APPLICATION FORM

UniMed
YOUR HEALTH INSURER
UNION MEDICAL BENEFITS SOCIETY LTD

UniMed is assessed by AM Best Company Inc. to have a Financial Strength Rating of: A (Excellent)

To help interpret the rating the AM Best's Financial Strength 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)

✓ ☐ **RESIDENCY: Are you and all family members named in this application New Zealand citizens, holders of a resident visa or holders of a work visa for a minimum of two years or otherwise entitled to free public healthcare for all services as determined by the Ministry of Health? If not, please do not proceed. Contact your UniMed Representative or UniMed Head Office on 0800 600 666.**

PERSONAL DETAILS – PRIMARY MEMBER

Mr/Mrs/Miss/Ms Surname _____ First name(s) _____

Postal address _____

Telephone: Home _____ Work _____ Mobile _____

Date of birth ___/___/___ Gender at birth M / F

Email _____ ☐ I agree to receive all correspondence from UniMed via email

ADDITIONAL FAMILY MEMBERS TO BE COVERED UNDER THIS POLICY

	Surname	First Name(s)	Gender at Birth		Date of Birth
Spouse/Partner			M	F	/ /
Child 1			M	F	/ /
Child 2			M	F	/ /
Child 3			M	F	/ /
Child 4			M	F	/ /

THIS APPLICATION IS FOR *✓Tick appropriate box*

☐ New membership ☐ Addition of family to existing policy ☐ Upgrade of existing policy ☐ Other

Plan applied for _____ Membership No. _____ Cover Start Date ___/___/___

PREMIUM PAYMENT OPTIONS *✓Tick appropriate box*

☐ I have completed my direct debit/credit card authority and it is attached.

☐ **Group Schemes Only – If your scheme is wage deduction –** I authorise my employer to deduct regular premium instalments from my salary and provided I am first notified, to alter the amount of such instalments as required. I authorise my employer to hold a copy of this page.

Name of Employer _____

APPLICANT'S DECLARATION

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

1. I declare that all statements made for the purposes of this application to be true, correct and complete and that I have not omitted, and I am not aware, of any other medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application. If, after submitting this application, I become aware of any such medical information or circumstances, I agree to inform the Society immediately of such information or circumstances.
2. I acknowledge that failure to make any statements truthfully, or to omit any medical information or circumstances which might affect the risk of insurance on my health or that of any other person listed in my application, may mean my application is rejected, or any claim made is declined, or the policy becoming void. I further acknowledge that if this application is accepted by the Society, there is no cover for any health conditions I have not declared, but only for those conditions I have declared which are accepted by the Society.
3. I understand that the written declaration in the Application Form constitutes the basis of the contract with the Society. No oral representation, inducement, statements and promises made by or on behalf of either party, including the Sales Representative, and not contained in the Application Form or the brochure for the Health Plan selected, shall be relied upon or binding.
4. Where other persons are listed in my application, I confirm that I have full authority and consent to submit this application on behalf of all such persons. I understand that any statements made concerning such persons (or persons added to the policy at a later date) may affect whether this application is accepted or their entitlements to cover.
5. I agree that any payment accompanying this application shall be a deposit only and I understand that any coverage will not commence until the Society has issued a Membership Certificate. I further agree that the maintenance of membership and cover is conditional upon the continual payment of all premiums as they fall due.
6. I understand that any special joining concessions or restrictions of cover in relation to my declared existing conditions will be shown on my Membership Certificate.
7. I authorise the obtaining of any medical information the Society may require in relation to this application or future claims as submitted by me from any medical practitioner who has attended or examined me or any other person listed in my application. I agree to do anything necessary to facilitate the Society obtaining such information, including completing or signing any necessary consents or authorities.
8. I authorise the Society to obtain details regarding my previous medical insurance.
9. Pursuant to the Privacy Act 1993 and the Health Information Privacy Code 1994 (incorporating amendments), in this application form the Society collects personal information for the purpose of evaluating your membership application and future claims. The Society may disclose information related to this application and future claims to the Integrity Register* for the purposes of the detection and prevention of fraudulent and suspicious conduct.
10. I agree to the terms and conditions of Membership and the rules of the Society.
11. If this application has been completed online, I acknowledge and agree that my electronic acceptance of this declaration (whether by electronic signature or otherwise) makes it fully binding on me and any other persons listed in the application.

