

3 Details of spouse/partner

Title Mr Mrs Miss Ms Other Date of birth ____/____/____
dd mm yy

Family name _____

First name(s) _____ Female Male

Height ____ m/ft Weight ____ kg/st Have you smoked in the last 12 months? No Yes

Occupation _____

Name of your usual GP _____

Name of your GP's practice _____

4 Details of other participants Participants include dependants/whāngai and parents.

To be included under the plan(s), your child(ren) must be under 25 years of age.

Child 1 Family name _____ First name(s) _____

Male Female Date of birth ____/____/____
dd mm yy

Name of your usual GP _____

Name of your GP's practice _____

Child 2 Family name _____ First name(s) _____

Male Female Date of birth ____/____/____
dd mm yy

Name of your usual GP _____

Name of your GP's practice _____

Child 3 Family name _____ First name(s) _____

Male Female Date of birth ____/____/____
dd mm yy

Name of your usual GP _____

Name of your GP's practice _____

Parent 1 Family name _____ First name(s) _____

Male Female Date of birth ____/____/____
dd mm yy

Height ____ m/ft Weight ____ kg/st Have you smoked in the last 12 months? No Yes

Occupation _____

Name of your usual GP _____

Name of your GP's practice _____

Parent 2 Family name _____ First name(s) _____

Male Female Date of birth ____/____/____
dd mm yy

Height ____ m/ft Weight ____ kg/st Have you smoked in the last 12 months? No Yes

Occupation _____

Name of your usual GP _____

Name of your GP's practice _____

5 Health declaration

Pre-existing conditions are not covered unless they have been declared by you in this health declaration section and specifically accepted by **Accuro Health Insurance**. Conditions arising between signing the application form and the cover start date will equally be deemed to be pre-existing. Therefore, it is important that you advise us of any changes to the information provided between submission of this application and acceptance by us.

You are hereby obliged on request to provide any further information that we might require.

Only **pre-existing conditions** that have been declared on the application form and specifically accepted by **Accuro Health Insurance** will be covered.

Have you or any person named in the application ever displayed evidence of, or had any sign(s) or symptom(s) of and/or consulted a healthcare provider for any of the following:

5.1	Respiratory system	Respiratory conditions/diseases including asthma, bronchitis, emphysema and smoking-related conditions (If yes, please complete the respiratory disorders questionnaire in section 6.1.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.2	Digestive	Digestive tract conditions/diseases including bowel or digestive disorders, ulcers, reflux, polyps, irritable bowel syndrome, ulcerative colitis, haemorrhoids and rectal/anal bleeding	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.3	Musculoskeletal	Spinal or skeletal conditions/diseases including bone, muscle, disc, joint and ligament disorders, arthritis and rheumatism (If yes, please complete the musculoskeletal disorders questionnaire in section 6.2.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.4	Circulatory	Circulatory disorders including lymphatic system, bleeding disorders, anaemia, B12 deficiency, genetic or acquired blood conditions, arterial or venous diseases including varicose veins/ulcers	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.5	Endocrine	Conditions/diseases of the endocrine system including diabetes, pancreas, thymus, thyroid, adrenal, testes, ovaries and pituitary glands (If yes to diabetes, please complete the diabetes questionnaire in section 6.3.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.6	Otolaryngology	Conditions/diseases of the ear, nose and/or throat including sinusitis, hayfever, tonsillitis/enlargement of adenoids, ear conditions/deafness, uvula and palate conditions (If yes, please complete the ear, nose and throat disorders questionnaire in section 6.4.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.7	Eyes	Conditions/diseases including visual defects - long or short sightedness, cataracts, glaucoma, retinal conditions and macular degeneration	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.8	Cardiac	Cardiac conditions including chest pain, angina, artery disease, valve disease, rheumatic heart disease, heart failure (If yes, please complete the cardiac questionnaire in section 6.5.)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.9	Oral	Oral surgery conditions/diseases of the jaw, mouth or teeth including over/under bite, gum disease, wisdom teeth and apicectomy	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.10	Urinary	Excretory system conditions/disease of the kidney, renal tract including ureter, bladder or urethra, incontinence and kidney stones	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.11	Men's health	Men's health including conditions of the prostate, elevated PSA, undescended testes and other testicular conditions	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
5.12	Women's health	Women's health and menstrual disorders - pain or irregular bleeding, abnormal smears, endometriosis, infertility, complications of pregnancy and gestational diabetes, pelvic disease and breast conditions/pain	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

