

Please complete all the details of the mandatory sections relevant to you

- ☐ I am a current Subscriber
☐ I am a Family/Whanau non union Subscriber

☐ I am a new Subscriber

HCP Ref : (For office use only)

Union: _____

☐ Linked through (name): _____ at non union rate.

His/Her HCP Ref: _____

HealthCarePlus POLICY REQUIRED: (tick as appropriate)

- ☐ Subscriber ☐ Subscriber & Partner ☐ Subscriber & Children ☐ Subscriber, Partner & Children

Plus 'Hospital Cover' – There are separate forms required for Hospital Cover. Please ask your HealthCarePlus Representative.

Hospital Cover Provider: _____ Specialist & Tests Y / N

Policy Name: _____ HealthCarePlus Representative (if known): _____

SUBSCRIBER & FAMILY MEMBER DETAILS (children must be under 21 years)

	Title	Surname	Given Names	Sex	DOB	Plan Type HCP / Hos
Subscriber					/ /	✓
Partner					/ /	
Child 1					/ /	
Child 2					/ /	
Child 3					/ /	
Child 4					/ /	
Child 5					/ /	

SUBSCRIBER: ADDITIONAL DETAILS

Postal Address: _____

Postcode: _____

Home Phone: (0) _____ Work Phone: (0) _____ Mobile: (0) _____

Preferred Email: _____

Alternative Email: _____

Place of Work: _____

DECLARATION & COMMENCEMENT OF COVER (tick as appropriate)

- ☐ The rate/new rate will be \$_____ which I understand is subject to review in accordance with the Primary Care Policy wording.
- ☐ I understand my/our **HealthCarePlus Primary Care** cover will commence from the date of the first direct debit of premium from my bank. **(Fortnightly direct debits are deducted every second Wednesday in conjunction with HealthCarePlus payroll dates. Monthly direct debits are deducted on the first business day of the month.)**
- ☐ I have attached my completed direct debit form.
(Direct debit forms can be downloaded at www.healthcareplus.org.nz or Freephone 0800 800 441.)
- ☐ I declare that I am a full financial member of the above named union.
- ☐ I declare that I am linked as Family/Whanau/non union.
- ☐ I confirm that I am authorised by each person named in this application form to complete and sign on their behalf.
- ☐ I consent to receiving all documentation that HealthCarePlus is required by law to give to me in electronic form and I consent to HealthCarePlus communicating with me via the preferred email address specified in this application form.
- ☐ In completing and submitting this form I consent to the collection, disclosure and use of my/our information in accordance with the Privacy Act 1993, the Health Information Privacy Code and the HealthCarePlus Privacy Statement which is available at <http://healthcareplus.org.nz/Privacy+Statement>. I also consent to the collection, disclosure and use of my/our information for the purposes of the Integrity Register and as set out in the HealthCarePlus Privacy Statement.
- ☐ I declare that the information provided in this form is true and correct. This application is for cover under the Primary Care Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

Subscriber's Signature: _____ Date: ____/____/____

Financial Strength: Education Benevolent Society Incorporated trading as HealthCarePlus has a B++ (Good) financial strength rating from A.M. Best Company Inc. of New Jersey, United States of America. A.M. Best is an approved insurance rating agency in terms of the Insurance (Prudential Supervision) Act 2010.

Secure Ratings						Vulnerable Ratings						
A++	A+	A	A-	B++	B+	B	B-	C++	C+	C	C-	D
Superior		Excellent		Good		Fair		Marginal		Weak		Poor

Primary Care Benefits: Primary Care offers reimbursements towards day-to-day health care costs. The following is a brief outline of the benefits Primary Care has to offer. Please refer to our online Policy Document for full conditions applicable to each benefit at www.healthcareplus.org.nz

Optical: 50% of the net cost of an eye examination, glasses/lenses due to a change in vision, to a maximum of \$250 a year each for Subscriber, partner and children (maximum total \$750) - providing subscriptions have been paid for six months prior to the date of the optical examination.

"Please Note - The effective date for the optical benefit is the date of the eye examination, NOT the date the lenses/glasses are purchased or supplied."

Medical Treatment: 50% of the net cost of doctors' fees and prescription charges (\$10 per item limit applies) to a maximum of \$750 a year each for Subscriber, partner and children (maximum total \$2250).

Complementary Medical: (e.g., homeopathic, fertility treatment) 50% of the net cost of specified expenses to a maximum of \$400 a year each for Subscriber, partner and children (maximum total \$1200).

Hospital Expenses: 50% of the net cost to a maximum of \$700 a year each for Subscriber, partner and children (maximum total \$2100).

Standard \$500 Excess Reimbursement:* is available to HealthCarePlus linked and approved Hospital Cover policies only (dental related oral surgery is excluded).

Major Diagnostic: 50% of the net cost of CAT & MRI scans and Angiograms to a maximum of \$600 a year each for Subscriber, partner and children (maximum total of \$1,800) - providing subscriptions have been paid for six months prior to the date of the procedure.

Medical Appliance: 50% of the net cost of specified items (e.g., hearing aids) to a maximum of \$400 a year each for Subscriber, partner and children (maximum total \$1200).

Orthodontic: 30 percent of orthodontic and associated fees to a maximum of \$750 per registered child. The maximum benefit payable for the duration of the Subscribers' membership is \$1,500

Sick Leave Without Pay: \$50 per week plus \$5 for each child to a maximum of \$60 per week for 26 weeks.

Birth: \$200 for each live child born to a Subscriber or partner.

Bereavement: \$1000 on the death of a Subscriber, registered partner or child (including still birth).

Entitlements cannot be aggregated to allow more than the annual maximum per adult or child.

** Hospital Cover excess is available to HealthCarePlus linked and approved Hospital Cover policies only.*

*HealthCarePlus Primary Care rates are based on the age of the Subscriber. **Please note that rates may change from time to time; check with your HealthCarePlus Representative, our website, or HealthCarePlus before making a decision.** Hospital Cover rates are additional to the Primary Care rates and are available on request, please call 0800 268 3763.

Primary Care rates – effective 29 March 2017

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	6.09	13.19	158.26	13.81	29.92	359.09	13.08	28.35	340.18	18.56	40.21	482.58
46-60	7.10	15.37	184.47	17.19	37.25	446.99	14.36	31.12	373.42	22.77	49.33	591.99
61-65	8.81	19.09	229.10	20.78	45.02	540.26	14.60	31.64	379.66	24.23	52.50	629.96
66-99	10.57	22.89	274.70	24.00	51.99	623.94	16.05	34.77	417.20	27.26	59.06	708.68

Primary Care Non Union rates (conditions apply) – effective 29 March 2017

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	6.70	14.51	174.08	15.19	32.92	395.00	14.39	31.18	374.20	20.42	44.24	530.83
46-60	7.80	16.91	202.92	18.91	40.97	491.69	15.80	34.23	410.76	25.05	54.27	651.18
61-65	9.69	21.00	252.00	22.98	49.78	597.41	16.06	34.80	417.63	26.65	57.75	692.96
66-99	11.62	25.18	302.17	26.40	57.19	686.34	17.65	38.24	458.91	29.98	64.96	779.54