

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

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

I am a new Member

UniMed Ref : (For office use only)

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					/ /	
Child 5					/ /	

**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 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.
- I have attached my completed direct debit form.  
**(Direct debit forms can be downloaded at [www.healthcareplus.org.nz](http://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 2020, 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 Primary Care Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

**Member's Signature:** \_\_\_\_\_ **Date:**    /    /

**Financial Strength Rating:** Union Medical Benefits Society Limited (UniMed) has been given an A (Excellent) Financial Strength 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)



**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](http://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 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 \$750 a year each for Member, 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 Member, partner and children (maximum total \$1200).

**Hospital Expenses:** 50% of the net cost to a maximum of \$700 a year each for Member, 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 Member, 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 Member, 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 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 Member or partner.

**Bereavement:** \$1000 on the death of a Member, 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 Member. **Please note that rates may change from time to time.** Hospital Cover rates are additional to the Primary Care rates and are available on request, please call 0800 268 3763.

**Primary Care rates – effective 1 April 2021**

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	7.05	15.28	183.34	15.85	34.34	412.04	15.01	32.53	390.35	21.20	45.92	551.08
46-60	8.18	17.72	212.68	19.63	42.54	510.44	16.40	35.53	426.42	25.87	56.06	672.75
61-65	10.31	22.33	268.00	24.07	52.16	625.94	16.92	36.66	439.88	27.94	60.53	726.37
66-99	12.60	27.29	327.53	28.34	61.41	736.87	18.95	41.06	492.71	32.04	69.41	832.97

**Primary Care Non Union rates (conditions apply) – effective 1 April 2021**

Age	Single			Couple			One Parent Family			Two Parent Family		
	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	7.76	16.81	201.67	17.43	37.77	453.25	16.51	35.78	429.39	23.31	50.52	606.19
46-60	9.00	19.50	233.96	21.60	46.79	561.49	18.04	39.09	469.07	28.46	61.67	740.03
61-65	11.34	24.57	294.79	26.48	57.38	688.53	18.61	40.32	483.86	30.73	66.58	799.00
66-99	13.86	30.02	360.26	31.18	67.55	810.56	20.85	45.16	541.98	35.24	76.36	916.27

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](mailto:sales@unimed.co.nz) W [www.unimed.co.nz](http://www.unimed.co.nz)

01 April 2021