

MOE Employee Number (if applicable)

UniMed Ref : (For office use only)

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

- I am a current Member I am a new Member
 I am a Family/Whanau non union Member

Union: _____

Linked through (name): _____ at non union rate. His/Her UniMed Ref: _____

HealthCarePlus POLICY REQUIRED: (tick as appropriate)

- Member Member & Partner Member & Children Member, 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): _____

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

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

MEMBER: 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 #care4U Policy wording.
- I understand my/our **HealthCarePlus #care4U** cover will commence from the date of my first fortnightly salary deduction of premium. (n/a PSA members or a non Novopay payroll)
- I understand my/our **HealthCarePlus #care4U** cover will commence from the date of the first direct debit of premium from my bank.
- I have attached my completed direct debit form.
(Direct debit forms can be downloaded at www.healthcareplus.org.nz or Freephone 0800 600 666.)
- 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 in electronic form and I consent to receiving communications to 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 Privacy Statement contained in the UniMed/HealthCarePlus Conditions of Membership. I also consent to the collection, disclosure and use of my/our information for the purposes of the Integrity Register.
- I declare that the information provided in this form is true and correct. This application is for cover under the #care4U Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

Member's Signature: _____ **Date:** ____ / ____ / ____

Authority to make HealthCarePlus deductions from salary (n/a PSA members or a non Novopay payroll)

Surname: _____ Given Names: _____

Worksite: _____ This is a new authority This replaces an existing authority

I authorise you to deduct \$_____ (or such other amount from time to time determined by UniMed) from my salary

Financial Strength: Union Medical Benefits Society Limited (UniMed) has been given an A (Excellent) insurer financial rating by AM Best. AM Best's ratings are as follows:
 Secure: A++, A+ (Superior); A, A- (Excellent); B++, B+ (Good)
 Vulnerable: B, B- (Fair); C++, C+ (Marginal); C, C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Suspended)



#care4U Benefits: #care4U offers reimbursements towards day-to-day health care costs. The following is a brief outline of the benefits #care4U has to offer. Please refer to our online Policy Document for full terms and conditions applicable to each benefit at www.healthcareplus.org.nz

Dental: 50% of the net cost of dental consultations and minor treatment to a maximum of \$250 a year each for Member, partner and children (maximum total \$750).

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 Member, 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 \$250 a year each for Member, partner and children (maximum total \$750).

Complementary Medical: (e.g., homeopathic, fertility treatment) 50% of the net cost of specified expenses to a maximum of \$250 a year each for Member, partner and children (maximum total \$750).

*HealthCarePlus #care4U rates are based on the age of the Member. **Please note that rates may change from time to time.** Hospital Cover rates are additional to the #care4U rates and are available on request, please call 0800 268 3763.

#care4U rates – effective 1 April 2019

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	7.31	15.84	190.09	15.81	34.26	411.18	15.29	33.12	397.42	22.15	48.00	575.95
46-60	8.05	17.43	209.18	18.28	39.60	475.17	16.22	35.13	421.62	25.22	54.63	655.61
61-65	9.29	20.14	241.66	20.89	45.26	543.07	16.39	35.51	426.15	26.28	56.94	683.25
66-99	10.57	22.90	274.86	23.23	50.33	603.99	17.44	37.79	453.48	28.48	61.71	740.55

#care4U non union rates (conditions apply) – effective 1 April 2019

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	7.75	16.80	201.60	16.82	36.44	437.32	16.24	35.18	422.18	23.50	50.92	611.08
46-60	8.56	18.55	222.60	19.53	42.31	507.71	17.26	37.40	448.79	26.87	58.22	698.70
61-65	9.94	21.53	258.34	22.49	48.72	584.68	17.45	37.82	453.79	28.04	60.76	729.11
66-99	11.34	24.57	294.86	24.98	54.12	649.41	18.61	40.32	483.85	30.47	66.01	792.15

HealthCarePlus is administered and underwritten by Union Medical Benefits Society Ltd (UniMed). Any cover issued in response to this application is subject to the terms and conditions contained in the relevant policy documentation and UniMed/HealthCarePlus Conditions of Membership. UniMed, PO Box 1721, Christchurch 8140. Level 3, 165 Gloucester Street, Christchurch 8011.

P 03 365 4048 FP 0800 600 666 F 03 365 4066 E sales@unimed.co.nz W www.unimed.co.nz

18 February 2019