> Transport, postal and warehousing</div><div><input type="radio"/> Information media and telecommunications</div></div> <div><div><input type="radio"/> Financial and insurance services</div><div><input type="radio"/> Rental, hiring and real estate services</div><div><input type="radio"/> Professional, scientific, technical, administrative and support services</div><div><input type="radio"/> Public administration and safety</div><div><input type="radio"/> Education and training</div><div><input type="radio"/> Health care and social assistance</div><div><input type="radio"/> Arts, recreation and other services</div></div>	

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Do you wish to insure other family members/whānagai on this policy or add someone to an existing policy? ☐ Yes ☐ No (go to Q9)

Additional participants to be insured This can include your parents and/or participants under the age of 25.					
	Participant 1:	Participant 2:	Participant 3:	Participant 4:	Participant 5:
Relationship to the main member					
Title	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):	<input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> 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
Assigned gender at birth	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Male <input type="radio"/> Female
Email*					
Height and weight*	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg
Have you smoked in the last 12 months?*	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Name of your usual GP and practice	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): GP _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): GP _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): GP _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): GP _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): GP _____ Practice _____ _____ Fax _____
Name of your usual dentist and practice	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): Dentist _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): Dentist _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): Dentist _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): Dentist _____ Practice _____ _____ Fax _____	<input type="radio"/> Same as main member <input type="radio"/> Other (please specify): Dentist _____ Practice _____ _____ Fax _____

\* Not required for dependants under the age of 18 (dependant means a member's child (including any stepchild or adopted child) who has been accepted as a participant in the member's plan).

\*\* Not required for dependants under the age of 25.

SECTION C

Health declaration

These questions need to be answered by everyone who is:

- » applying for a new policy, or
- » making changes to an existing policy.

**Important:** You must complete this section for each applicant. If you need more space, please see our website for supplementary pages.

9 Heart conditions

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for angina/chest pain, heart attack, heart failure, abnormal heart beat, arrhythmia, heart murmur or rheumatic fever?

☐ Yes ☐ No (go to Q10)

☐ Yes ☐ No (go to Q10)

	Name of participant:	Name of participant:
Please provide details of the cardiac disorder.		
When did you first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms of this condition?	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you ever undergone or been advised to undergo any investigations and/or treatment for this condition?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you experienced any residual effects?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Do you require any on-going treatment, medication and/or monitoring?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details including treatment undertaken and/or medication prescribed:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details including treatment undertaken and/or medication prescribed:

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## Raised blood pressure; raised or abnormal cholesterol

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for raised blood pressure or raised or abnormal cholesterol?

☐ Yes ☐ No (go to Q11)

☐ Yes ☐ No (go to Q11)

	Name of participant:	Name of participant:
Do you suffer from or have you been advised by a medical practitioner that you suffer from:	<input type="radio"/> Raised blood pressure <input type="radio"/> Raised or abnormal cholesterol	<input type="radio"/> Raised blood pressure <input type="radio"/> Raised or abnormal cholesterol
When did you first become aware you had raised blood pressure?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you first become aware you had abnormal cholesterol?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment and/or medication have you been prescribed?		
Has your treatment changed in the last 12 months?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
How often is your blood pressure and/or cholesterol checked and by whom?		
What were your three most recent blood pressure readings and cholesterol results?	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR
Have you ever been admitted to hospital or consulted a specialist or been referred to a specialist as a result of your blood pressure and/or cholesterol readings?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:
Do you suffer from any complications or associated conditions?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:



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Breathing or respiratory disorders

Have you, or any of the participants to be insured, 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, emphysema or sleep disorders?

☐ Yes    ☐ No (go to Q12)

☐ Yes    ☐ No (go to Q12)

	Name of participant:	Name of participant:
Please provide details of the breathing disorder (e.g. asthma, bronchitis).		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms?	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going
What treatment and/or medication have you been prescribed?		
How frequent are/were the symptoms?	_____ per month/per year (delete one)	_____ per month/per year (delete one)
Do you consider your breathing disorder to be:	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Other	<input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe <input type="radio"/> Other
Have you been hospitalised and/or been on a nebuliser in the last two years?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you been prescribed steroids (e.g. prednisone) in the last two years?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you been referred to a specialist for investigations and/or treatment?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:

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

Have you, or any of the participants to be insured, 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, fatty liver, cirrhosis, gallstones or hernias?

