HEALTH INSURANCE

APPLICATION FORM

accuro
HEALTH INSURANCE

At Accuro Health Insurance, we actively look for ways to add value and support our members, not just if things go wrong, but to keep things going right.

Accuro is a co-operative that is 100% owned and managed in New Zealand, so we are always working for our members, not shareholders.

That's what makes Accuro, New Zealand's best little health insurer.

Eligibility

To qualify for a SmartCare or SmartCare+ policy, you need to be a New Zealand citizen or permanent resident, hold a work visa valid in New Zealand for two years or more or be covered under New Zealand's public health system. The same applies to the other participants included in this application.

To qualify for a SmartStay policy, the main member needs to hold a work visa valid in New Zealand for less than two years and not have cover under New Zealand's public health system. Your family can also be covered under SmartStay as long as they have a visitor visa valid in New Zealand.

Your medical history

Health insurance only covers you for the things that happen after you take out cover. Don't be concerned if you already have a medical condition – just make sure you give us as much information as possible so we can fairly assess your medical history.

If you have a condition – or have had a condition or symptoms in the past that might result in further issues – we may exclude coverage for that condition in the first instance. We're happy to review any exclusions if you can provide further medical information. We will assess all the information you provide and make a decision based on the level of risk involved. Excluding coverage for pre-existing conditions enables us to minimise our costs and keep premiums low.

We're here to help

If you have questions or need help, either talk to your adviser or call us on **0800 222 876**.

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SECTION A

Type of application

1 Is this a new application? ◯ Yes ◯ No (go to Q4)

2 If you have a promotional code, please list it here _____

3 Are you applying as an individual or part of a group scheme?

◯ Individual (please fill in the below) ◯ Group scheme (go to Q6)

Please choose a base plan	If you are a New Zealand citizen or resident, hold a work visa valid for two years or more or are covered by the New Zealand public health system, you can select: ◯ SmartCare Hospital and Surgical base plan ◯ SmartCare+ Hospital and Surgical base plan ◯ Other _____	If you are **not** a New Zealand citizen or resident but hold a work visa valid for at least one month or a visitor visa valid for at least three months, you can select: ◯ SmartStay Hospital and Surgical base plan
Please choose your excess The excess is the amount you agree to pay towards the cost of any claims on your plan. The higher the excess, the lower your premium.	◯ $0 ◯ $4,000 ◯ $250 ◯ $6,000 ◯ $500 ◯ $8,000 ◯ $1,000 ◯ $10,000 ◯ $2,000	◯ $0 ◯ $1,000 ◯ $250 ◯ $2,000 ◯ $500 ◯ $4,000
Once you have chosen your base plan, you can add other plans	◯ Specialist plan (Excess: ◯ $0 ◯ $250) ◯ GP plan ◯ Natural Health plan ◯ Dental and Optical plan	◯ Specialist plan ◯ GP plan
When would you like this policy to start?	DAY / MONTH / YEAR or ◯ as soon as possible	

4 Are you making a change to an existing policy? ◯ Yes ◯ No (go to Q5)

◯ **Add a participant to an existing policy**	All new participant(s) need to complete Section B, answer the health questions in Section C and sign the declaration under Section D. The payment details section (Section E) does not need to be completed for any new participant that is added to an existing policy.
◯ **Add a new plan to an existing policy**	Please state the new plan(s) to be added _____ Please include excess option if applicable
◯ **Decrease the excess that applies to an existing policy** If you'd like to increase your excess, just send us a letter signed by the main member.	◯ $0 ◯ $500 ◯ $2,000 ◯ $6,000 ◯ $250 ◯ $1,000 ◯ $4,000 ◯ $8,000

5 Do you wish to add an adviser on your policy? ◯ Yes ◯ No (go to Q6)

Your adviser's name and company	

FOR OFFICE USE ONLY Membership number: Agent name/number:

