SmartCare, SmartCare+, SmartStay APPLICATION FORM

2602K v1.1

UniMed

Applicants must select the Health Plan for which they are eligible, based on their citizenship, residency, or visa status at the time of application.

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

Type of application

SECTION A

1. Is this a new application?

◯ Yes ◯ No (go to Q3)

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

◯ Individual (please fill in the below) ◯ Group scheme (go to Q5)

Please choose a base plan	To qualify for a SmartCare or SmartCare+ policy, you need to be a New Zealand citizen or permanent resident, hold a New Zealand work visa valid for two years or more, or be covered under New Zealand's public health system. The same applies for additional Members included in this application. You can select: ◯ SmartCare Hospital and Surgical base plan ◯ SmartCare+ Hospital and Surgical base plan ◯ Other _____	To qualify for a SmartStay policy, the Primary Member must hold a valid New Zealand work or visitor visa for between three months and two years, and not have cover under New Zealand's public health system. They cannot be a New Zealand citizen or resident. Family members can also be covered under SmartStay provided they have a valid New Zealand visa. ◯ SmartStay Hospital and Surgical base plan
Please choose your excess The excess is the amount you agree to pay towards the cost of specified claims on your Health Plan. The higher the excess, the lower your premium.	◯ $0 ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $4,000 ◯ $6,000 ◯ $8,000 ◯ $10,000	◯ $0 ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $4,000
Once you have chosen your base plan, you can add modules	☐ Specialist module – choose excess: ◯ $0 ◯ $250 ☐ GP module ☐ Natural Health module ☐ Dental and Optical module	☐ Specialist module ☐ GP module

When would you like this policy to start?

DD/MM/YY or ◯ as soon as possible

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

◯ Yes ◯ No (go to Q4)

☐ **Add a Member to an existing policy**

All new Member(s) need to complete Section B and answer the health questions in Section C. The payment method form does not need to be completed for any new Member that is added to an existing policy.

☐ **Add a new module to an existing policy**

Please state the new module(s) to be added (please include excess option if applicable)

☐ **Decrease the excess that applies to an existing policy**

If you'd like to increase your excess, just send us a letter signed by the Primary Member.

◯ $0 ◯ $250 ◯ $500 ◯ $1,000

◯ $2,000 ◯ $4,000 ◯ $6,000 ◯ $8,000

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

Note: if you are part of a group insurance scheme that has an Adviser, they will be automatically linked to your policy. This will be referenced in your welcome pack.

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Membership number:

Adviser name/number:

5. Are you applying to join a group insurance scheme?

◯ Yes ◯ No (go to Q6)

Name of company/association/organisation/partnership

Date employed (dd/mm/yy)

Employee number (if applicable)

Please choose a base plan

◯ StaffCare Hospital and Surgical base plan

◯ StaffCare+ Hospital and Surgical+ base plan

◯ StaffStay Hospital and Surgical base plan

◯ Other:

Please choose your excess

The excess is the amount you agree to pay towards the cost of specified claims on your Health Plan. The higher the excess, the lower your premium.

◯ $0 ◯ $250 ◯ $500

◯ $1,000 ◯ $2,000

Once you have chosen your base plan, you can add other modules

StaffCare additional modules:

☐ Specialist module – excess ◯ $0 ◯ $250

☐ GP module

StaffStay additional modules:

☐ Specialist module

☐ GP module

StaffCare+ additional modules:

☐ Specialist module – excess ◯ $0 ◯ $250

☐ GP+ module ☐ Dental and Optical+ module

☐ Natural Health+ module

Personal details

6. Please complete the details for the Primary Member to be insured

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:

Residential address

Street

Town/city

Postcode

Postal address (if different from above)

Street

Town/city

Postcode

Mobile phone number

Alternative phone number

Email

Height (cm)

Weight (kg)

Have you smoked and/ or vaped in the last 12 months?

◯ Yes ◯ No

Name of your usual GP and practice

GP

Practice

Name of your usual dentist and practice

Dentist

Practice

7. Do you wish to insure other family members/whānau on this policy or add someone to an existing policy?

○ Yes ○ No (go to Q8)

Additional Members to be insured This can include your parents and/ or Members under the age of 25.

