



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](mailto: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	<p>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:</p> <p>SmartCare Hospital and Surgical base plan</p> <p>SmartCare+ Hospital and Surgical base plan</p> <p>Other _____</p>	<p>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.</p> <p>SmartStay Hospital and Surgical base plan</p>
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.	<p><input type="radio"/> \$0      \$250      \$500</p> <p>\$1,000      \$2,000      \$4,000</p> <p>\$6,000      \$8,000      \$10,000</p>	<p><input type="radio"/> \$0      \$250      \$500</p> <p>\$1,000      \$2,000      \$4,000</p>
Once you have chosen your base plan, you can add modules	<p>Specialist module – choose excess: \$0      \$250</p> <p>GP module</p> <p>Natural Health module</p> <p>Dental and Optical module</p>	<p>Specialist module</p> <p>GP module</p>

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

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

\$0              \$250              \$500              \$1,000              \$2,000              \$4,000              \$6,000              \$8,000

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

### 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.

**FOR OFFICE USE ONLY**

**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

#### StaffCare+ additional modules:

Specialist module – excess      \$0      \$250

GP+ module

Natural Health+ module

Dental and Optical+ module

#### StaffStay additional modules:

Specialist module - excess      \$0      \$250

GP 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**

**Gender**

Male

Female

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

**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:

Yes  
No (go to Q8)

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

\* 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 [unimed.co.nz/important-documents](http://unimed.co.nz/important-documents) 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 If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Have you 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
Have you experienced any residual effects?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Do you 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 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 <b>yes</b> , please provide details:	Yes No If <b>yes</b> , please provide details:
How often is your blood pressure and/or cholesterol checked and by whom?		
What were your three most recent blood pressure readings and cholesterol results?	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio 1. 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 <b>yes</b> , please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:	Yes No If <b>yes</b> , please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:
Do you suffer from any complications or associated conditions?	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 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?	_____ X	per month per year	_____ X	per month per year
Do you consider your breathing disorder to be:	Mild Severe	Moderate Other	Mild Severe	Moderate Other
Have you been hospitalised and/ or been on a nebuliser in the last two years?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Have you been prescribed steroids (e.g. prednisone) in the last two years?	Yes If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Have you 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

## 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 <b>no</b> , when did you last experience symptoms? If <b>yes</b> , how many times per year?	Yes	No If <b>no</b> , when did you last experience symptoms? If <b>yes</b> , 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 <b>yes</b> , please provide details:	Yes	No If <b>yes</b> , 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 <b>yes</b> , please provide details:	Yes	No If <b>yes</b> , please provide details:
Have you undergone or been advised to undergo any treatment (including surgery)?	Yes	No If <b>yes</b> , please provide details including date(s) and outcome:	Yes	No If <b>yes</b> , 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 <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 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	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:	
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	Yes	No
	If <b>yes</b> , please provide details:		If <b>yes</b> , please provide details:	

### 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 If <b>yes</b> , please provide details:	No	Yes If <b>yes</b> , please provide details:	No
Have you 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
Have you had any investigations?	Yes If <b>yes</b> , please provide details of type, date and results:	No	Yes If <b>yes</b> , please provide details of type, date and results:	No
Have you had any treatment (including surgery)?	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 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?	<p>Yes      No</p> <p>I have not yet returned to work/school</p> <p>If <b>yes</b>, please provide start date and duration:</p> <p>DD/MM/YY</p>	<p>Yes      No</p> <p>I have not yet returned to work/school</p> <p>If <b>yes</b>, please provide start date and duration:</p> <p>DD/MM/YY</p>
Have you 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>
Are you currently receiving treatment?	<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 awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery will be required?	<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>
Have you 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 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 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?	_____ X per month per year Mild Moderate Severe Other	_____ X per month per year Mild Moderate Severe Other
Have you 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:
Have you 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 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?	_____ X per month per year Mild Moderate Severe Other	_____ X per month per year Mild Moderate Severe Other
Have you 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:
Have you 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 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?	_____ X per month per year  Mild Moderate Severe Other		_____ X per month per year  Mild Moderate Severe Other	
Have you 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:	
Have you 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 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?	_____ X per month per year Mild Moderate Severe Other		_____ X per month per year Mild Moderate Severe Other	
Have you 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:	
Have you 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 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?	_____ X    per month    per year  Mild            Moderate  Severe         Other		_____ X    per month    per year  Mild            Moderate  Severe         Other	
Have you 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:	
Have you 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 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?	_____ X per month per year  Mild Moderate Severe Other	_____ X per month per year  Mild Moderate Severe Other
Have you 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:
Have you 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 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?	_____ X Mild Severe	per month Moderate Other	_____ X Mild Severe	per month Moderate Other
Have you had any investigations and/ or received any treatment?	Yes If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	No	Yes If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	No
Have you been referred to a specialist?	Yes If <b>yes</b> , when and what was the outcome?	No	Yes If <b>yes</b> , when and what was the outcome?	No

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?	_____ X per month per year  Mild Moderate Severe Other	_____ X per month per year  Mild Moderate Severe Other
Have you 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:
Have you 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 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?	_____ X per month per year  Mild Moderate Severe Other		_____ X per month per year  Mild Moderate Severe Other	
Have you 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:	
Have you 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 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?	_____ X	per month per year	_____ X	per month per year
	Mild	Moderate	Mild	Moderate
	Severe	Other	Severe	Other
Have you had any investigations and/ or received any treatment?	Yes	No	Yes	No
	If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:	
Have you been referred to a specialist?	Yes	No	Yes	No
	If <b>yes</b> , when and what was the outcome?		If <b>yes</b> , 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?	_____ X per month per year  Mild Moderate Severe Other	_____ X per month per year  Mild Moderate Severe Other
Have you 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:
Have you 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 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?	_____ X per month per year  Mild Moderate Severe Other		_____ X per month per year  Mild Moderate Severe Other	
Have you 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:	
Have you 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 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)

	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?	_____ X per month per year  Mild Moderate Severe Other		_____ X per month per year  Mild Moderate Severe Other	
Have you 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:	
Have you 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 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?	_____ X	per month	per year	_____ X	per month	per year
	Mild	Moderate		Mild	Moderate	
	Severe	Other		Severe	Other	
Have you had any investigations and/ or received any treatment?	Yes	No		Yes	No	
	If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:			If <b>yes</b> , please provide details regarding type of investigations, treatment and/ or medication:		
Have you been referred to a specialist?	Yes	No		Yes	No	
	If <b>yes</b> , when and what was the outcome?			If <b>yes</b> , when and what was the outcome?		

## 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.







## Declaration

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

1. 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.
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 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.
4. 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.
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.
6. 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 the UniMed Rules.

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](https://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.**

# 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/claims](https://unimed.co.nz/claims) 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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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 2.

**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 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.