5.13	Skin	Skin conditions/disorders including eczema, rosacea, acne, moles and psoriasis	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.14	Nervous system	Nervous system neurological conditions including headache, epilepsy, migraine, TIA, stroke, Parkinson's, meningitis and tinnitus	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.15	Hypertension/ Cholesterol	High blood pressure and/or raised cholesterol (If yes, please complete the high blood pressure and/or raised cholesterol questionnaire in section 6.6.)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.16	Cancer	Cancer, tumour (malignant or benign), cyst, breast lump, moles, skin or any other lesion, abscess or ulcer (If yes, please complete the cysts, lesions or tumours questionnaire in section 6.7.)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.17	General	Allergies, external or systemic	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.18		Accidents/accidental injuries with or without treatment	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.19		Congenital conditions and/or development conditions (include genetic conditions)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.20	Other	Any symptoms, signs or conditions not already disclosed, for example (without limitation) rheumatic fever, hepatitis, human papilloma virus, tuberculosis, hernia and pelvic inflammatory disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Is any person named in this application:

5.21	Currently taking any medication or under regular medical treatment or supervision?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.22	Currently awaiting the completion or results of any medical investigation?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
5.23	Intending to seek or currently seeking any medical advice, examination or procedure?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

6 Health condition details

If you answered yes to any of the questions (1-23) in the health declaration, please give all necessary details below or complete the relevant questionnaire. **If there's not enough space on the form, please provide your details on a separate sheet.**

<input type="checkbox"/>	Question number	Name of condition _____	Person's name _____
		Date first diagnosed _____	Duration of condition _____
			Date of full recovery _____
	Symptoms (type, frequency and severity)	_____	

	Investigation/treatment (tests, surgery, drugs/medication etc)	_____	

Have you ever been hospitalised or had any time off work/school as a result of this condition? No Yes

<input type="checkbox"/>	Question number	Name of condition _____	Person's name _____
		Date first diagnosed _____	Duration of condition _____
			Date of full recovery _____
	Symptoms (type, frequency and severity)	_____	

	Investigation/treatment (tests, surgery, drugs/medication etc)	_____	

Have you ever been hospitalised or had any time off work/school as a result of this condition? No Yes

Question number

Name of condition _____ Person's name _____

Date first diagnosed _____ Duration of condition _____ Date of full recovery _____

Symptoms (type, frequency and severity) _____

Investigation/treatment (tests, surgery, drugs/medication etc) _____

Have you ever been hospitalised or had any time off work/school as a result of this condition? No Yes

Question number

Name of condition _____ Person's name _____

Date first diagnosed _____ Duration of condition _____ Date of full recovery _____

Symptoms (type, frequency and severity) _____

Investigation/treatment (tests, surgery, drugs/medication etc) _____

Have you ever been hospitalised or had any time off work/school as a result of this condition? No Yes

6.1 Respiratory disorders

Person's name _____

Have you ever suffered any of the following? Asthma Bronchitis Other respiratory conditions (please name)

Date of last symptoms _____

Describe the treatment you have received _____

How frequent are the symptoms? _____ per month/per year (delete one)

Have you ever been referred to a specialist for treatment or investigation? No Yes (If yes, please provide details including name of specialist, the result of the treatment/investigation or provide a copy of the report.)

How would you describe your symptoms? Mild Moderate Severe

Have you ever been prescribed steroids? No Yes (If yes, please provide details including frequency and last occasion.)

Have you ever been hospitalised as a result of your disorder? No Yes (If yes, please provide details including last occasion.)

