

# Group Member change and application

2602K v1.2



**If your policy number starts with PL, this is your form.**

This form is for Members on SmartCare, SmartCare+, StaffCare, StaffCare+, StaffStay and other Health Plans or group insurance schemes originally issued under the Accuro brand.



For use only in nominated group insurance schemes. This application must be submitted during the eligibility period for your group insurance scheme; otherwise, underwriting may be required. Applicants must select the Health Plan for which they are eligible, based on their citizenship, residency, or visa status at the time of application.

Return your completed form to us at [contact@unimed.co.nz](mailto:contact@unimed.co.nz).

## 1. Group details

### Name of group/employer

I am:  joining a group scheme, date employed   leaving a group scheme

## 2. Details of Primary Member

### Title

Mr  Mrs  Miss  Ms  Mx  Other (please specify):

### Full name

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Gender**

Male  Female  Male  Female  Another:

### Address

Street

Town/city

Postcode

**Home phone number**

**Mobile phone number**

### Email

#### Joining a group:

I would like to take the employer-paid modules only

I would like to take out additional modules which I will pay for myself

#### Leaving a group:

I would like to take the same cover as before

I am changing my cover to the modules selected below

### 3. Health Plan details

#### Please choose a base plan

StaffCare Hospital and Surgical base plan  
StaffCare+ Hospital and Surgical+ base plan  
Other (please specify):

#### Choose your excess

\$0      \$250      \$500  
\$1,000      \$2,000

#### Once you have selected your base plan, you can add modules

Specialist module – excess      \$0      \$250  
GP module      Natural Health module      Dental and Optical module

### 4. Additional Members to be insured

**Note:** To be included on your policy, your children must be under 25 years of age.

#### Additional Member 1

##### Title

Mr      Mrs      Miss      Ms      Mx      Other (please specify):

##### Full name

First name(s)

Last name

Date of birth (dd/mm/yy)

Sex at birth

Gender

Male      Female      Male      Female      Another:

##### Relationship to Primary Member

##### Hospital and Surgical excess

\$0      \$250      \$500      \$1,000      \$2,000

##### Add module/s

Specialist module – excess      \$0      \$250  
GP module      Natural Health module      Dental and Optical module



### Additional Member 2

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Gender**

Male Female Male Female Another:

**Relationship to Primary Member**

**Hospital and Surgical excess**

\$0 \$250 \$500 \$1,000 \$2,000

**Add module/s**

Specialist module – excess \$0 \$250

GP module Natural Health module Dental and Optical module

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### Additional Member 3

**Title**

Mr Mrs Miss Ms Mx Other (please specify):

**Full name**

First name(s)

Last name

**Date of birth** (dd/mm/yy)

**Sex at birth**

**Gender**

Male Female Male Female Another:

**Relationship to Primary Member**

**Hospital and Surgical excess**

\$0 \$250 \$500 \$1,000 \$2,000

**Add module/s**

Specialist module – excess \$0 \$250

GP module Natural Health module Dental and Optical module

## 5. Declaration and authorisation

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

1. I declare that all the information provided in this Application is true, correct and complete and that I have not omitted or misrepresented any information.
2. I understand that I need to include in this Application all information requested, even if I have already shared this information with a representative of UniMed or with my Adviser.
3. I understand that this Application is not a guarantee of cover and cover will not commence until the policy start date listed on the Membership Certificate issued by UniMed.
4. I understand that this Application and any policy issued is subject to the UniMed Terms and Conditions or the Terms and Conditions contained within the Health Plan document, and to the UniMed Rules.
5. I authorise UniMed to obtain from any person or organisation any further information required to assess this Application or future claims, and I authorise those persons or organisations to disclose such information to UniMed. This may include, but is not limited to, obtaining details regarding previous medical history and previous health insurance.

The personal and health information about you and those covered under your Health Plan is collected for the purpose of evaluating your Application.

If your Application is approved then this information will be used by us to help you access our products and services, including administering your policy and associated claims.

Please refer to our Privacy Statement for more information about how your information will be used, our privacy practices, and your associated rights – [unimed.co.nz/privacy](http://unimed.co.nz/privacy).

**I have read and agree to the Declaration.**

**I am authorised by all persons listed in this Application to submit this Application on their behalf and I confirm they are aware the information I provide will be disclosed to UniMed.**

**Primary Member full name**

**Signature**

**Date signed (dd/mm/yy)**

### Financial strength rating

UniMed has an **A (Excellent)** Financial Strength Rating from AM Best.

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).

**IT IS IMPORTANT THAT YOU RETURN THIS FORM WITHIN 45 DAYS OF YOU SIGNING OR IT MAY BECOME INVALID.**