Southern Cross Health Society

Health insurance application

For office use only

Membership number

1. YOUR DETAILS

Please complete this form in full. Print using a black or blue pen only. Please initial any corrections you make.
A child can only be named as a dependant on its parent's policy, and must be under the age of 21 years.

This section is to be completed by the applicant only.

Health insurance plan _____ **Start date** ____/____/____

New Zealand Residency: Are you and all family members named in this application New Zealand citizens, holders of a resident visa or a work visa for a minimum of two years or otherwise entitled to publicly funded health and disability services as determined by the Ministry of Health?

Yes ☐

If not, please don't proceed. Contact your Adviser.

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Previous member ☐ Yes

Physical address _____
Street number Street Suburb Town/city

Postal address _____
(if different from above) Street number Street Suburb Town/city

Home phone ☐☐ ☐☐☐☐☐☐☐ Work phone ☐☐ ☐☐☐☐☐☐☐ Extn ☐☐☐☐

Mobile phone ☐☐☐☐ ☐☐☐☐☐☐☐ Email _____

Partner/spouse

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Previous member ☐ Yes

Dependant 1

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Dependant 2

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Dependant 3

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Dependant 4

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

FOR OFFICE USE ONLY

Adviser sales code	NB %	Renewal %
ARM code		

Policy transfer ☐ Addtl info attached ☐ Copy to Admin ☐

Group name

Group code ☐☐☐☐☐☐☐☐☐☐

Previous membership no ☐☐☐☐☐☐☐☐☐☐

Campaign code

Terms E/C ☐ 90 ☐ L ☐

Start ☐☐/☐☐

2. YOUR HEALTHY LIFESTYLE QUESTIONS

If you are already taking steps to maintain good health we would like to reward you. If you wish to apply for a Healthy Lifestyle Reward please complete the following:

	Applicant	Spouse/partner	Other dependants 18 years or older	
Are you a non-smoker?† †*Have not smoked at all over the past 12 months.*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you eat at least 5 servings of fruit and vegetables a day?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you do 30 minutes of moderate physical activity on most days of the week?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
FEMALE: Do you drink 2 or less glasses of alcohol a day (14 per week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
MALE: Do you drink 3 or less glasses of alcohol a day (21 per week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
For office use only. Eligible for Healthy Lifestyle Reward?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Please note: If you qualify for the Healthy Lifestyle Reward it will only be applied from age 21. If you are a member of a subsidised employer's work scheme you will not receive a Healthy Lifestyle Reward personally, but your health will be taken into account in your group's premium.

3. YOUR HEALTH

This section must be completed for each person on this application.

For yourself and each of your family members named in this application, please provide all the following details of the LAST time they consulted their GP/family doctor.

Applicant

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Partner/spouse

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 1

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 2

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 3

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 4

Person's name _____ Date of consultation ____/____/____

Reason for consultation _____

Treatment/medication received _____

Outcome _____

4. HEALTH CONDITIONS

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?