6.2 Musculoskeletal disorders

Person's name _____

Name of condition _____

What limbs are affected? _____

When did you first suffer from this condition? _____

How severe is/was the pain? Mild Moderate Severe

Do you have current symptoms and what is the date and frequency of these symptoms? _____

Do you or have you ever had pain, numbness, or pins and needles in your arms, shoulders, buttocks or legs? No Yes (If yes, please provide details.) _____

Have you had any special investigations, X-rays, MRI, CT scans or surgery? No Yes (If yes, please provide details.) _____

Have you ever had any time off work or school as a result of this condition? No Yes (If yes, please provide details.) _____

Are you awaiting investigations, treatment or surgery, have you been referred to a specialist or has one been suggested to you? No Yes (If yes, please provide details.) _____

6.3 Diabetes

Person's name _____

When were you diagnosed with diabetes? _____

What type of diabetes do you have? _____

Have you been referred to a specialist for treatment or investigation? No Yes (If yes, please provide details including name and address of specialist, the result of the treatment/investigation or provide a copy of the report.) _____

Please provide the dates and results of your last three blood sugar tests (your most recent first)

1 _____

2 _____

3 _____

What is your current treatment regime (please include dosage, type etc)? _____

Has this treatment changed during the last five years? No Yes (If yes, please provide details.) _____

Have you ever had complications (including but not limited to diabetic coma, insulin shock and kidney disease)? No Yes (If yes, please provide details.) _____

6.4 Ear, nose and throat disorders

Person's name _____

Have you ever suffered any of the following? Nasal blockage Polyps Hay fever/Rhinitis Sinusitis
Upper chest infection Tonsillitis Adenitis Ear disorders

Date of last symptoms _____

Describe the treatment you have received _____

How frequent are the symptoms? _____ per month/per year (delete one)

Have you been referred to a specialist for treatment or investigation? No Yes (If yes, please provide details including name of specialist, the result of the treatment/investigation or provide a copy of the report.)

How severe is/was the pain? Mild Moderate Severe

Have you ever been prescribed antibiotics? No Yes (If yes, please provide details including condition, frequency and date.)

Have you suffered any hearing loss? No Yes N/A

Have you ever had grommets inserted? No Yes N/A (If yes, please provide details including if they are still inserted.)

6.5 Cardiac

Person's name _____

Name of condition _____

How old were you when you first suffered the condition? _____

What treatment, investigation or surgery did you have? _____

Are there any residual effects? No Yes (If yes, please provide details.) _____

Have you been referred to a specialist for treatment or investigation? No Yes (If yes, please provide details including name of specialist, result of the treatment/investigation or provide a copy of the report.) _____

Please give details of any ongoing treatment or medication required _____

6.6 High blood pressure and/or raised cholesterol

Person's name _____

Name of condition _____

When were you first treated for this condition? _____

What is your current medication? _____

Has your treatment changed in the last 12 months? No Yes (If yes, please provide details and reason.) _____

How often is your condition checked? _____

Please provide the dates and results of your last three blood pressure and cholesterol readings (your most recent first)

1 _____

2 _____

3 _____

Have you ever been referred to a specialist for treatment or investigation? No Yes (If yes, please provide details including date, treatment and dosage.) _____

6.7 Cysts, lesions or tumours

Person's name _____

Type, location and histology of the condition Malignant or pre-malignant _____

Benign _____

Unknown _____

How long ago was the initial diagnosis made? _____ (years/months)

Have you received any treatment in the last three years? No Yes (If yes, please provide details.) _____

Has there been any recurrence? No Yes (If yes, please provide details.) _____

Have you seen a specialist, do you require any ongoing follow-up treatment or has follow-up/further treatment been recommended? No Yes (If yes, please provide details.) _____

7 Premiums Which method would you like to use for payment of your premiums?

Direct debit Premiums will be debited from your nominated account. Please complete the attached direct debit form.

Cheque (annually) All cheques must be made out to 'Accuro Health Insurance'. Please ensure the name of the main member (as declared in section 2 of this form) is clearly stated on the reverse of the cheque. Please attach the cheque to this application form.

