

# Continuation.

**If your policy starts with a number (not letters) this is your form.**

This form is for Members on Health Positive, Hospital Select Plus Modules, UniCare Advantage and other Health Plans or group insurance schemes issued by UniMed.



Use this form when you are leaving a group insurance scheme or if a child or other Member is moving to their own policy.

Return your completed form to us at [retention@unimed.co.nz](mailto:retention@unimed.co.nz).

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**Any field marked by an asterisk (\*) is mandatory and must be completed in all cases.**

## 1. Primary Member details

**Full name\***

First name(s)

Last name

**Policy/ Membership number**

**Date of birth\*** (dd/mm/yy)

**Address\***

**Email\***

**Phone number**

## 2. Continuation details

**Policy start date**

DD/MM/YY

**Reason for continuation**

Leaving a group insurance scheme – go to Q3

Child/ other Member transferring to own policy – go to Q5

## 3. Leaving a group insurance scheme

**Preferred new Health Plan / Modules/ Excess:**

## 4. Additional Members to be insured on my new policy

### Additional Member 1

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Relationship to Primary Member**

Male Female

**Email\***

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### Additional Member 2

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Relationship to Primary Member**

Male Female

**Email\***

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### Additional Member 3

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Relationship to Primary Member**

Male Female

**Email\***

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

#### Additional Member 4

**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**

**Relationship to Primary Member**

Male Female

**Email\***

### 5. Child/ other Member transferring to their own policy

**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**

**Relationship to Primary Member**

Male Female

**Email**

**Residential address**

Street

Town/city

Postcode

**Mobile phone number**

**Alternative phone number**

**Preferred new Health Plan / Modules/ Excess:**

## 6. Declaration and authorisation

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

1. I declare that all the information provided in this Application is true, correct and complete and that I have not omitted or misrepresented any information.
2. I understand that I need to include in this Application all information requested, even if I have already shared this information with a representative of UniMed or with my Adviser.
3. I understand that this Application is not a guarantee of cover and cover will not commence until the policy start date listed on the Membership Certificate issued by UniMed.
4. I understand that this Application and any policy issued is subject to the UniMed Terms and Conditions, or the Terms and Conditions contained within the Health Plan document, and to the UniMed Rules.
5. I authorise UniMed to obtain from any person or organisation any further information required to assess this Application or future claims, and I authorise those persons or organisations to disclose such information to UniMed. This may include, but is not limited to, obtaining details regarding previous medical history and previous health insurance.

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

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

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – [unimed.co.nz/privacy](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 that they are aware the information I provide will be disclosed to UniMed.**

I have attached my completed Payment Authority form (available at [unimed.co.nz/important-documents](https://unimed.co.nz/important-documents)).

**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).