

Authority to Act.



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

1. Primary Member details

Title

 Mr

 Mrs

 Miss

 Ms

 Mx

 Other (please specify):

Full name

First name(s)

Last name

Date of birth (dd/mm/yy)

Membership/ Policy number

Address

Street

Town/ city

Postcode

Mobile phone number

Home phone number

Email

2. Your nominated person

Title

 Mr

 Mrs

 Miss

 Ms

 Mx

 Other (please specify):

Full name

First name(s)

Last name

Date of birth (dd/mm/yy)

Relationship to Primary Member (optional)

Address

Street

Town/ city

Postcode

Mobile phone number

Home phone number

Email

3. Your authority

I authorise UniMed to (please choose one):

Full Authority to Act

Act on the instructions of my nominated person and share my personal and health information (including claims history) with them. This includes submitting claims and prior approvals on my behalf, changing policy details including excesses, adding and removing Members or modules to my policy, or suspending my policy.

Full Authority to Act does not give your nominated person the authority to cancel your policy or change your bank account details for reimbursements. Your nominated person with Full Authority to Act will not be able to access the claims history of or submit claims for any other person on your policy.

Partial Authority to Act

Share my personal and health information (including claims history) with my nominated person.

Partial Authority to Act does not give your nominated person the authority to transact on your policy in any way. Your nominated person with Partial Authority to Act will not be able to access the claims history of any other person on your policy.

4. Declaration and authorisation

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

I understand that:

1. My nominated person will have access to my claims history and all policy and premium information for everyone covered by the policy. It is my responsibility to ensure that everyone on my policy is aware of and consents to this.
2. UniMed is not responsible for any actions of my nominated person using this authority.
3. This authority comes into effect from the date UniMed receives this form.
4. I am giving my nominated person access to my information by phone, email, and letter.
5. My nominated person or I can contact UniMed at any time to cancel this authority. Cancellation will not be effective until it is confirmed by UniMed.

I have read and agree to the Declaration.

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

Primary Member's full name

Signature

Date signed (dd/mm/yy)

Personal information

The personal information about you and your nominated person is collected for the purposes of administering your policy.

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. It is your responsibility to ensure your nominated person is aware of our Privacy Statement.