6 Are you applying for a group scheme? ◯ Yes ◯ No (go to Q7)

Name of company/association/ organisation/partnership		
Date employed	DAY / MONTH / YEAR	Employee number (if applicable):
Please choose a base plan	◯ StaffCare Hospital and Surgical base plan ◯ StaffStay Hospital and Surgical base plan ◯ StaffCare+ Hospital and Surgical+ base plan	
Please choose your excess The excess is the amount you agree to pay towards the cost of any claims on your plan. The higher the excess, the lower your premium.	◯ $0 ◯ $1,000 ◯ $250 ◯ $2,000 ◯ $500	
Once you have chosen your base plan, you can add other plans	StaffCare additional plans: ◯ Specialist plan (Excess: ◯ $0 ◯ $250) ◯ GP plan	
	StaffCare+ additional plans: ◯ Specialist+ plan (Excess: ◯ $0 ◯ $250) ◯ GP+ plan ◯ Dental and Optical+ plan ◯ Natural Health+ plan	
	StaffStay additional plans: ◯ Specialist plan ◯ GP plan	

SECTION B

Personal details

7 Please complete the details for the main member to be insured

Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):
First name(s)	
Surname	
Date of birth	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female
Residential address	Street Town/city Postcode
Postal address (if different from above)	Street Town/city Postcode
Telephone	Home ( ) Business ( ) Mobile
Email	◯ I would like to receive all correspondence from Accuro Health Insurance via email Home Business
Industry	◯ Agriculture, forestry and fishing ◯ Mining ◯ Manufacturing ◯ Electricity, gas, water and waste services ◯ Construction ◯ Wholesale trade ◯ Retail trade and accommodation ◯ Transport, postal and warehousing ◯ Information media and telecommunications ◯ Financial and insurance services ◯ Rental, hiring and real estate services ◯ Professional, scientific, technical, administrative and support services ◯ Public administration and safety ◯ Education and training ◯ Health care and social assistance ◯ Arts, recreation and other services
Height and weight	_____ cm _____ kg
Have you smoked in the last 12 months?	◯ Yes ◯ No
Name of your usual GP and practice	GP Practice Fax ( )
Name of your usual dentist and practice	Dentist Practice Fax ( )
How did you hear about us?	◯ Search engine ◯ Social media ◯ District Health Board or NZNO ◯ Online advertisement ◯ Radio ◯ Print advertisement ◯ Event ◯ Adviser ◯ FreeStart Plan ◯ From a current member (please provide the member's name and membership number if available) ◯ Other (please provide details)

8 Do you wish to insure other family members/whāngai on this policy or add someone to an existing policy? ◯ Yes ◯ No (go to Q9)

Additional participants to be insured This can include your parents and/or participants under the age of 25.

	Participant 1:	Participant 2:	Participant 3:	Participant 4:	Participant 5:
Relationship to the main member					
Title	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):	◯ Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Other (please specify):
First name(s)					
Surname					
Date of birth	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Gender	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female	◯ Male ◯ Female
Email*					
Height and weight*	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg	_____ cm _____ kg
Have you smoked in the last 12 months?**	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Name of your usual GP and practice	◯ Same as main member ◯ Other (please specify): GP _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): GP _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): GP _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): GP _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): GP _____ Practice _____ _____ Fax _____
Name of your usual dentist and practice	◯ Same as main member ◯ Other (please specify): Dentist _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): Dentist _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): Dentist _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): Dentist _____ Practice _____ _____ Fax _____	◯ Same as main member ◯ Other (please specify): Dentist _____ Practice _____ _____ Fax _____

* Not required for dependants under the age of 16 (dependant means a member's child (including any stepchild or adopted child) who has been accepted as a participant in the member's plan).
** Not required for dependants under the age of 25.

SECTION C

Health declaration

These questions need to be answered by everyone who is:

- applying for a new policy, or
- making changes to an existing policy.

9 Heart conditions

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for angina/chest pain, heart attack, heart failure, abnormal heart beat, arrhythmia, heart murmur or rheumatic fever?

◯ Yes ◯ No (go to Q10) ◯ Yes ◯ No (go to Q10)

	Name of participant:	Name of participant:
Please provide details of the cardiac disorder.		
When did you first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms of this condition?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations and/or treatment for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any residual effects?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Do you require any on-going treatment, medication and/or monitoring?	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:	◯ Yes ◯ No If **yes**, please provide details including treatment undertaken and/or medication prescribed:

If you require more space to write, please use pages 27-29.

10 Raised blood pressure; raised or abnormal cholesterol

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for raised blood pressure or raised or abnormal cholesterol?

