Making changes to your policy.

2602K v1.2

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.

- 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)

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

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** **Gender**

Male Female 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** **Gender**

Male Female 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** **Gender**

Male Female 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** **Gender**

Male Female 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 and authorisation

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

1. 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.
2. 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 Adviser.
3. I understand that this Application is not a guarantee of cover and cover will not commence until the policy start date listed on the Membership Certificate issued by UniMed.
4. I understand that this Application and any policy issued is subject to the UniMed Terms and Conditions or the Terms and Conditions contained within the Health Plan document, and to the UniMed Rules.
5. 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.

The personal and health information about you and those covered under your Health Plan is collected for the purpose of evaluating your Application.

If your Application is approved then this information will be used by us to help you access our products and services, including administering your policy and associated claims.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – unimed.co.nz/privacy.

I have read and agree to the Declaration.

I am authorised by all persons listed in this Application to submit this Application on their behalf and I confirm they are aware the information I provide will be disclosed to UniMed.

Primary Member 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.