Credit card (annually) Visa MasterCard Card number

Cardholder's name _____ Expiry date month _____ year _____

Cardholder's signature _____ Amount of premium \$ _____ annually

8 Declaration Please read carefully before signing.

Information for applicants

Under the Insurance Companies Act 1994, Accuro Health Insurance is not required to have a rating because it provides health insurance only and, accordingly, it has elected not to be rated.

Declaration and authorisation to obtain and use information

I/We, the person applying for this Accuro Health Insurance plan, confirm that I/we:

1. Agree that this application and any other information obtained/provided about persons to be included on my/our plan forms the basis of the contract.
2. Declare that the information I/we have given is correct and complete and that no material fact has been omitted. I/We undertake to advise Accuro Health Insurance of any health condition or event that may affect me/us or any of the other people named in this application, or any relevant information that may affect the policy between the date I/we sign this application and the date I/we receive a membership certificate from Accuro Health Insurance.
3. Declare that, if I/we have not completed in my/our own handwriting the sections in this application that relate to me/us, I/we have read the details and approve them, and no material information has been withheld.
4. Have read and understood this declaration and authorisation, the applicability of the Privacy Act 1993 and Health Information Code 1994 to this application, the contents of the brochure describing the plan(s) and the pre-existing condition exclusion.
5. Understand the nature of the plan(s) I/we have chosen and that it/they meet(s) my requirements.
6. Understand that, once the certificate of membership has been issued, I/we will have fourteen (14) days from the date I/we receive it to confirm the plan is to my/our satisfaction and that subscriptions paid will be refunded should I/we cancel the plan within the 14-day "free look" period, provided that, during this period, no claim has been made in respect of any person covered by this application.
7. Understand that, if the application is approved, cover will start from the date stated on the membership certificate issued by Accuro Health Insurance.
8. For the purpose of investigating and assessing this application and future claims, I/we authorise Accuro Health Insurance to request and obtain information and records about me/us and any other people named in this application from the following persons, and direct and authorise those persons to give you the information and records:
 - Any doctor, medical specialist, health agency or hospital or Accident Compensation Corporation or other relevant person, as applicable to the nature of the application or claim.
 - Other insurers or other persons relating to any insurance held by me/us.
9. In relation to any other people named in this application, on their behalf, I/we confirm that:
 - I/we am/are authorised to complete the application on their behalf and to disclose to Accuro Health Insurance their personal and health information
 - I/we have made each of them aware of the contents of this application and each of them confirms that the information provided on their behalf is true and accurate
 - each of the people named in this application has authorised me to sign this declaration on their behalf.

Under the Privacy Act 1993 and the Health Information Privacy Code 1994, please note the following:

1. This proposal collects personal information about you in connection with the insurance you are seeking.
2. The intended recipient of the information is Accuro Health Insurance.
3. You have the right to access and request correction of this information subject to the provisions of the Privacy Act 1993.
4. While, for the most part, we are able to treat this information as confidential between you and us, there are some situations where we may need to disclose this information to a third party, and by signing the declaration opposite, you acknowledge that you authorise such disclosure.

These situations are as follows:

 - (a) For Accuro Health Insurance and insurance industry statistical purposes (but you are not identified).
 - (b) For the evaluation of claims under this policy.
 - (c) To enable Accuro Health Insurance in arranging this insurance to provide ongoing client service and information.
5. In signing the declaration opposite, you authorise Accuro Health Insurance to give or obtain from your records, other insurers or other parties, any information relating to any insurance held or any claim made by you or to any other applicant in the plan.

Important information

1. This form is your application to become a member of Accuro Health Insurance, which administers health benefit plans for members.
2. Accuro Health Insurance is the trading name for Health Service Welfare Society Limited. Health Service Welfare Society Limited is registered under the Industrial and Provident Societies Act 1908. Like all societies, it has rules that will bind you. The rules govern the way this Society is run and the health benefit plans it administers. The rules are subject to change. If you want a copy of the current rules before making this application, please feel free to ask us for a copy.