☐ Yes ☐ No (go to Q13)

☐ Yes ☐ No (go to Q13)

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

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Cancer, cysts, tumours or growths

Have you, or any of the participants to be insured, 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 Q14)

☐ Yes    ☐ No (go to Q14)

	Name of participant:	Name of participant:
Please provide details of the condition.		
Please advise the name of the medical condition.		
When did you 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?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Do you know if the condition was:	<input type="radio"/> Malignant <input type="radio"/> Pre-malignant <input type="radio"/> Benign <input type="radio"/> Unsure	<input type="radio"/> Malignant <input type="radio"/> Pre-malignant <input type="radio"/> Benign <input type="radio"/> Unsure
Has there been any recurrence?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you seen a specialist, do you require any on-going follow-up, treatment or monitoring or has any follow-up/further treatment been recommended?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:

## 14 Muscle or skeletal problems (including cartilage, tendon and ligament problems)

Have you, or any of the participants to be insured, 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 or any disorders of the hips, knees, ankles, feet, toes, shoulders, arms, elbows, wrists, hands or fingers?

☐ Yes ☐ No (go to Q15)

☐ Yes ☐ No (go to Q15)

	Name of participant:	Name of participant:
What is the name of the condition/ complaint/injury?		
What body part is affected? Please indicate if left or right limb.		
When did you 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 you last suffer from symptoms?	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going
Has this condition occurred more than once?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details:
Have you had any investigations?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details of type, date and results:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details of type, date and results:
Have you had any treatment (including surgery)?	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details including date:	<input type="radio"/> Yes <input type="radio"/> No If <b>yes</b> , please provide details including date:

Muscle or skeletal problems (continued)

	Name of participant:	Name of participant:
Have you had any time off work or school as a result of this condition?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div><input type="radio"/> I have not yet returned to work/school</div> <div>If <b>yes</b>, please provide start date and duration:</div> <div>DAY / MONTH / YEAR</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div><input type="radio"/> I have not yet returned to work/school</div> <div>If <b>yes</b>, please provide start date and duration:</div> <div>DAY / MONTH / YEAR</div>
Have you made a claim to ACC in respect of this condition?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>
Are you currently receiving treatment?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>
Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery will be required?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>
Have you experienced any pain or discomfort since the last episode/symptoms?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>
Are you aware of any arthritis or degeneration in the affected body part(s)?	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>	<div><input type="radio"/> Yes <input type="radio"/> No</div> <div>If <b>yes</b>, please provide details:</div>

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Blood, immune or circulatory disorders

Have you, or any of the participants to be insured, 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 varicose veins, DVT or blood clots?

☐ Yes ☐ No (go to Q16)

☐ Yes ☐ No (go to Q16)

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

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Endocrine (glandular) disorders

Have you, or any of the participants to be insured, 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 Q17)

☐ Yes    ☐ No (go to Q17)

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

17

Urinary or kidney disorders

Have you, or any of the participants to be insured, 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 Q18)

☐ Yes ☐ No (go to Q18)

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



18

Anal/rectal problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for haemorrhoids, change in bowel habit, anal fissures, anal bleeding or pilonidal sinus?

☐ Yes ☐ No (go to Q19)

☐ Yes ☐ No (go to Q19)

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

19

Skin problems

Have you, or any of the participants to be insured, 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 Q20)

☐ Yes    ☐ No (go to Q20)

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

20

Brain or nervous system disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for stroke, TIA, aneurysms, migraine, repeated headaches, vertigo, fainting, dizziness, multiple sclerosis, epilepsy/seizures, paralysis, motor neuron disease, nerve pain or meningitis?

☐ Yes    ☐ No (go to Q21)

☐ Yes    ☐ No (go to Q21)

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

21 Fatigue or pain syndromes

Have you, or any of the participants to be insured, 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 Q22)                      ☐ Yes    ☐ No (go to Q22)

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

22

Eye, ear or throat problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for cataracts, glaucoma, 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 Q23)

☐ Yes    ☐ No (go to Q23)

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

23

Allergies, nasal and/or sinus problems

Have you, or any of the participants to be insured, 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 Q24)

☐ Yes    ☐ No (go to Q24)

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

24

Dental problems

Have you, or any of the participants to be insured, 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 Q25)

☐ Yes    ☐ No (go to Q25)

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

25

Mental health conditions

Have you, or any of the participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the participants to be insured, currently receiving or have ever received counselling, investigations or treatment for, any psychiatric or psychological condition, including anxiety, stress or depression?