The Privacy Act 1993 requires UniMed to inform you about certain rights and obligations relating to the information which we collect on this form. In this regard, we recommend that you read the Privacy Statement on our webpage https://www.unimed.co.nz/about-unimed/privacy-statement/

**The Integrity Register is a register of health insurance claims and administered by PwC (on behalf of HFANZ) for the purposes of the prevention and detection of fraudulent and suspicious conduct.*

_____ Date ___/___/___
Signature of Applicant

_____ Date ___/___/___
Signature of UniMed Representative (where applicable)

NOTE: PRE-EXISTING MEDICAL CONDITIONS NOT DECLARED ARE AUTOMATICALLY EXCLUDED FROM COVER

Have you or any family member named in this application ever displayed evidence of, or had any sign or symptom and/or consulted a provider of health care regarding, any of the following?

✓Tick appropriate box

1. Congenital conditions and/or developmental disorders ..... Yes ☐ No ☐
2. Stomach, bowel, rectal or digestive disorders including haemorrhoids ..... Yes ☐ No ☐
3. Back pain, or any condition including neck/cervical, thoracic, lumbar and sacral spine ..... Yes ☐ No ☐
4. Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis, gout and bunions ..... Yes ☐ No ☐
5. Heart disease or disorder including chest pain, angina, coronary artery disease, dysrhythmias, aneurysms, heart valve replacements or rheumatic fever ..... Yes ☐ No ☐
6. High blood pressure and/or high cholesterol ..... Yes ☐ No ☐
7. Blood or bleeding disorders including anaemia or B12 deficiency ..... Yes ☐ No ☐
8. Vascular or arterial disorders including varicose veins ..... Yes ☐ No ☐
9. Diabetes, thyroid or other glandular disorders ..... Yes ☐ No ☐
10. Liver or gall bladder disorders including hepatitis ..... Yes ☐ No ☐
11. Gynaecological or menstrual disorders including irregular, heavy or painful periods, any abnormal smears, or endometriosis ..... Yes ☐ No ☐
12. Eye disease including cataracts or glaucoma ..... Yes ☐ No ☐
13. Recurrent upper respiratory tract infections, adenoids, sore throat, ear infections, tonsillitis and sinusitis ..... Yes ☐ No ☐
14. Kidney or bladder disorders including stones, hernia, incontinence or pelvic floor disorder and prolapse ..... Yes ☐ No ☐
15. Suspicious moles, cysts, skin lesions, lipomas, including treatment for melanoma ..... Yes ☐ No ☐
16. Neurological or nerve conditions including migraines, epilepsy, paralysis or stroke ..... Yes ☐ No ☐
17. Cancerous and pre-cancerous conditions or tumours ..... Yes ☐ No ☐

SUPPLEMENTARY INFORMATION

If you answered Yes to any questions above, please complete full details (use additional paper if needed):

Question No.	Name	Date/Year	Description of Symptoms/Treatment/Investigation/Operation

Have any named applicants been advised that they may require any diagnostics, medical or surgical treatment in the future?

✓ Yes ☐ No ☐

Name	Medical Condition	Treatment

✓ Have any named applicants suffered an accident or injury? Yes ☐ No ☐

Name	Medical Condition	Side?	ACC Covered?	Workplace Injury?
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No
		Left / Right	Yes / No	Yes / No

✓ Have any named applicants taken in the past, or are currently taking, any medication on a regular basis? Yes ☐ No ☐

Name	Medication	Reason	Time Period

✓ Are any named applicants currently suffering from, or have suffered from in the past, any condition/ailment or received treatment not already disclosed? Yes ☐ No ☐

Name	Medical Condition	Treatment	Year

CURRENTLY INSURED?

✓ Are you currently insured elsewhere? Yes ☐ No ☐

Name of current Provider and Plan type _____

Please provide a copy of your current medical insurance certificate, so we may confirm your *like with like plan and special joining concessions.
*Only available in certain Groups.