1.	Abdominal or pelvic pain	Yes ☐ No ☐
2.	Accidents or injuries which have required, or could require treatment *(State left or right side in Section 5)*	Yes ☐ No ☐
3.	Allergic condition including hay fever	Yes ☐ No ☐
4.	Asthma, chronic bronchitis or any other disease or disorder of the lungs	Yes ☐ No ☐
5.	Back pain or condition including neck/cervical, thoracic, lumbar and sacral spine	Yes ☐ No ☐
6.	Blood or bleeding disorder including anaemia or B12 deficiency	Yes ☐ No ☐
7.	Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis	Yes ☐ No ☐
8.	Breast lumps (benign or cancerous) or breast pain or any other breast condition	Yes ☐ No ☐
9.	Cancerous and pre-cancerous conditions, cysts or tumours	Yes ☐ No ☐
10.	Congenital conditions and/or developmental disorders	Yes ☐ No ☐
11.	Diabetes, gout, thyroid or other glandular disorders	Yes ☐ No ☐
12.	Ear, nose or throat condition including ear infections, sinusitis, or tonsillitis	Yes ☐ No ☐
13.	Eye disease or disorder including cataracts	Yes ☐ No ☐
14.	Heart disease or disorder including shortness of breath, chest pain, angina or coronary artery disease	Yes ☐ No ☐
15.	Hernia – If yes, what type:	Yes ☐ No ☐
16.	High blood pressure and/or high cholesterol	Yes ☐ No ☐
17.	Jaw, mouth or teeth condition including wisdom teeth and/or over or under bite	Yes ☐ No ☐
18.	Kidney or bladder condition including stones, urinary incontinence or pelvic floor disorder	Yes ☐ No ☐
19.	Liver or gall bladder condition including hepatitis	Yes ☐ No ☐
20.	Men: Prostate condition including abnormal PSA tests, urinary symptoms, or signs or testicular lump(s) or pain	Yes ☐ No ☐
21.	Neurological or nerve condition including headaches, migraines or stroke	Yes ☐ No ☐
22.	Psychiatric or psychological condition including anxiety, stress or depression	Yes ☐ No ☐
23.	Rectal or anal condition including haemorrhoids, or bleeding from bowel or rectum	Yes ☐ No ☐
24.	Skin disorders including skin cancer, skin lesions under surveillance, eczema, rosacea or acne	Yes ☐ No ☐
25.	Stomach, bowel, or digestive disorder including ulcers, polyps, irritable bowel syndrome or gastric reflux	Yes ☐ No ☐
26.	Vascular or arterial disorders including varicose veins	Yes ☐ No ☐
27.	Women: Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, or endometriosis	Yes ☐ No ☐
28.	Women: Recurrent miscarriage(s) and/or infertility	Yes ☐ No ☐
29.	Any symptoms, signs or conditions not already disclosed	Yes ☐ No ☐

Is any person named on the application

30.	Currently taking any medication or under regular medical treatment or supervision	Yes ☐ No ☐
31.	Currently awaiting the completion or results of any medical investigation	Yes ☐ No ☐
32.	Intending to seek or currently seeking any medical advice, examination or procedure	Yes ☐ No ☐

If you have answered **yes** to any of the above you must complete section 5.

5. DETAILS OF THE HEALTH CONDITIONS

If you have answered YES to any of the questions in section 4, please provide details below. If there is not enough space on the form please supply the details on a separate sheet. *(Use a separate field for every condition of each person).*

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

5. DETAILS OF THE HEALTH CONDITIONS (CONTINUED)

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

____

____

CHECKLIST

HLR ☐ PEC concessions ☐ Standard business ☐

Member	Code	Exclusions			

Underwriter's name ______________ **Underwriter's signature** ______________ **Date** ____/____/____

6. SCHEME DETAILS

If you are eligible to join a Southern Cross employer's work scheme or association scheme please complete the following:

Company or association _____ Employee no _____

Branch/department _____ Occupation _____

Employed from _____/_____/_____ Address _____

7. PAYMENT OPTION

INDIVIDUAL AND ASSOCIATION MEMBERS PAYMENT OPTIONS

Direct debit

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Annually

Recurring credit card

☐ Monthly ☐ 3 Monthly ☐ 6 Monthly ☐ Annually

Invoice

☐ 3 Monthly ☐ 6 Monthly ☐ Annually

Please attach cheque

EMPLOYER'S WORK SCHEME MEMBERS PAYMENT OPTIONS

Salary/wage deduction

☐ Weekly ☐ Fortnightly ☐ Monthly

Direct debit

☐ Weekly ☐ Fortnightly ☐ Monthly

☐ **Fully subsidised group – payment method not applicable**

Note: Please complete the form included. Billing and payment options vary from scheme to scheme, please check which options are available to you and ask your adviser for the relevant form.

8. YOUR DECLARATION

Please read carefully before signing. Failure to make this declaration truthfully may invalidate the policy.

1. I apply for membership of the Southern Cross Medical Care Society ("Southern Cross") and agree to be bound by the Rules of Southern Cross.