◯ Yes ◯ No (go to Q11) ◯ Yes ◯ No (go to Q11)

	Name of participant:	Name of participant:
Do you suffer from or have you been advised by a medical practitioner that you suffer from:	◯ Raised blood pressure ◯ Raised or abnormal cholesterol	◯ Raised blood pressure ◯ Raised or abnormal cholesterol
When did you first become aware you had raised blood pressure?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you first become aware you had abnormal cholesterol?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment and/or medication have you been prescribed?		
Has your treatment changed in the last 12 months?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
How often is your blood pressure and/or cholesterol checked and by whom?		
What were your three most recent blood pressure readings and cholesterol results?	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR	Please provide results of total cholesterol, HDL, LDL, triglycerides and chol/HDL ratio. 1 _____ DAY / MONTH / YEAR 2 _____ DAY / MONTH / YEAR 3 _____ DAY / MONTH / YEAR
Have you ever been admitted to hospital or consulted a specialist or been referred to a specialist as a result of your blood pressure and/or cholesterol readings?	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:	◯ Yes ◯ No If **yes**, please provide dates, outcome of consultation(s) and details regarding any investigations and/or treatment:
Do you suffer from any complications or associated conditions?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 27-29.

11 Breathing or respiratory disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis, tuberculosis, emphysema or sleep disorders?

◯ Yes ◯ No (go to Q12) ◯ Yes ◯ No (go to Q12)

	Name of participant:	Name of participant:
Please provide details of the breathing disorder (e.g. asthma, bronchitis).		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
What treatment and/or medication have you been prescribed?		
How frequent are/were the symptoms?	_____ per month/per year (delete one)	_____ per month/per year (delete one)
Do you consider your breathing disorder to be:	◯ Mild ◯ Moderate ◯ Severe ◯ Other	◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you been hospitalised and/or been on a nebuliser in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been prescribed steroids (e.g. prednisone) in the last two years?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to a specialist for investigations and/or treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 27-29.

12 Digestive disorders; stomach, intestine, liver or gall bladder problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for gastritis, ulcers, reflux, irritable bowel, Crohn's disease, colitis, coeliac disease, bowel polyps, abdominal pain, pancreatitis, liver inflammation, fatty liver, cirrhosis, gallstones or hernias?

◯ Yes ◯ No (go to Q13) ◯ Yes ◯ No (go to Q13)

	Name of participant:	Name of participant:
Please provide details of the type of digestive disorders and/ or stomach, intestine, liver or gall bladder problems.		
When did you first experience symptoms of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Do you still experience symptoms of this condition?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?	◯ Yes ◯ No If **no**, when did you last experience symptoms? If **yes**, how many times per year?
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you ever undergone or been advised to undergo any investigations of the gastrointestinal tract (e.g. gastroscopy, endoscopy, colonoscopy)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you undergone or been advised to undergo any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome:	◯ Yes ◯ No If **yes**, please provide details including date(s) and outcome.
Have you in the past or are you currently taking any medication for this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 27-29.

13 Cancer, cysts, tumours or growths

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for polyps, benign growths, any cancers or pre-cancerous condition, suspicious moles, cysts, abscesses, ganglion, basal cell carcinoma or melanoma?

◯ Yes ◯ No (go to Q14) ◯ Yes ◯ No (go to Q14)

	Name of participant:	Name of participant:
Please provide details of the condition.		
Please advise the name of the medical condition.		
When did you first experience symptoms or become aware of this condition?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
What treatment was undertaken or advised? If surgical removal, please provide date.		
If no treatment was undertaken, is the condition still present?	◯ Yes ◯ No	◯ Yes ◯ No
Do you know if the condition was:	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure	◯ Malignant ◯ Pre-malignant ◯ Benign ◯ Unsure
Has there been any recurrence?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you seen a specialist, do you require any on-going follow-up, treatment or monitoring or has any follow-up/further treatment been recommended?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 27-29.

14 Muscle or skeletal problems (including cartilage, tendon and ligament problems)

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for arthritis, back pain, neck/shoulder problems, whiplash, sciatica, scoliosis, ankylosing spondylitis, OOS, RSI, carpal tunnel, joint replacements, fractures, osteoporosis, gout or inflammatory conditions or any disorders of the hips, knees, ankles, feet, toes, shoulders, arms, elbows, wrists, hands or fingers?