3. Acceptance by Accuro Health Insurance will not have immediate binding effect. You will be afforded a period in which to consider the extent of the cover Accuro Health Insurance is prepared to provide, any exclusions, the conditions of membership and the like.
4. The Board of Directors of this Society reserves the right at all times to vary general policy terms and conditions and the benefits however it deems appropriate.
5. Because the information contained in this application will form the basis of any contract that eventuates, it is essential that it be completed accurately and truthfully. Applicants for cover are also under an obligation to volunteer information not specifically asked for, which would be material in deciding whether to offer cover.
6. If in any doubt, disclose the information, and leave it for Accuro Health Insurance to determine the significance of what you have disclosed.
7. The same applies for additional persons for whom you are seeking cover. Be aware that what you state about them can affect their entitlement, so it is better that you inform them of that and ensure the comprehensiveness of the information provided.
8. Premiums are subject to change on 21 days' notice.

I/We accept the terms and conditions (including the limitations and exclusions) of the policy, including Accuro Health Insurance general policy terms and conditions

Please note: If you are applying for the SmartStay plan, you need to attach a copy of the front page of your passport and a copy of your New Zealand visa/permit. This requirement also applies to your family members.

Member's name in full _____

Signature _____

Date _____

Partner's name in full _____

Signature _____

Date _____

Participant's name in full (aged 16 years and over) _____

Signature _____

Date _____

Participant's name in full (aged 16 years and over) _____

Signature _____

Date _____

Participant's name in full (aged 16 years and over) _____

Signature _____

Date _____

Participant's name in full (aged 16 years and over) _____

Signature _____

Date _____

It is important that Accuro Health Insurance receives your application within 10 working days of you signing this form or your application may become invalid. Once received, this application will be valid for 45 days.

9 Checklist

- Answered all the questions
- Provided additional information in the appropriate questionnaire if a question required more detail to be provided
- Carefully read and signed the declaration in section 8 (This must be signed by every person to be insured aged 16 and over.)
- If additional participants are being added to any existing policy, only sections 1, 2/3, 4, 5, 6 and 8 need to be completed.

Please note, only the new participant(s) need to complete all health declarations.

Relevant payment details:

- If paying by direct debit, please complete the direct debit form in section 11 (Please return this with the application form.)
- If paying by credit card, please complete the credit card details in section 7
- If paying by cheque, please enclose a cheque with this application form