I hereby declare as follows

1. That the information I have disclosed is true and complete.
2. That any further information I disclose to Southern Cross between the date I sign this application and the date I receive a Membership Certificate from Southern Cross is, at the time of disclosure, true and complete. I undertake to advise Southern Cross of any health condition or event that may affect me or any of the other people named in this application, or any other relevant information that may affect the policy, between the date I sign this application and the date I receive a Membership Certificate from Southern Cross.
3. I accept the terms and conditions (including the limitations and exclusions) of the policy.
4. I accept that a three month no claim period exists from the policy start date unless specifically waived at enrolment.
5. I understand that premiums may change with market variations and will change when any person named on this application enters a different age band.

Privacy – application details

1. I understand that:

   (a) the information Southern Cross collects in this application form and in the wider application process will be used to consider and process my application for health insurance and, if approved, consider the specific terms that apply to my policy, to administer my policy and for marketing purposes.

   (b) if any of the information requested as part of this application is not provided, it may delay the application being processed, or result in Southern Cross not providing the people named in this application with cover or associated benefits.

   (c) the people named in this application are entitled to have access to, and request correction of, any of their personal or health information held by Southern Cross.

2. I authorise Southern Cross to collect from, and to disclose to:

   - my husband/wife/partner (if named in this application form);
   - any person(s) nominated in writing by me;
   - third parties such as health services providers and medical authorities (including ACC and Ministry of Health), group administrators, agents, contractors, suppliers and other business partners;

   information relating to people named in this application form and I authorise these parties to disclose to Southern Cross and receive from Southern Cross this information, in accordance with the Southern Cross Privacy Statement.

In relation to any other people named in this application, I confirm that:

- I am authorised to complete this application form on their behalf;
- I am authorised to disclose to Southern Cross and to receive from Southern Cross their personal and health information;
- I have made each of them aware of the contents of this application; and
- each of the people named have authorised me to give the acknowledgements, undertakings and authorities set out above on their behalf.

Management of this and other personal and health information provided to Southern Cross is subject to the terms of the Southern Cross Privacy Statement. For an up to date copy of the full Southern Cross Privacy Statement, please refer to your policy document, visit our website at www.southerncross.co.nz/society or contact Member Services on 0800 800 181.

Financial strength rating

Southern Cross Medical Care Society (trading as Southern Cross Health Society) has an A+ (Strong) financial strength rating given by Standard & Poor's (Australia) Pty Limited.

The rating scale is:

AAA	**(Extremely Strong)**	**BBB**	**(Good)**	**CCC**	**(Very Weak)**
AA	**(Very Strong)**	**BB**	**(Marginal)**	**CC**	**(Extremely Weak)**
A	**(Strong)**	**B**	**(Weak)**	**R**	**(Regulatory Action)**

Plus (+) or minus (-) signs following ratings from "AA" to "CCC" show relative standing within the major rating categories. Standard & Poor's is an approved rating agency under the Insurance (Prudential Supervision) Act 2010.

Thank you for your application

We will review your application and advise you in writing of the specific terms applying to your policy and the policy start date. If you are not satisfied with the policy during the first 14 days after receiving it, you can cancel the policy and we will provide a full refund of all premiums paid. You can only do this if you have not made a claim under the policy during this period.

Applicant's signature _____ **Date** _____/_____/_____

FINAL CHECK LIST

Please make sure you have completed everything in the check list before sending this form to Southern Cross.

☐ FORM SIGNED AND DATED ☐ PAYMENT AUTHORISATION SIGNED/CHEQUE ATTACHED ☐ ANSWERED ALL QUESTIONS IN SECTION 3 and 4

Southern Cross Health Society

Direct debit authority

Fill in the required details clearly in BLOCK CAPITALS and make sure that you have given us your signature and contact phone number.

Members of an employer work scheme - your deduction date and frequency may be according to your current pay cycle.

To ensure your correct bank account is debited, **please enclose a deposit slip for the bank account you have nominated.** Then simply send this to us in the postage paid envelope provided.

We will automatically adjust the deduction amount when changes happen to your policy and notify you in advance of the deduction date. You don't have to fill in another form.

This information is being collected by Southern Cross Medical Care Society for administration purposes, including billing. You have the right of access to, and to request correction of, any personal information held by us.

If you need any further information just call us toll-free on **0800 800 181** and one of our Member Services team will help you.

YOUR DETAILS

Membership or policy number

Group code (for office use only)

Please read Conditions of the authority overleaf.

