



**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.

Complete and return to us at [contact@unimed.co.nz](mailto:contact@unimed.co.nz).

## Type of application

SECTION A

### 1. Is this a new application?

Yes      No (go to Q3)

### 2. Choose your KidSmart options

#### Hospital and Surgical base plan excess

\$0 excess      or      \$250 excess

#### Please tick if you would like to add the Specialist module

Specialist module

#### When would you like this policy to start?

or      as soon as possible

### 3. Are you making a change to an existing KidSmart policy?

Yes      No (go to Q4)

#### Do you want to add a child to an existing KidSmart policy?

Yes      No

#### Do you want to add the Specialist module to an existing KidSmart policy?

Yes      No

Name(s) of child(ren) to have the Specialist module

### 4. Do you wish to add an Adviser on your policy?

Yes      No (go to Q5)

#### Your Adviser's name and company

Full name

Company

**FOR OFFICE USE ONLY****Membership number:****Adviser name/number:**

# Personal details

## 5. 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

Mx

Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)**Postal address**

Street

Town/city

Postcode

**Home phone number****Mobile phone number****Email**

**6. Children (under the age of 18) to be insured on the policy**

	Child 1:	Child 2:	Child 3:	Child 4:
First name(s)				
Last name				
Date of birth	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY
Sex at birth	Male      Female	Male      Female	Male      Female	Male      Female
Gender	Male      Female Another: _____	Male      Female Another: _____	Male      Female Another: _____	Male      Female Another: _____
Relationship to guardian				
Name of child's usual GP and medical practice	GP:  Practice:	GP:  Practice:	GP:  Practice:	GP:  Practice:
Name of child's usual dentist and dental practice	Dentist:  Practice:	Dentist:  Practice:	Dentist:  Practice:	Dentist:  Practice:

# How to provide a child's medical information

Please complete one of the two following options:

## OPTION 1

COMPLETE SECTION C, PAGE 5  
ATTACH FULL MEDICAL RECORDS

OR

## OPTION 2

COMPLETE SECTION D, PAGE 8  
HEALTH DECLARATION

- answer questions 7, 8, 9 for each child
- attach full medical records for each child (from their date of birth to today). Request these from your GP.

With Option 1, you will not need to provide us with an additional medical report for any child's claims.

- answer questions 10-29 in relation to each child's medical history.

With Option 2, an additional medical report may be required from the child's GP with claims made in the first 5 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.

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### 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 6 and then proceed to the declaration page (Section E).

# Option 1 - Provide medical records

- Answer questions 7, 8, and 9 for each child aged six months or older.
- Attach full medical records for each child (from date of birth to today) – get these from your GP.
- If you need more space, see our website for supplementary pages.
- Then go to Section E - Declaration.

## 7. 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 Q8)	Yes	No (go to Q8)
	Name of child:		Name of child:	
Please advise the name of the medical condition.				
When did the child first experience symptoms?	DD/MM/YY		DD/MM/YY	
If wisdom teeth have been removed, please confirm how many.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	
Has the child been referred to a specialist?	Yes      No If <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 8. 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 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 school or paid/ formal 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 Q9)

Yes

No (go to Q9)

	Yes	No (go to Q9)	Yes	No (go to Q9)
	Name of child:		Name of child:	
Please advise the name of the medical condition, treatment and/ or surgery. If elective surgery, when did the child first receive treatment?				
When did the child first experience symptoms?		DD/MM/YY		DD/MM/YY
Please describe the symptoms.				
When did the child last experience any symptoms?		DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	
Has the child been referred to a specialist?	Yes      No If <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 9. Family history

Have any of the children 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 child:		Name of child:	
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)			
	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).				

If you require more space to write, please use pages 29-30.

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

# Option 2 - Health declaration

- Answer questions 10-29 for each child aged six months or older.
- If you have selected Option 1 and completed section C, you do not need to answer these questions.
- If you need more space, see our website for supplementary pages.