◯ Yes ◯ No (go to Q15) ◯ Yes ◯ No (go to Q15)

	Name of participant:	Name of participant:
What is the name of the condition/ complaint/injury?		
What body part is affected? Please indicate if left or right limb.		
When did you first suffer from this condition/complaint/injury, and how did it occur?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
How long did the symptoms last?		
When did you last suffer from symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
Has this condition occurred more than once?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you been referred to or consulted a GP or specialist about symptoms of any of the above?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you had any investigations?	◯ Yes ◯ No If **yes**, please provide details of type, date and results:	◯ Yes ◯ No If **yes**, please provide details of type, date and results:
Have you had any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details including date:	◯ Yes ◯ No If **yes**, please provide details including date:

If you require more space to write, please use pages 27-29.

Muscle or skeletal problems (continued)

	Name of participant:	Name of participant:
Have you had any time off work or school as a result of this condition?	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DAY / MONTH / YEAR	◯ Yes ◯ No ◯ I have not yet returned to work/school If **yes**, please provide start date and duration: DAY / MONTH / YEAR
Have you made a claim to ACC in respect of this condition?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you currently receiving treatment?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you awaiting investigations, treatment or surgery, or have you been advised that treatment or surgery will be required?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Have you experienced any pain or discomfort since the last episode/ symptoms?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:
Are you aware of any arthritis or degeneration in the affected body part(s)?	◯ Yes ◯ No If **yes**, please provide details:	◯ Yes ◯ No If **yes**, please provide details:

If you require more space to write, please use pages 27-29.

15 Blood, immune or circulatory disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for abnormal blood tests, anaemia, hepatitis, HIV, haemochromatosis, vitamin B12 deficiency, haemophilia, lupus or any autoimmune disorder or varicose veins, DVT or blood clots?

◯ Yes ◯ No (go to Q16)

◯ Yes ◯ No (go to Q16)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

16 Endocrine (glandular) disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for diabetes (type 1 or type 2), thyroid problems, Graves' disease, abnormal thyroid function tests, pituitary problems or abnormal blood sugar and/or glucose tolerance tests?

◯ Yes ◯ No (go to Q17) ◯ Yes ◯ No (go to Q17)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication.
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

17 Urinary or kidney disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for kidney or bladder problems, incontinence, urinary difficulties, kidney stones or kidney infections, kidney failure or recent and/or recurrent UTIs?

◯ Yes ◯ No (go to Q18)

◯ Yes ◯ No (go to Q18)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

18 Anal/rectal problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for haemorrhoids, change in bowel habit, anal fissures, anal bleeding or pilonidal sinus?

◯ Yes ◯ No (go to Q19) ◯ Yes ◯ No (go to Q19)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

19 Skin problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for eczema, dermatitis, rashes, psoriasis, acne or allergic conditions?

◯ Yes ◯ No (go to Q20) ◯ Yes ◯ No (go to Q20)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

20 Brain or nervous system disorders

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for stroke, TIA, aneurysms, migraine, repeated headaches, vertigo, fainting, dizziness, multiple sclerosis, epilepsy/seizures, paralysis, motor neuron disease, nerve pain or meningitis?

◯ Yes ◯ No (go to Q21)

◯ Yes ◯ No (go to Q21)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

21 Fatigue or pain syndromes

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for chronic fatigue, fibromyalgia or chronic pain syndrome?

◯ Yes ◯ No (go to Q22) ◯ Yes ◯ No (go to Q22)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

22 Eye, ear or throat problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for cataracts, glaucoma, visual impairment, hearing loss, tinnitus, recent and/or recurrent ear infections, grommets, enlargement of adenoids, tonsillitis or recent and/or recurrent throat infections?

◯ Yes ◯ No (go to Q23) ◯ Yes ◯ No (go to Q23)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

23 Allergies, nasal and/or sinus problems

Have you, or any of the participants to be insured, ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for anaphylaxis, nasal obstruction, hay fever, sinusitis or recent and/or recurrent sinus infections?

◯ Yes ◯ No (go to Q24) ◯ Yes ◯ No (go to Q24)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

24 Dental problems

Have you, or any of the participants to be insured, ever had oral surgery or experienced, had symptoms of, been treated for or been advised to seek testing or treatment for wisdom teeth, impacted or unerupted teeth, cysts or gum disease?