Name of policyholder _____ Daytime phone no _____

1. Please choose **one of the following** deduction frequencies and specify the deduction date.

☐ Weekly
☐☐ Day ☐☐ Month

☐ Fortnightly
☐☐ Day ☐☐ Month

☐ Monthly
☐☐ Day ☐☐ Month

Note: 1. Enter the date that you want the direct debit deduction cycle to start deducting money from your bank account.

2. Direct debit deductions can only occur on a week day (not Saturday/Sunday). Should the date fall on a public holiday, deduction will occur on the next available business day.
3. Southern Cross is required to give you **10 days notice** in writing prior to your first deduction. An invoice/statement will be sent to you 10 days prior to the deduction. To meet this requirement, please ensure we receive this form **at least 15 days** prior to your nominated deduction date.
4. If Southern Cross is unable to meet the 10 day notice requirement, your deduction will occur on the next deduction date according to your deduction frequency. The first deduction may include more than one bill period.

2. Bank account details

Name of bank account holder _____

Please provide your bank/branch number, account number and suffix of the account to be debited in the spaces below.

BANK/BRANCH NUMBER

ACCOUNT NUMBER

SUFFIX

Bank/branch _____

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

AUTHORISATION CODE
1200357
(user number)

I/We authorise you until further notice in writing to debit my/our account with all the amounts which Southern Cross Medical Care Society, Level 1, Ernst & Young Building, 2 Takutai Square, Auckland 1010 (hereafter 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 authority only on the conditions overleaf.

Information to appear on my/our Bank Statement

S	O	U	T	H	E	R	N	C	R	O	S	S

PAYER PARTICULARS

PAYER CODE

H	E	A	L	T	H	S	O	C

PAYER REFERENCE

Authorised signature(s) _____

FOR BANK USE ONLY

APPROVED	DATE RECEIVED	RECORDED BY	CHECKED BY	BANK STAMP

Southern Cross
Health Society

CONDITIONS OF THE AUTHORITY TO ACCEPT DIRECT DEBITS

1. The Initiator:
   (a) Undertakes to give written notice to me/us of the commencement date, frequency and amount of the Direct Debit at least 10 calendar days (but no more than 2 calendar months) before the first Direct Debit is drawn. Where the Direct Debit System is used for the collection of payments which are regular as to frequency, but variable as to amounts, the Initiator undertakes to provide me/us with a schedule detailing each payment amount and each payment date. In the event of any subsequent change to the frequency or amount of the Direct Debit, the Initiator has agreed to give written notice at least 30 days before that change comes into effect.
   (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 this authority. Upon receipt of such notice, the Bank may terminate this authority as to future payments by notice in writing to me/us.
   (c) May rely on this authority to debit a different bank account upon receipt of instructions from me/us via a bank to which my/our account has been transferred.
2. The Customer may:
   (a) At any time, terminate this authority as to future payment by giving written notice of termination to both the Bank and 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.
   (c) Where a variation to the amount agreed between the Initiator and the Customer from time to time to be direct debited has been made without notice being given in terms of clause 1(a) above, request the Bank to reverse or alter any such Direct Debit initiated by the Initiator by debiting the amount of the reversal or alteration of a Direct Debit back to the Initiator through the Initiator's Bank, PROVIDED such a request is made not more than 120 days from the date when the Direct Debit was debited to his/her account.
3. The Customer acknowledges that:
   (a) This authority will remain in full force and effect in respect of all Direct Debits passed to my/our accounts 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 any 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) The Bank accepts no responsibility or liability for the accuracy of the information about Direct Debits on Bank Statements.
   (e) The Bank is not responsible for, or under any liability in respect of:
      – any variations between notices given by the Initiator and the amounts of the Direct Debits on Bank Statements.
      – 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.
   (f) Notice given by the Initiator in terms of clause 1(a) to the debtor responsible for the payment shall be effective. Any communication necessary because of the debtor responsible for payment is a person other than me/us, is a matter between me/us and the debtor concerned.
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 the service in force from time to time.
   (d) Upon receipt of an "authority to transfer form" signed by me/us from a bank to which my/our account has been transferred, transfer to that bank this authority to accept Direct Debits.