HealthCare
It's good to belong

#care4U Application

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	Plan Type 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 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 #care4U Policy in accordance with the relevant policy wording and the declarations and commencement of cover set out above.

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

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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 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)

#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 atwww.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 2023

	Single			Couple			One Parent Family			Two Parent Family		
Age	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	8.15	17.65	211.86	17.63	38.19	458.30	17.04	36.91	442.95	24.69	53.50	641.95
46-60	8.97	19.43	233.15	20.37	44.13	529.62	18.07	39.16	469.94	28.10	60.89	730.73
61-65	10.36	22.45	269.36	23.28	50.44	605.29	18.27	39.58	474.97	29.29	63.46	761.54
66-99	11.78	25.53	306.35	25.89	56.10	673.20	19.44	42.12	505.43	31.75	68.78	825.40

#care4U non union rates (conditions apply) – effective 1 April 2023

	Single			Couple			One Parent Family			Two Parent Family		
Age	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual	Fortnight	Month	Annual
00-45	8.89	19.27	231.25	19.29	41.80	501.63	18.63	40.35	484.26	26.96	58.41	700.93
46-60	9.82	21.28	255.34	22.40	48.53	582.37	19.80	42.90	514.78	30.82	66.79	801.44
61-65	11.40	24.69	296.33	25.79	55.89	670.65	20.02	43.38	520.51	32.17	69.69	836.32
66-99	13.01	28.18	338.22	28.65	62.07	744.90	21.35	46.25	555.01	34.95	75.72	908.62