Specialist plan
Short application form

accuro HEALTH INSURANCE

This form is to be used to apply for the Specialist plan for participants who have an existing Accuro Health Insurance SmartCare, SmartCare+, SmartStay or KidSmart policy. Once completed, please email to info@accuro.co.nz.

1 Policy details

Membership number	
Main member/ Guardian's full name	
Full names of all existing participants on the policy who wish to have the Specialist plan added Please include the Main member if they wish to have the Specialist plan added.	_____ _____ _____
Choose the excess you would like for the Specialist plan Please choose the excess that is applicable under the insurance product that you currently have.	SmartCare: ☐ $0 or ☐ $250 excess SmartCare+: ☐ $0 or ☐ $250 excess SmartStay: ☐ $0 excess KidSmart: ☐ $0 excess

2 Health disclosures

WARNING: You have an obligation to disclose all matters which may influence Accuro Health Insurance's decision to accept your application. If you fail to do so, we may decline your request, cancel any upgrade/change applied for, void your plan(s) from inception and/or decline any claim that you may make.

Please complete the below questions for all participants who wish to have the Specialist plan added.

You need to advise of any condition or event (including signs and symptoms) that has occurred, this includes before your cover with Accuro began as well as during your cover up until the date you sign the application.

Any exclusions will only apply to the Specialist plan, unless we are made aware of something that was missed on the original application.

Have you, or any of the participants to be insured ever experienced, had signs or symptoms of, been treated for, been advised to seek testing or treatment for, are currently receiving testing, treatment or counselling for, or have ever received counselling or investigations for the following:

2.1 Heart conditions Angina/chest pain, heart attack, heart failure, abnormal heart beat, arrhythmia, heart murmur or rheumatic fever?	○ No ◉ Yes
2.2 Raised blood pressure; raised or abnormal cholesterol Raised blood pressure or raised or abnormal cholesterol?	○ No ○ Yes
2.3 Breathing or respiratory disorders Shortness of breath, asthma, COPD, chest infections, pneumonia, bronchitis or emphysema?	○ No ○ Yes
2.4 Digestive disorders; stomach, intestine, liver or gall bladder problems Gastritis, reflux, irritable bowel, Crohn's disease, colitis, coeliac disease, bowel polyps, abdominal pain, pancreatitis, liver inflammation, fatty liver or cirrhosis?	○ No ○ Yes
2.5 Cancer, cysts, tumours or growths Polyps, benign growths, any cancers or pre-cancerous condition, suspicious moles, cysts, abscesses, ganglion, basal cell carcinoma or melanoma?	○ No ○ Yes

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

Back pain, neck/shoulder problems, scoliosis, fractures, osteoporosis, gout or inflammatory conditions or any disorders of the hips, knees, ankles, feet, toes, shoulders, arms, elbows, wrists, hands or fingers?

◯ No ◯ Yes

2.7 Blood, immune or circulatory disorders

Abnormal blood tests, anaemia or any autoimmune disorder or varicose veins, DVT or blood clots?

◯ No ◯ Yes

2.8 Endocrine (glandular) disorders

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?

◯ No ◯ Yes

2.9 Urinary or kidney disorders

Kidney or bladder problems, incontinence, urinary difficulties or kidney infections or recent and/or recurrent UTIs?

◯ No ◯ Yes

2.10 Anal/rectal problems

Change in bowel habit, anal fissures, anal bleeding or pilonidal sinus?

◯ No ◯ Yes

2.11 Skin problems

Eczema, dermatitis, rashes, psoriasis, acne or allergic conditions?

◯ No ◯ Yes

2.12 Brain or nervous system disorders

Aneurysms, migraine, repeated headaches, vertigo, fainting, dizziness, multiple sclerosis, epilepsy/seizures, paralysis, nerve pain or meningitis?

◯ No ◯ Yes

2.13 Fatigue or pain syndromes

Chronic fatigue, fibromyalgia or chronic pain syndrome?

◯ No ◯ Yes

2.14 Eye, ear or throat problems

Glaucoma, hearing loss, tinnitus, recent and/or recurrent ear infections or recent and/or recurrent throat infections?

◯ No ◯ Yes

2.15 Allergies, nasal and/or sinus problems

Nasal obstruction, hay fever, sinusitis or recent and/or recurrent sinus infections?

◯ No ◯ Yes

2.16 Mental health conditions

Any psychiatric or psychological condition, including anxiety, stress or depression?

◯ No ◯ Yes

2.17 To be completed by males only

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?

◯ No ◯ Yes

2.18 To be completed by females only

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?

◯ No ◯ Yes

2.19 Other conditions

Any other illness, accident, injury, condition, complaint, disability, medication or disorder not already stated?

◯ No ◯ Yes

Has anyone:

- 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?

◯ No ◯ Yes

- had more than five consecutive days off work or school in the past five years due to any condition not already stated?

◯ No ◯ Yes

If you have answered 'Yes' to any of the questions in this section, then please give full details on each medical condition in the next section (Section 3 - Details of health disclosures). You will need to complete an answer box with the full details of each medical condition that you have advised of, for all participants who wish to add the Specialist plan.

If we require any further information, we will get in contact with you.

3 Details of health disclosures

If you have answered 'Yes' to any of the questions in the Health disclosures section, then please give full details on each medical condition in one of the answer boxes below. Remember to include the question number and also the participant's name. If there is not enough space or you require more answer boxes then please attach additional pages.

Question number:_____ Participant's name: _____

Please advise the name of the medical condition.	
When did you first experience symptoms?	DAY / MONTH / YEAR
Describe the symptoms.	
When did you last experience any symptoms?	DAY / MONTH / YEAR or ◯ 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 _____
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:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?

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If you require more space to write, please supply the details on a seperate page and attach to this form.

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4 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 updated 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 are authorised, as the main member/ guardian, including where any person insured is less than 16 years of age, to act on the participants' behalf.
4. Have read and understand this declaration and authorisation and its applicability to the Privacy Act 1993 and Health Information Privacy Code 1994 (see below for further information).
5. Understand the nature of the Specialist plan and believe it meets my/our requirements.
6. Understand that, upon issuance of the revised membership certificate, I/we have fourteen (14) days to cancel my/our Specialist plan (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. 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 1993 and the Health Information Privacy Code 1994

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 plan 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 1993. This information will be held at our head office.
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 third party.
5. By signing this declaration, you authorise the disclosure of the personal information of each member named in this plan (including any dependants) to third parties and any other member named in the plan:
   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 agreeing to 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.

Important information

1. This form represents an application by each person named above to add the Specialist plan.
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 Health Service Welfare Society Limited (as registered under the Industrial and Provident Societies Act 1908)..
4. Accuro Health Insurance is also a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008.
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. Applicants are obliged, beyond that which is requested, to volunteer information that would have a material impact on the cover offered. 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.

Main member/ guardian's name in full

Date DD / MM / YY

☐ By checking this box:
- I confirm that, as the main member/ guardian of the policy, I am authorised to act on behalf of all participants on the policy.
- I accept the terms and conditions (including the limitations and exclusions) of the policy, including Accuro Health Insurance general policy terms and conditions.
- I confirm the information provided to be correct and complete.

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+** (Stable) 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.