Making changes to your policy.

2602K v1.1

UniMed

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

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

This form is to make changes to an existing policy that does not require health questions to be answered. If you'd like to add the Specialist module, or start a new Health Plan, please contact us or speak to your Adviser.

Complete and return to us at contact@unimed.co.nz.

Existing membership number

1. Purpose: What would you like to do?

(please select one):

- ◯ **Transfer to a new policy**
  Please complete and return a payment method form.

- ◯ **Increase the excess that applies to your policy**
  If you'd like to decrease your excess, you will need to complete an Application.
  - ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000
  - ◯ $4,000 ◯ $6,000 ◯ $8,000 ◯ $10,000

- ◯ **Add an additional module to your policy**

SmartCare	SmartCare+	SmartStay
◯ Natural Health module	◯ Natural Health+ module	◯ GP module
◯ GP module	◯ GP+ module	
◯ Dental and Optical module	◯ Dental and Optical+ module	

- ◯ **Add a child under the age of 6 months to your policy**
  ◯ Yes ◯ No

- ◯ I would like the same level of cover as my previous policy
- ◯ I would like to change my level of cover
  (please specify the change below)

2. Please complete the details for the Primary Member

Title

Mr Mrs Miss Ms Mx Other (please specify):

Full name

First name(s)

Last name

Date of birth (dd/mm/yy)

Sex at birth

Male Female

Gender

Male Female Another:

Address

Street

Town/city

Postcode

Home phone number

Mobile phone number

Email

We recommend using a personal email address.

3. Additional Members to be insured

Additional Member 1

Title

Mr Mrs Miss Ms Mx Other (please specify):

Full name

First name(s) Last name

Date of birth (dd/mm/yy)

Sex at birth

Male Female

Gender

Male Female Another:

Relationship to Primary Member

Email*

Additional Member 2

Title

Mr Mrs Miss Ms Mx Other (please specify):

Full name

First name(s) Last name

Date of birth (dd/mm/yy)

Sex at birth

Male Female

Gender

Male Female Another:

Relationship to Primary Member

Email*

Additional Member 3

Title

Mr Mrs Miss Ms Mx Other (please specify):

Full name

First name(s) Last name

Date of birth (dd/mm/yy)

Sex at birth

Male Female

Gender

Male Female Another:

Relationship to Primary Member

Email*

* Email address not required for dependants under the age of 16 (dependant means a Member's child including any stepchild or adopted child)

4. 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.**

Primary Member'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.