	Additional Member 1	Additional Member 2	Additional Member 3	Additional Member 4
Title	○ Mr ○ Mrs ○ Miss ○ Ms ○ Mx ○ Other (please specify): _____	○ Mr ○ Mrs ○ Miss ○ Ms ○ Mx ○ Other (please specify): _____	○ Mr ○ Mrs ○ Miss ○ Ms ○ Mx ○ Other (please specify): _____	○ Mr ○ Mrs ○ Miss ○ Ms ○ Mx ○ Other (please specify): _____
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 the Primary Member				
Email*				
Height and weight*	cm kg	cm kg	cm kg	cm kg
Have you smoked and/ or vaped in the last 12 months?**	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Name of your usual GP and practice	○ Same as Primary Member ○ Other (please specify): GP: Practice:	○ Same as Primary Member ○ Other (please specify): GP: Practice:	○ Same as Primary Member ○ Other (please specify): GP: Practice:	○ Same as Primary Member ○ Other (please specify): GP: Practice:
Name of your usual dentist and practice	○ Same as Primary Member ○ Other (please specify): Dentist: Practice:	○ Same as Primary Member ○ Other (please specify): Dentist: Practice:	○ Same as Primary Member ○ Other (please specify): Dentist: Practice:	○ Same as Primary Member ○ Other (please specify): Dentist: Practice:

* 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 an Additional Member in the Primary Member's policy). ** Not required for dependants under the age of 25.

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.

8. Heart conditions

Have you, or any of the Members 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 Q9) ◯ Yes ◯ No (go to Q9)

	Name of Member:	Name of Member:
Please provide details of the cardiac disorder.		
When did you first experience symptoms of this condition?	DD/MM/YY	DD/MM/YY
When did you last experience symptoms of this condition?	DD/MM/YY ◯ This condition is ongoing	DD/MM/YY ◯ This condition is ongoing
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations and/ or treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any residual effects?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Do you require any ongoing treatment, medication and/ or monitoring?	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/ or medication prescribed:	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/ or medication prescribed:

If you require more space to write, please use pages 28-30.

9. Raised blood pressure; raised or abnormal cholesterol

Have you, or any of the Members 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 Q10) ◯ Yes ◯ No (go to Q10)

	Name of Member:	Name of Member:
Do you suffer from or have you been advised by a medical practitioner that you suffer from:	◯ Raised blood pressure ◯ Raised or abnormal cholesterol	◯ Raised blood pressure ◯ Raised or abnormal cholesterol
When did you first become aware you had raised blood pressure?	DD/MM/YY	DD/MM/YY
When did you first become aware you had abnormal cholesterol?	DD/MM/YY	DD/MM/YY
What treatment and/ or medication have you been prescribed?		
Has your treatment changed in the last 12 months?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, 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. DD/MM/YY 2. DD/MM/YY 3. DD/MM/YY	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio 1. DD/MM/YY 2. DD/MM/YY 3. DD/MM/YY
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?	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/ or treatment:	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/ or treatment:
Do you suffer from any complications or associated conditions?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

10. Breathing or respiratory disorders

Have you, or any of the Members 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 Q11)	◯ Yes ◯ No (go to Q11)
	Name of Member:	Name of Member:
Please provide details of the breathing disorder (e.g. asthma, bronchitis).		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
When did you last experience symptoms?	DD/MM/YY ◯ This condition is ongoing	DD/MM/YY ◯ This condition is ongoing
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:	◯ Mild ◯ Moderate ◯ Severe ◯ Other	◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you been hospitalised and/ or been on a nebuliser in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been prescribed steroids (e.g. prednisone) in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to a specialist for investigations and/ or treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

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

Have you, or any of the Members 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 Q12) ◯ Yes ◯ No (go to Q12)

	Name of Member:	Name of Member:
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?	DD/MM/YY	DD/MM/YY
Do you still experience symptoms of this condition?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations of the gastrointestinal tract (e.g. gastroscopy, endoscopy, colonoscopy)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you undergone or been advised to undergo any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome:	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome:
Have you in the past or are you currently taking any medication for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

12. Cancer, cysts, tumours or growths

Have you, or any of the Members 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 Q13) ◯ Yes ◯ No (go to Q13)

	Name of Member:	Name of Member:
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?	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 condition was:	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure
Has there been any recurrence?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you seen a specialist, do you require any ongoing follow-up, treatment or monitoring or has any follow-up/ further treatment been recommended?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