## 10. 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 Q11)	Yes	No (go to Q11)
	Name of child:		Name of child:	
Please provide details of the cardiac disorder.				
When did the child first experience symptoms of this condition?	DD/MM/YY		DD/MM/YY	
When did the child last experience symptoms of this condition?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
Has the child been referred to or consulted a GP or specialist about symptoms of any of the above?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Has the child ever undergone or been advised to undergo any investigations and/ or treatment for this condition?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Has the child experienced any residual effects?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Does the child require any ongoing treatment, medication and/ or monitoring?	Yes If <b>yes</b> , please provide details including treatment undertaken and/ or medication prescribed:	No	Yes If <b>yes</b> , please provide details including treatment undertaken and/ or medication prescribed:	No

If you require more space to write, please use pages 29-30.

## 11. 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 Q12)	Yes	No (go to Q12)
	Name of child:		Name of child:	
Please provide details of the breathing disorder (e.g. asthma, bronchitis).				
When did the child first experience symptoms?	DD/MM/YY		DD/MM/YY	
When did the child last experience symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 Severe	Moderate Other	Mild Severe	Moderate 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 If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
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 If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Has the child been referred to a specialist for investigations and/ or treatment?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No

If you require more space to write, please use pages 29-30.

## 12. 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 Q13)	Yes	No (go to Q13)
	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?	DD/MM/YY		DD/MM/YY	
Does the child still experience symptoms of this condition?	Yes If <b>no</b> , when did you last experience symptoms? If <b>yes</b> , how many times per year?	No	Yes If <b>no</b> , when did you last experience symptoms? If <b>yes</b> , how many times per year?	No
Has the child been referred to or consulted a GP or specialist about symptoms of any of the above?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Has the child ever undergone or been advised to undergo any investigations of the gastrointestinal tract (e.g. gastroscopy, endoscopy, colonoscopy)?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Has the child ever undergone or been advised to undergo any treatment (including surgery) for this condition?	Yes If <b>yes</b> , please provide details including date(s) and outcome:	No	Yes If <b>yes</b> , please provide details including date(s) and outcome:	No
Has the child in the past taken or is currently taking any medication for this condition?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No

If you require more space to write, please use pages 29-30.

### 13. 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 Q14)	Yes	No (go to Q14)
	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?	DD/MM/YY		DD/MM/YY	
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	Malignant	Pre-malignant
	Benign	Unsure	Benign	Unsure
Has there been any recurrence?	Yes	No	Yes	No
	If <b>yes</b> , please provide details:		If <b>yes</b> , please provide details:	
Has the child seen a specialist, does the child require any ongoing follow-up, treatment or monitoring or has any follow-up/ further treatment been recommended?	Yes	No	Yes	No
	If <b>yes</b> , please provide details:		If <b>yes</b> , please provide details:	

If you require more space to write, please use pages 29-30.

## 14. 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 Q15)	Yes	No (go to Q15)
	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?		DD/MM/YY		DD/MM/YY
How long did the symptoms last?				
When did the child last suffer from symptoms?		DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing
Has this condition occurred more than once?	Yes      No If <b>yes</b> , please provide details:		Yes      No If <b>yes</b> , 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 <b>yes</b> , please provide details:		Yes      No If <b>yes</b> , please provide details:	
Has the child had any investigations for the condition?	Yes      No If <b>yes</b> , please provide details of type, date and results:		Yes      No If <b>yes</b> , please provide details of type, date and results:	
Has the child had any treatment (including surgery) for the condition?	Yes      No If <b>yes</b> , please provide details:		Yes      No If <b>yes</b> , please provide details:	

If you require more space to write, please use pages 29-30.

