SECTION A - APPLICATION FORM

MEMBERSHIP APPLICATION FORM

Union Medical Benefits Society Ltd
Head Office: PO Box 1721, Christchurch 8140. Telephone (03) 365-4048, Fax (03) 365-4066

DR MR MRS MISS MS SURNAME	FIRST NAMES	
MAILING ADDRESS		
DATE OF BIRTH / /	EMAIL ADDRESS:	TELEPHONE WORK: HOME:
EMPLOYER (FULL COMPANY NAME)	EMPLOYER ADDRESS	

ADDITIONAL FAMILY MEMBERS TO BE COVERED UNDER THIS POLICY

SPOUSE/ PARTNER	DR MR MRS MISS MS SURNAME	FIRST NAMES	DATE OF BIRTH / /	OCCUPATION

	SURNAME	FIRST NAMES	GENDER	DATE OF BIRTH
CHILD 1			M / F	/ /
CHILD 2			M / F	/ /
CHILD 3			M / F	/ /
CHILD 4			M / F	/ /
CHILD 5			M / F	/ /
CHILD 6			M / F	/ /

PLAN APPLIED FOR ✓ *TICK APPROPRIATE BOX*

- ☐ UNICARE PLUS 80 PLAN
- ☐ MEDICALCARE BASE PLAN
  - ☐ GP/Prescriptions (Option 1)
  - ☐ Health Maintenance (Option 2)
  - ☐ Dental 100/Vision (Option 3)
  - ☐ Dental 400/Vision (Option 4)
  - ☐ Other _____

THIS APPLICATION IS FOR: *TICK APPROPRIATE BOX* ✓

- NEW MEMBERSHIP ☐
- ADDITION OF DEPENDANT(S) TO EXISTING POLICY ☐
- UPGRADE OF AN EXISTING POLICY ☐

CURRENTLY INSURED?

IF YOU ARE CURRENTLY INSURED ELSEWHERE YES ☐ ✓ NO ☐ *TICK APPROPRIATE BOX*

Plan covered under: _____

We must request a copy of your current medical insurance certificate, so that we may confirm your Special Joining Concessions.

OFFICE USE

UNIMED MEMBERSHIP NUMBER: ☐☐☐☐☐☐ SCHEME ELIGIBILITY DATE: _____ COVER EFFECTIVE DATE: _____

APPLICANT'S DECLARATION

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

1. I declare that all entries made on this form to be true and correct and that I am not aware of any other circumstances which might affect the risk of insurance on my health or that of any other person listed on my application. I acknowledge that failure to make this declaration truthfully may invalidate my insurance.
2. I understand that the written declaration in the Application Form constitutes the basis of the contract with the Society.
   No oral representation, inducements, 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.
3. I understand that the Society's Membership/Sales Representative does not have the authority to advise me upon such disclosure and that the said Representative has explained the terms and conditions of the Society.
4. 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.
5. 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.
6. 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 doctor who has attended or examined me or my listed dependants.
7. I authorise UniMed to obtain details from my employer regarding my previous medical insurance.
8. Persuant to the Privacy Act 1993 and the Health Information Privacy Code 1994. The information provided in this application form collects personal information for the purpose of evaluating you Membership Application and future claims. UniMed 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.
9. I agree to the terms and conditions of Membership and the rules of the Society.
10. I authorise my employer to deduct regular premium instalments from my wages/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 (section A only).

_____ _____
Signature of Applicant Date

_____ _____
Signature of Agent Date

*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 www.unimed.co.nz. *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.*

SECTION B - APPLICATION FORM

HEALTH DECLARATION – *ALL QUESTIONS APPLY TO ALL PERSONS LISTED ON APPLICATION FORM*

YOUR PERSONAL MEDICAL INFORMATION IS STRICTLY CONFIDENTIAL

Please use a separate sheet if more space is required.

Residency: Are you and all family members named in this application a New Zealand citizen, 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 Account Manager or UniMed Head Office on 0800 600 666. **YES** ☐

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1 Have you, or your spouse, or any named dependants at any time been admitted (other than for childbirth) to a hospital or private surgical centre? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

Name of person	Treatment, investigation or operation	Doctor's name	Year

2 Have you, or your spouse, or any named dependants been advised that you may require medical or surgical treatment in the future? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

Name of person	Details (including type of treatment, approximate dates)	Doctor's name	Year

3 Have you, or your spouse, or any named dependants suffered from either personal injury or an employment related condition that has required medical treatment/ advice? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

Name of person	Details (including type of treatment, approximate dates)	Doctor's name	Year

4 Have you, or your spouse, or any named dependants had symptoms or received medical advice and/or treatment for any of the following? ✓ *TICK APPROPRIATE BOX*

	YES	NO		YES	NO
Disorders of the eyes, ears, nose or throat	☐	☐	Respiratory disease including asthma	☐	☐
High blood pressure, chest pain or heart disease	☐	☐	Disorder of stomach, intestine, liver, gall bladder, peptic ulcer	☐	☐
Disease of kidney, bladder, reproductive organs, hernia	☐	☐	Varicose veins or haemorrhoids	☐	☐
Disease or damage of joints, muscles, bones including arthritis/rheumatism or bunions	☐	☐	Diabetes, epilepsy, stroke, cancer, obesity	☐	☐
Disorders of the skin including lesions or moles	☐	☐	Gynaecological disorders including abnormal cervical smears, complications of previous pregnancies	☐	☐

If yes to any of the above, please specify below:

Name of person	Details (including type of treatment, approximate dates)	Doctor's name	Year

5 Have you, or your spouse, or any named dependants either taken in the past, or are currently taking, any form of medication on a regular basis? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

Name of person	Details (including dates, duration, reasons, treatment and results - whichever are applicable)	Year

6 Have/are you, or your spouse, or any named dependants suffering from, or have suffered in the past from, any illness or condition not disclosed above already? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

Name of person	Details (including dates, duration, reasons, treatment and results - whichever are applicable)	Year

7 Are you a smoker? **YES** ☐ **NO** ☐ Is your spouse/partner a smoker? **YES** ☐ **NO** ☐ ✓ *TICK APPROPRIATE BOX*

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