☐ Yes    ☐ No (go to Q26 for males  
or Q27 for females)

☐ Yes    ☐ No (go to Q26 for males  
or Q27 for females)

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



26

To be completed by males only

Have you, or any of the male participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the male participants to be insured, currently receiving or have 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, disease or disorder of the testicles, bladder, urethra or prostate, sexual dysfunction or abnormal prostate tests?

☐ Yes    ☐ No (go to Q28)

☐ Yes    ☐ No (go to Q28)

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

27

Have you, or any of the female participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the female participants to be insured, currently receiving or have ever received counselling, investigations or treatment from a health professional for, any of the following: breast disease or disorder, breast lumps, cysts or breast pain, gynaecological disorder of any kind, endometriosis, polycystic ovarian syndrome, irregular, heavy or painful menstrual bleeding, current symptoms of menopause, ovarian or hormonal problems, complications of pregnancy, abnormal smear(s), painful intercourse and/or prolapse?

☐ Yes    ☐ No (go to Q28)

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

28

Other conditions

Have you, or any of the participants to be insured:

- 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 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 and laparoscopy?
- had more than five consecutive days off work or school in the past five years due to **any condition not already stated**?
- ever had elective surgery for any reason?

☐ Yes    ☐ No (go to Q29)

☐ Yes    ☐ No (go to Q29)

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

29

Family history (please answer both questions below)

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 your grandparents, parents, brothers, sisters or children (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 D)

☐ Yes
 ☐ No (go to Section D)

☐ Yes
 ☐ No (go to Section D)

☐ Yes
 ☐ No (go to Section D)

	Name of participant:	Name of participant:	Name of participant:	Name of participant:
Medical condition (If cancer, specify type and site)				
Family member affected  Please specifcy which side of the family ie: maternal/paternal				
Age at diagnosis				
Current age				
Age at death (if applicable)				

Please use the next three pages if you require more space to answer any of the health questions. Make sure you include the question number (e.g. Q8) and the participant's name.

This image shows a full page of blank, white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page, providing a guide for handwriting or typing. There are no margins, text, or other markings on the paper.

[illegible]

[illegible]

## SECTION D

## 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](http://www.unimed.co.nz/about-unimed/financial/strength)



SECTION E

# Payment method form

For information on discounts available at Accuro, visit [accuro.co.nz/about/discounts](https://accuro.co.nz/about/discounts)

Preferred first date of payment	Date <b>DAY / MONTH / YEAR</b> or <input type="radio"/> as soon as possible
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## Invoice

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

Recurring payment frequency	<input type="radio"/> Monthly <input type="radio"/> Annually
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## Credit/Debit card

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

Recurring payment frequency	<input type="radio"/> Weekly <input type="radio"/> Fortnightly <input type="radio"/> Monthly <input type="radio"/> Annually	Please note that we only accept Visa or Mastercard. We do not accept other cards such as American Express or Diners Club.
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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 <b>DAY / MONTH / YEAR</b>
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## Direct Debit authority

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

Recurring payment frequency	<input type="radio"/> Weekly <input type="radio"/> Fortnightly <input type="radio"/> Monthly <input type="radio"/> Annually
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Name of account
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Account number
<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>

### To the manager:

Bank name
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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

**AUTHORITY  
TO ACCEPT  
DIRECT DEBITS**

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

**0 3 4 3 6 0 4**

(User number)

Authorised signatures	Date signed: <b>DAY / MONTH / YEAR</b>
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### For bank use only

Approved	Date received	Recorded by	Checked by	Bank stamp	Original Retain at branch
4360					<b>Copy</b> Forward to Initiator if requested
06 2024					

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.

# Checklist

## Make sure you have:

- ☐ Answered all the questions.
- ☐ Provided additional information in the appropriate questionnaire if a question required you to provide more detail.
- ☐ Read and signed the declaration in Section D.  
(This must be signed by every person to be insured aged 16 and over.)

## Payment details

- ☐ If paying by direct debit, please complete the form on page 31.
- ☐ If paying by credit/debit card, please complete the form on page 31.
- ☐ If additional participant(s) are being added to any existing policy, do not fill out Section E.

## Attachments

- ☐ If you are providing any supporting documentation, please ensure it has been attached to this application.
- ☐ If any person is a non-resident, please attach a copy of their visa to this application.

**accuro**  
HEALTH INSURANCE

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