◯ Yes ◯ No (go to Q25) ◯ Yes ◯ No (go to Q25)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
If wisdom teeth have been removed, please confirm how many.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

25 Mental health conditions

Have you, or any of the participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the participants to be insured, currently receiving or have ever received counselling, investigations or treatment for, any psychiatric or psychological condition, including anxiety, stress or depression?

◯ Yes ◯ No (go to Q26 for males or Q27 for females)

◯ Yes ◯ No (go to Q26 for males or Q27 for females)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

26 To be completed by males only

Have you, or any of the male participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the male participants to be insured, currently receiving or have ever received counselling, investigations or treatment from a health professional for, any of the following: blood in the urine, slow urinary stream, problems with passing urine, disease or disorder of the testicles, bladder, urethra or prostate, sexual dysfunction or abnormal prostate tests?

◯ Yes ◯ No (go to Q28) ◯ Yes ◯ No (go to Q28)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	AY / MONTH / YEAR ◯ This condition is on-going	AY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

27 To be completed by females only

Have you, or any of the female participants to be insured, ever experienced any signs or symptoms of, or are you, or any of the female participants to be insured, currently receiving or have ever received counselling, investigations or treatment from a health professional for, any of the following: breast disease or disorder, breast lumps, cysts or breast pain, gynaecological disorder of any kind, endometriosis, polycystic ovarian syndrome, irregular, heavy or painful menstrual bleeding, current symptoms of menopause, ovarian or hormonal problems, complications of pregnancy, abnormal smear(s), painful intercourse and/or prolapse?

◯ Yes ◯ No (go to Q28) ◯ Yes ◯ No (go to Q28)

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

28 Other conditions

Have you, or any of the participants to be insured:

- ever experienced, had symptoms of, been treated for or been advised to seek testing or treatment for any other illness, accident, injury, condition, complaint, disability, medication or disorder not already stated?
- been hospitalised or had any tests, medical treatment or investigations in the last five years or be intending to for **any condition not already stated**, including but not limited to blood and/or urine test, X-ray, ultrasound, CT scan, mammogram, MRI, gastroscopy, colonoscopy, endoscopy, hysteroscopy and laparoscopy?
- had more than five consecutive days off work or school in the past five years due to **any condition not already stated**?
- ever had elective surgery for any reason?

◯ Yes ◯ No (go to Q29) ◯ Yes ◯ No (go to Q29)

	Name of participant:	Name of participant:
Please advise the name of the medical condition, treatment and/or surgery.		
When did you first experience symptoms? If elective surgery, when did you first receive treatment?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Please describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Moderate ◯ Severe ◯ Other
Have you had any investigations and/or received any treatment (including surgery)?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment, surgery and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment, surgery and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please use pages 27-29.

29 Family history (please answer both questions below)

Have you, or any of the participants to be insured, ever undertaken testing or treatment, or been advised to seek testing or treatment in relation to family history?

◯ Yes ◯ No (go to the question below) ◯ Yes ◯ No (go to the question below)

	Name of participant:	Name of participant:
Please advise the name of the medical condition tested, the reason why the testing was required and the outcome		

Have any of your grandparents, parents, brothers, sisters or children (living or dead) had or been diagnosed with any of the following: cancer, stroke, heart disease, diabetes, kidney disease, Huntington's chorea, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, bowel and/or colon polyps, multiple sclerosis, inherited neurological or blood disease or any familial and/or congenital disease or disorder?

◯ Yes ◯ Yes ◯ Yes ◯ Yes
◯ No (go to Section D) ◯ No (go to Section D) ◯ No (go to Section D) ◯ No (go to Section D)

	Name of participant:	Name of participant:	Name of participant:	Name of participant:
Medical condition (If cancer, specify type and site)				
Family member affected Please specifcy which side of the family ie: maternal/paternal				
Age at diagnosis				
Current age				
Age at death (if applicable)				

If you require more space to write, please use pages 27-29.

Once you have completed all health questions, please go to Section D (page 30).

Please use the next three pages if you require more space to answer any of the health questions.
Make sure you include the question number (e.g. Q8) and the participant's name.