Union Medical Benefits Society Ltd

Head Office
PO Box 1721, Christchurch 8140, www.unimed.co.nz
Phone: 03 365 4048 Fax: 03 365 4066 Email: sales@unimed.co.nz

TOLL FREE 0800 600 666

DIRECT DEBIT AUTHORITY

UniMed
YOUR HEALTH INSURER
UNION MEDICAL BENEFITS SOCIETY LTD

PAYMENT FREQUENCY

Frequency (please tick one) ☐ fortnightly ☐ monthly ☐ annually

Start Date ☐☐ ☐☐ ☐☐☐☐
Day Month Year

BANK INSTRUCTIONS

Name: _____
(Of Bank Account)

Bank Account from which payments to be made:

☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐ ☐☐☐
Bank Branch Account Number Suffix

AUTHORITY TO ACCEPT DIRECT DEBITS
(Not to operate as an assignment or agreement)

AUTHORISATION CODE
0 2 0 1 3 1 9

To: The Bank Manager

Bank _____

Branch _____

Town/City _____

I/We authorise you until further notice, to debit my/our account with all amounts which **Union Medical Benefits Society Limited** (hereinafter referred to as the Initiator) the registered Initiator of the above Authorisation Code, may initiate by Direct Debit.
I/We acknowledge and accept that the bank accepts this authority only upon the conditions listed below.

Information to appear on my/our bank statement

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Payer Particulars Payer Code Payer Reference

Your Signature(s) _____ Date __/__/__

AUTHORITY TO ACCEPT RECURRING CARD PAYMENTS

Card Type ☐ Visa ☐ MasterCard

Card Number ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ **Expiry Date** __/__/__

Cardholder's Name _____ **Cardholder's Signature** _____

Customer Authorisation

I (hereinafter referred to as the Customer) authorise Union Medical Benefits Society Limited (hereinafter referred to as the initiator), until further notice in writing, to debit my card number as detailed above (the "nominated Card"). I acknowledge and accept that the initiator accepts this Authority only upon the conditions listed below.

CONDITIONS OF THIS AUTHORITY TO ACCEPT DIRECT DEBITS

1. The Initiator
   (a) Has agreed to give advance Notice of the net amount of each direct debit and the due date of debiting at least 10 calendar days before (but not more than 2 calendar months) the date the direct debit will be initiated. This notice will be provided either:
   (i) in writing; or
   (ii) by electronic mail where the Customer has provided prior written consent to the Initiator
   The advance notice will include the following message:-
   "Unless advice to the contrary is received from you by (*date), the amount of $..... will be directly debited to our Bank account on (initiating date)."
   * This date will be at least two days prior to the due date to allow for amendment of direct debits
   (b) May, upon the relationship which gave rise to this Authority being terminated, give notice to the Bank that no further Direct Debits are to be initiated under the Authority. Upon receipt of such notice the Bank may terminate this Authority as to future payments by notice in writing to me/us.
2. The Customer may:-
   (a) At any time, terminate this Authority as to future payments by giving written notice of termination to the Bank and to the Initiator.
   (b) Stop payment of any direct debit to be initiated under this authority by the Initiator by giving written notice to the Bank prior to the direct debit being paid by the Bank
3. The Customer acknowledges that:-
   (a) This authority will remain in full force and effect in respect of all direct debits made from me/our account in good faith notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such event is received by the Bank.
   (b) In any event this authority is subject to any arrangement now or hereafter existing between me/us and the Bank in relation to my/our account.
   (c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the Bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the Initiator.
   (d) Where the Bank has used reasonable care and skill in acting in accordance with this authority, the Bank accepts no responsibility or liability in respect of:-
   - the accuracy of information about Direct Debits on Bank statements
   - any variations between notices given by the Initiator and the amounts of Direct Debits
   (e) The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation the dispute lies between me/us and the Initiator.
4. The Bank may:-
   (a) In its absolute discretion conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the Bank.
   (b) At any time terminate this authority as to future payments by notice in writing to me/us.
   (c) Charge its current fees for this service in force from time-to-time.

CONDITIONS OF THIS AUTHORITY TO ACCEPT RECURRING CARD PAYMENTS

1. The Initiator agrees:
   (a) To give advance written notice (including by electronic means) to the Customer in the form of a schedule of payment dates and the net amounts to be debited to the Nominated Card.
   (b) In the event of any subsequent change to the frequency or amount of the debits to the Nominated Card, the Initiator has agreed to give advance written notice of at least 10 days to the Customer before the changes comes into effect.
2. The Customer may:
   (a) At any time, terminate this Authority by giving written notice of termination to the Initiator.
3. The Customer acknowledges that:
   (a) This Authority will remain in full force and effect in respect of all amounts to be debited to my Nominated Card in good faith notwithstanding my death, bankruptcy or other revocation of this authority.