## Muscle or skeletal problems (continued)

	Name of child:	Name of child:
Has the child had any time off school or paid/formal childcare as a result of this condition?	<p>Yes      No</p> <p>The child has not returned to school/childcare</p> <p>If <b>yes</b>, please provide start date and duration:</p> <p style="text-align: center;">DD/MM/YY</p>	<p>Yes      No</p> <p>The child has not returned to school/childcare</p> <p>If <b>yes</b>, please provide start date and duration:</p> <p style="text-align: center;">DD/MM/YY</p>
Has the child made a claim to ACC in respect of this condition?	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>
Is the child currently receiving treatment for this condition?	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>
Is the child awaiting investigations, treatment or surgery, or has the child been advised that treatment or surgery will be required for this condition?	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>
Has the child experienced any pain or discomfort since the last episode/symptoms?	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>
Are you aware of any arthritis or degeneration in the child's affected body part(s)?	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>	<p>Yes      No</p> <p>If <b>yes</b>, please provide details:</p>

If you require more space to write, please use pages 29-30.

## 15. 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 Q16)	Yes	No (go to Q16)
	Name of child:		Name of child:	
Please advise the name of the medical condition.				
When did the child first experience symptoms?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes          No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes          No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 16. 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 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?	DD/MM/YY		DD/MM/YY	
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 17. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 18. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 19. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 20. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 21. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 22. 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 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?	DD/MM/YY		DD/MM/YY	
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 23. 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 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?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing	DD/MM/YY This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?	Yes      No If <b>yes</b> , when and what was the outcome?

If you require more space to write, please use pages 29-30.

## 24. 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 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?	DD/MM/YY		DD/MM/YY	
If wisdom teeth have been removed, please confirm how many.				
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing		DD/MM/YY This condition is ongoing	
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 25. 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 Q26 for males  
or Q27 for females)

Yes

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

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DD/MM/YY	DD/MM/YY
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing	DD/MM/YY This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?	Yes      No If <b>yes</b> , when and what was the outcome?

If you require more space to write, please use pages 29-30.

## 26. To be completed for male children only

Has any male 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 Q28)

Yes

No (go to Q28)

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing	DD/MM/YY This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?	Yes      No If <b>yes</b> , when and what was the outcome?

If you require more space to write, please use pages 29-30.

## 27. To be completed for female children only

Has any female 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 Q28)

Yes

No (go to Q28)

	Name of child:	Name of child:
Please advise the name of the medical condition.		
When did the child first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did the child last experience any symptoms?	DD/MM/YY This condition is ongoing	DD/MM/YY This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	Yes            No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?	Yes            No If <b>yes</b> , when and what was the outcome?

If you require more space to write, please use pages 29-30.

## 28. 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 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 school or paid/ formal 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 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? If elective surgery, when did they first receive treatment?	DD/MM/YY	DD/MM/YY	DD/MM/YY	DD/MM/YY
Please describe the symptoms.				
When did the child last experience any symptoms?	DD/MM/YY	This condition is ongoing	DD/MM/YY	This condition is ongoing
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 <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		Yes      No If <b>yes</b> , 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 <b>yes</b> , when and what was the outcome?		Yes      No If <b>yes</b> , when and what was the outcome?	

If you require more space to write, please use pages 29-30.

## 29. Family history

Have any of the children 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 child:		Name of child:	
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)			
	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).				

If you require more space to write, please use pages 29-30.