SECTION D

Declaration

Declaration and authorisation to obtain and use information

I/We, the person(s) applying for this Accuro Health Insurance Plan, confirm that I/we:

1. Agree that this application and any other information obtained/provided about persons to be included on my/our plan forms the basis of the contract.
2. Declare that the information I/we have given is correct and complete and that no material fact has been omitted. I/We undertake to advise Accuro Health Insurance of any health condition or event that may affect me/us or any of the other people named in this application or any relevant information that may affect the policy between the date I/we sign this application and the date the policy commences with Accuro Health Insurance.
3. Declare that any information supplied in this application, whether written by me/us or not, is true and accurate and that I am/we are authorised, where any person insured is less than 18 years of age, to act on their behalf.
4. Have read and understand this declaration and authorisation and its applicability to the Privacy Act 2020 and Health Information Privacy Code 2020 (see below for further information).
5. Understand the nature of the plan(s) chosen and believe they meet my/our requirements.
6. Understand that, upon issuance of the membership certificate, I/we have fourteen (14) days to cancel my/our plan(s) (14-day free-look period) and that, subject to no claims having been made, I/we will receive a full refund.
7. Understand that, if the application is approved, cover will start from the date stated on the membership certificate issued by Accuro Health Insurance.
8. For the purpose of assessing this application and any future claims, authorise Accuro Health Insurance to request and obtain information and records about me/us and any other people in this application.
9. I/We authorise the following people to give you any such information and records:
   - Any doctor, medical specialist, health agency, hospital, the Accident Compensation Corporation or other relevant person, including another insurer or person relating to any other insurance held by me/us.

Privacy Act 2020 and the Health Information Privacy Code 2020

Each person applying for this Accuro Health Insurance plan should please note the following:

1. This proposal collects personal information about you and each other member named in this policy in connection with the insurance that is sought.
2. The intended recipient of that personal information is Accuro Health Insurance.
3. You have the right to access and request corrections subject to the provisions of the Privacy Act 2020. The information you provide us is stored with our trusted third party cloud storage providers located inside and outside New Zealand.
4. While Accuro Health Insurance intends to treat this information as confidential, there are some situations where we may need to disclose your personal information to a trusted third party to help us undertake the purposes detailed in our Privacy Policy.
5. By signing this declaration, you authorise the disclosure of the personal information of each member named in this policy (including any dependants) to third parties and any other member named in the policy:
   a) for statistical purposes (where not individually identified)
   b) for evaluation and assessment of claims under the policy that results from this application
   c) for providing on-going client service and information
   d) for any other matter related to the policy.
6. By signing this declaration, you also authorise Accuro Health Insurance or any agency authorised by Accuro Health Insurance to give and obtain your personal information, including your medical records, from other insurers and from medical practitioners. You agree this may include information relating to any other insurance applied for or obtained or claims previously made by you.

For more information, please refer to the Accuro Privacy Policy, available on our website.

Important information

1. This form represents an application by each person named below to become a member of Accuro Health Insurance and relates only to the plan(s) indicated.
2. Anything in this declaration purporting to the singular may, by inference, include the plural.
3. Accuro Health Insurance is the trading name of the Accuro Health Insurance Society Limited (as registered under the Industrial and Provident Societies Act 1908). By making this application, you are accepting the rules of the Society, including obligations therein, and understand that the rules may subsequently be changed. If you would like a copy of the current rules before making this application, please do not hesitate to ask.
4. Accuro Health Insurance is also a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008 and a licenced insurer under the Insurance (Prudential Supervision) Act 2010.
5. The Board of Directors of the Society reserves the right, at all times, to vary the terms and conditions and benefits of plans however it deems appropriate.
6. This application forms the basis of any contract that eventuates and must be filled in truthfully and accurately. All information requested as part of this application is voluntary but any non-disclosure may lead to underwriting when the information becomes known and claims relating to the non-disclosure being declined. If you have doubts, you should disclose the information to Accuro Health Insurance for determination of significance.
7. Premiums are subject to change on 21 days' notice.
8. Changes to Direct Debit payments normally require 10 days' notice. However, you may authorise a Direct Debit to occur earlier so that a payment can occur prior to this.

I/We acknowledge the information provided in this declaration, including in relation to my/our privacy, and accept the terms and conditions (including the limitations and exclusions) of the policy, including Accuro Health Insurance general policy terms and conditions.