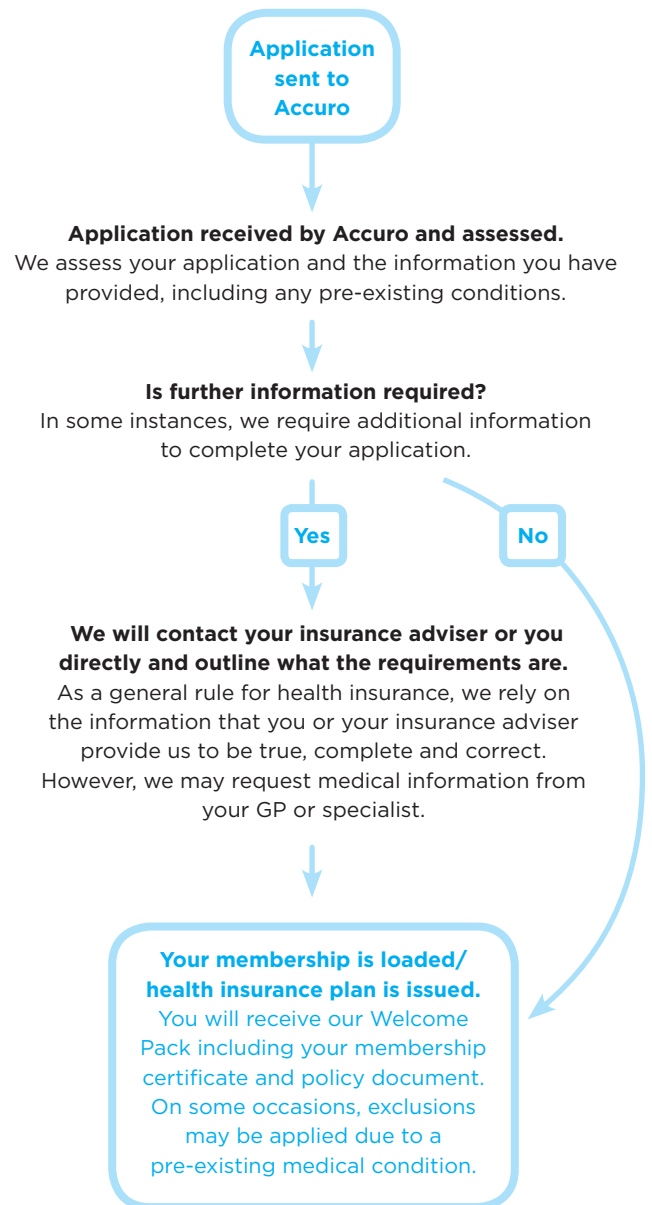
Attachments

- If you are providing any supporting documentation, please ensure it has been attached to this application
- If any person is a non-resident, please attach a copy of their work permit(s) and passport to this application

10 Next steps for your application

At Accuro, we want to ensure the application process is as easy as possible. Should you have any questions, please contact us on 0800 ACCURO (0800 222 876), email info@accuro.co.nz or talk to your insurance adviser.

Your cover will commence from the date stated on the policy issued by us. Premiums will be due from this date.



1. The initiator:
 - (a) Undertakes to give written notice to the acceptor of the commencement date, frequency and amount at least 10 calendar days before the first direct debit is drawn (but not more than two calendar months).

In the event of any subsequent change to the frequency or amount of the direct debit, the initiator has agreed to give written advance notice at least 30 days before the change comes into effect.
 - (b) May, upon the relationship that gave rise to this authority being terminated, give notice to the bank that no further direct debits are to be initiated under the authority. Upon receipt of such notice, the bank may terminate this authority as to future payments by notice in writing to me/us.
2. The customer may:
 - (a) At any time, terminate this authority as to future payments by giving written notice of termination to the bank and to the initiator.
 - (b) Stop payment of any direct debit to be initiated under this authority by the initiator by giving written notice to the bank prior to the direct debit being paid by the bank.
 - (c) Where a variation to the amount agreed between the initiator and the customer from time to time to be direct debited has been made without notice being given in terms of clause 1 (a) above, request the bank to reverse or alter any such direct debit initiated by the initiator by debiting the amount of the reversal or alternation of a direct debit back to the initiator through the initiator's bank, PROVIDED such request is made not more than 120 days from the date when the direct debit was debited to my/our account.
3. The customer acknowledges that:
 - (a) This authority will remain in full force and effect in respect of all direct debits passed to my/our account in good faith, notwithstanding my/our death, bankruptcy or other revocation of this authority until actual notice of such events is received by the bank.
 - (b) In any event, this authority is subject to any arrangement now or hereafter existing between me/us and the bank in relation to my/our account.
 - (c) Any dispute as to the correctness or validity of an amount debited to my/our account shall not be the concern of the bank except in so far as the direct debit has not been paid in accordance with this authority. Any other disputes lie between me/us and the initiator.
 - (d) Where the bank has used reasonable care and skill in acting in accordance with this authority, the bank accepts no responsibility or liability in respect of:
 - the accuracy or information about direct debits on bank statements
 - any variations between notices given by the initiator and the amounts of direct debits.
 - (e) The bank is not responsible for, or under any liability in respect of, the initiator's failure to give written advance notice correctly nor for the non-receipt or late receipt of notice by me/us for any reason whatsoever. In any such situation, the dispute lies between me/us and the initiator.
 - (f) Notice given by the initiator in terms of clause 1 (a) to the debtor responsible for the payment shall be effective. Any communication necessary because the debtor responsible for payment is a person other than me/us is a matter between me/us and the debtor concerned.
4. The bank may:
 - (a) In its absolute discretion, conclusively determine the order of priority of payment by it of any monies pursuant to this or any other authority, cheque or draft properly executed by me/us and given to or drawn on the bank.
 - (b) At any time, terminate this authority as to future payments by notice in writing to me/us.
 - (c) Charge it's current fees for this service in force from time to time.