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





## Declaration

### THIS DECLARATION IS VERY IMPORTANT. PLEASE ENSURE YOU READ IT CAREFULLY

1. I am authorised by all persons listed in this Application to submit this Application on their behalf.
2. I declare that all the information provided in this Application is true, correct and complete and that I have not omitted or misrepresented any information.
3. If, between the date this Application is signed and the policy start date, I become aware of any health condition or event, or other relevant information concerning any person listed in this Application, that has not been included in this Application, I agree to inform UniMed immediately.
4. I understand that I need to include in this Application all information requested, even if I have already shared this information with a representative of UniMed or with my financial adviser.
5. I understand that if I have provided information in this Application that is untrue, incomplete or misleading, or if I have failed to disclose any information asked for (including complete and true medical and health information), this may result in my Application being rejected, any claims made declined, additional terms applied to the policy and/ or the cancellation of the policy, in accordance with its terms and New Zealand law.
6. I understand that the information provided in this Application forms the basis of my contract with UniMed and will be treated as one of the documents that make up the policy.
7. I understand that this Application is not a guarantee of cover and cover will not commence until the policy start date listed on the Policy/ Membership Certificate issued by UniMed.
8. I understand and agree that my Membership and policy cover with UniMed is conditional upon the continual payment of all premiums as they fall due.
9. I understand that any restrictions of cover in relation to my declared existing conditions (Personal Exclusions) will be shown on my Policy/ Membership Certificate.
10. I authorise UniMed to obtain from any person or organisation any further information required to assess this Application or future claims, and I authorise those persons or organisations to disclose such information to UniMed. This may include, but is not limited to, obtaining details regarding previous medical history and previous health insurance. I understand this authorisation is ongoing and I agree to do anything necessary to assist UniMed in obtaining such information, including completing or signing any necessary consents or authorities.
11. I understand that the information collected in this Application is for the purpose of evaluating my Membership Application, future claims and otherwise in accordance with UniMed's [Privacy Statement](#). The intended recipient of this information is UniMed.
12. I understand that this Application and any policy issued is subject to UniMed's Terms and Conditions (contained within the Health Plan document) and the UniMed Rules.
13. If this Application has been completed online, I acknowledge and agree that my electronic acceptance of this declaration makes it fully binding on me and any other persons listed in the Application.

The Privacy Act 2020 requires UniMed to inform you about certain rights and obligations relating to the information which we collect in this Application. Please read the [Privacy Statement](#) on our website.

**I have read and agree to the Declaration.**

**Guardian's full name**

**Signature**

**Date signed (dd/mm/yy)**

#### Financial strength rating

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

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).

**IT IS IMPORTANT THAT YOU RETURN THIS FORM WITHIN 45 DAYS OF YOU SIGNING OR IT MAY BECOME INVALID.**

# Payment method.

## If your policy number starts with PL, this is your form.

This form is for Members on SmartCare, SmartCare+, StaffCare, StaffCare+, SmartStay and other Health Plans or group insurance schemes originally issued under the Accuro brand.



You can update payment information in your Member Portal.  
Go to [unimed.co.nz/portal](https://unimed.co.nz/portal) to login or register.

If you prefer to use this form, complete and return to us at [contact@unimed.co.nz](mailto:contact@unimed.co.nz).

**Policy number**

**Primary Member name**

**Preferred date of first payment** (dd/mm/yy)

or as soon as possible

## A. Direct Debit authority

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

**Recurring payment frequency**

Fortnightly    Monthly    Annually

**Name of account** (e.g John Smith)

**Bank name**

**Account number**

<input type="text"/>																		
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**AUTHORITY  
TO ACCEPT  
DIRECT DEBITS**  
(not to operate as an  
assignment or agreement)  
Authorisation Code

**0 3 4 3 6 0 4**

(User number)

Approved

4360

01

2026

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 on page 33.

**The following information will appear on your bank statement:**

<b>Payer particulars</b>	UniMed
<b>Payer code</b>	Health insurance
<b>Payer reference</b>	Your policy number

**Authorised signature/s**

**Date** (dd/mm/yy)

## 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 no less than 10 calendar days before the date of the 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.

---

## B. Credit/Debit authority

**Please fill in the details below if you would like to pay by credit/debit card.**

**Recurring payment frequency** (Note we only accept Visa or Mastercard. We do not accept other cards such as American Express or Diners Club)

Fortnightly      Monthly      Annually

**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.**

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's signature**

**Date** (dd/mm/yy)

---

## C. Invoice

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

**Recurring payment frequency**

Monthly      Annually

# 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 E. (This must be signed by the guardian listed on the application form.)

## Payment details

If paying by direct debit or credit/ debit card, please complete the Payment Method form on page 32.

If a child is being added to any existing policy, do not fill out the Payment Method form.

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 the Payment Method form.

## Attachments

If you have completed Section C Full medical history, please ensure that you have attached each child's full medical records (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.