Main member's name in full

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Participant's name in full (aged 18 years and over)

Signature Date signed: DD / MM / YY

Please be aware that you are required to advise Accuro Health Insurance of any new signs/symptoms or health condition for any applicant that arises between the date you sign the application form and the date the policy commences.

Financial strength rating

Accuro has achieved a **B** (Fair) AM Best financial strength rating.

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).

For more rating information, see **www.ambest.com/ratings/guide.pdf**

It is important that Accuro Health Insurance receives your application within 45 days of you signing this form or your application may become invalid.

SECTION E

Payment details

You don't need to complete this section if you are adding participants to an existing policy. If you are part of a group scheme and are adding on non-subsidised plans/participants, you will need to fill out this section.

Payment

Payment method ◯ Direct debit (there is a discount for paying by direct debit)* ◯ Credit/debit card ◯ Invoice**

Recurring payment frequency ◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Quarterly ◯ Six-monthly ◯ Annually (discount available)*

Preferred first date of payment DAY / MONTH / YEAR or ◯ as soon as possible

Credit/Debit Card

Name on card

Expiry date on card MONTH / YEAR

Card type ◯ Visa ◯ Mastercard

Please note that we only accept Visa or Mastercard.
We do not accept other cards such as American Express or Diners Club.

For security reasons, please do not provide your credit card number. Once we receive this form, we will phone you to obtain this information. Please remember, when your credit/debit card expires, you will need to call us on 0800 222 876 to update your credit/debit card details.

I/We authorise Accuro Health Insurance, until further notice in writing, to charge my/our credit/debit card account with all amounts due on my/our Accuro Health Insurance account from time to time, on or after the payment due date.

Cardholder signature

Date signed: DAY / MONTH / YEAR

Direct debit

Name of account

Customer (Acceptor) to complete bank/branch number and account number and suffix of account to be debited.

To the manager:

Bank name

I/We authorise you until further notice in writing to debit my/our account with you all amounts that Accuro Health Insurance (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 on the reverse of this form.

AUTHORITY TO ACCEPT DIRECT DEBITS

(not to operate as an assignment or agreement)
Authorisation Code

0	3	3	0	2	8	8

(User number)

The following information will appear on your bank statement:

Payer particulars	Accuro Health Insur
Payer code	Health cover
Payer reference	Your member number

Name of account (customer to complete)

Authorised signatures

Date signed: DAY / MONTH / YEAR

For bank use only

Approved		Date received	Recorded by	Checked by	Bank stamp
3028					
09	2018				

Original
Retain at branch

Copy
Forward to Initiator if requested

* This discount does not apply to group policies.
** This option is unable to be selected with a payment frequency of weekly or fortnightly.

Conditions of this authority to accept direct debit

1) **The Initiator:**

a) Undertakes to give notice of the commencement date, frequency and net amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months). This notice will be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

Where the Direct Debit system is used for the collection of payments which are regular as to frequency, but variable as to amount, the Initiator undertakes to provide the Customer 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 advance notice of at least 30 days before the change comes into effect. This notice must be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

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.

c) May, upon receiving written notice (dated after the date of this Authority) from a bank to which I/we have transferred my/our account, initiate Direct Debits in reliance of that written notice and this Authority from the account identified in the written notice.

2) The Customer may:

a) At any time, terminate this Authority as to future payments by giving notice of termination to the Bank and to the Initiator by the means agreed by me/us, 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 of alteration of Direct Debit back to the Initiator through the Initiator's Bank, PROVIDED such request is made not more than 120 days from the date when the Direct Debit was debited to my/our 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 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 dispute lies 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; and
- Any variations between notices given by the Initiator and the amounts of Direct Debit.

e) The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with 1(a), 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 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 signed 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

Checklist

Make sure you have:

- ◯ Answered all the questions.
- ◯ Provided additional information in the appropriate questionnaire if a question required you to provide more detail.
- ◯ Read and signed the declaration in Section D. (This must be signed by every person to be insured aged 16 and over.)

Payment details

- ◯ If paying by direct debit, please complete the form on page 31.
- ◯ If paying by credit/debit card, please complete the form on page 31.
- ◯ If additional participant(s) are being added to any existing policy, do not fill out Section E.

Attachments

- ◯ If you are providing any supporting documentation, please ensure it has been attached to this application.
- ◯ If any person is a non-resident, please attach a copy of their visa to this application.

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