13. Muscle or skeletal problems (including cartilage, tendon and ligament problems)

Have you, or any of the Members 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 Q14) ◯ Yes ◯ No (go to Q14)

	Name of Member:	Name of Member:
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?	DD/MM/YY	DD/MM/YY
How long did the symptoms last?		
When did you 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 **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you had any investigations?	◯ Yes ◯ No If **yes**, please provide details of type, date and results:	◯ Yes ◯ No If **yes**, please provide details of type, date and results:
Have you had any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

Muscle or skeletal problems (continued)

	Name of Member:	Name of Member:
Have you had any time off work or school as a result of this condition?	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DD/MM/YY	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DD/MM/YY
Have you made a claim to ACC in respect of this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you currently receiving treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery will be required?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any pain or discomfort since the last episode/ symptoms?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you aware of any arthritis or degeneration in the affected body part(s)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 28-30.

14. Blood, immune or circulatory disorders

Have you, or any of the Members 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 Q15) ◯ Yes ◯ No (go to Q15)

	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

15. Endocrine (glandular) disorders

Have you, or any of the Members 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 Q16)	◯ Yes ◯ No (go to Q16)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

16. Urinary or kidney disorders

Have you, or any of the Members 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 Q17) ◯ Yes ◯ No (go to Q17)

	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

17. Anal/ rectal problems

Have you, or any of the Members 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 Q18)	◯ Yes ◯ No (go to Q18)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

18. Skin problems

Have you, or any of the Members 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 Q19)	◯ Yes ◯ No (go to Q19)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

19. Brain or nervous system disorders

Have you, or any of the Members 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 Q20) ◯ Yes ◯ No (go to Q20)

	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

20. Fatigue or pain syndromes

Have you, or any of the Members 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 Q21)	◯ Yes ◯ No (go to Q21)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

21. Eye, ear or throat problems

Have you, or any of the Members 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 Q22)	◯ Yes ◯ No (go to Q22)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

22. Allergies, nasal and/ or sinus problems

Have you, or any of the Members 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 Q23) ◯ Yes ◯ No (go to Q23)

	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

23. Dental problems

Have you, or any of the Members 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 Q24)	◯ Yes ◯ No (go to Q24)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
If wisdom teeth have been removed, please confirm how many.		
When did you 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
Have you had any investigations and/ or received any treatm ent?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

24. Mental health conditions

Have you, or any of the Members to be insured, ever experienced any signs or symptoms of, or are you, or any of the Members 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 Q25 for males or Q26 for females) ◯ Yes ◯ No (go to Q25 for males or Q26 for females)

	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

25. To be completed by males only

Have you, or any of the male Members to be insured, ever experienced any signs or symptoms of, or are you, or any of the male Members 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 Q27)	◯ Yes ◯ No (go to Q27)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

26. To be completed by females only

Have you, or any of the female Members to be insured, ever experienced any signs or symptoms of, or are you, or any of the female Members 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 Q27)	◯ Yes ◯ No (go to Q27)
	Name of Member:	Name of Member:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

27. Other conditions

Have you, or any of the Members 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 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 Q28)	◯ Yes ◯ No (go to Q28)
	Name of Member:	Name of Member:
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?	DD/MM/YY	DD/MM/YY
Please describe the symptoms.		
When did you 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
Have you had any investigations and/ or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/ or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 28-30.

28. Family history (please answer both questions below)

Have you, or any of the Members 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 Member:	Name of Member:
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	◯ Yes	◯ Yes	◯ Yes
◯ No (go to Section D)	◯ No (go to Section D)	◯ No (go to Section D)	◯ No (go to Section D)

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

If you require more space to write, please use pages 28-30.

Once you have completed all health questions, please go to Section D (page 31).

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 Member's name.

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.

Payment method.

UniMed

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 to login or register.

If you prefer to use this form, complete and return to us at 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

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

Account number

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:

Payer particulars	UniMed
Payer code	Health insurance
Payer reference	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 D.

Payment details

- [ ] If paying by direct debit, please complete the form on page 32.
- [ ] If paying by credit/debit card, please complete the form on page 33.
- [ ] If additional Member(s) are being added to any existing policy, do not fill out the Payment Method form.

Attachments

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