Accuro linking form

nib Ultimate Health application

accuro HEALTH INSURANCE

This form is to be used to apply for health insurance from Accuro, using a nib Ultimate Health application form. Completing this form allows Accuro to use the information you have already provided to nib. Please attach a copy of the nib Ultimate Health application with this form, and if we require any further information we will get in contact with you.

1 What type of cover would you like to apply for?

Please choose a base plan	◯ SmartCare+ Hospital and Surgical base plan ◯ SmartCare Hospital and Surgical base plan ◯ Other _____
Please choose the excess for the base plan	◯ $0 ◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $4,000 ◯ $6,000 ◯ $8,000 ◯ $10,000
Would you like any additional plans?	◯ Specialist plan (Excess: ◯ $0 ◯ $250) ◯ GP plan ◯ Natural Health plan ◯ Dental and Optical plan ◯ Day to Day product
When would you like this policy to start?	DAY / MONTH / YEAR or ◯ as soon as possible

2 Adviser details

Please complete if you wish to add an adviser to your policy. Include the adviser's name, company and agency number	

Please note that your adviser will have authority to access your policy information.

3 Policy details

Name of main member (policy owner)	
Name of additional member(s) We are only able to assess cover for members included on the nib application form.	
Address	
Telephone	Home ( ) Mobile
Email	

All correspondence will be sent via email, unless advised otherwise.

Signed date of linking application	DAY / MONTH / YEAR

4 Health disclosures

WARNING: You have an obligation to disclose all matters which may influence Accuro Health Insurance's decision to accept your application. If you fail to do so, we may decline your request, cancel any upgrade/change applied for, void your plan(s) from inception and/or decline any claim that you may make.

Have you, or anyone to be insured, ever experienced, had signs or symptoms of, been treated for, been advised to seek testing or treatment for, are currently receiving testing, treatment or counselling for, or have ever received counselling or investigations for the following:

Other conditions

Any other illness, accident, injury, condition, complaint, disability, medication or disorder not already declared on the nib Ultimate Health application form or this linking form, including any that have arisen in the time between signing the nib Ultimate Health application and this form?

◯ No ◯ Yes (please complete section 4.1)

4.1 Other conditions

	Name of participant:	Name of participant:
Please advise the name of the medical condition.		
When did you first experience symptoms?	DAY / MONTH / YEAR	DAY / MONTH / YEAR
Describe the symptoms.		
When did you last experience any symptoms?	DAY / MONTH / YEAR ◯ This condition is on-going	DAY / MONTH / YEAR ◯ This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) ◯ Mild ◯ Severe ◯ Moderate ◯ Other	_____ per month/per year (delete one) ◯ Mild ◯ Severe ◯ Moderate ◯ Other
Have you had any investigations and/or received any treatment?	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:	◯ Yes ◯ No If **yes**, please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	◯ Yes ◯ No If **yes**, when and what was the outcome?	◯ Yes ◯ No If **yes**, when and what was the outcome?

If you require more space to write, please attach additional pages.

5 Declaration

Declaration and authorisation to obtain and use information

I/We, the person(s) applying for this Accuro Health Insurance Plan, confirm that I/we:

1. Understand and agree that the information I/we have provided in the nib Ultimate Health application will be provided to Accuro Health Insurance and will form part of the information Accuro Health Insurance will rely on in assessing my/our application. The information I/we provided in the nib application is deemed to have been provided directly by me to Accuro Health Insurance.
2. I/We confirm and declare that there has been no change in my/our health since I/we made the nib Ultimate Health application or I/we have provided Accuro Health Insurance with details of the change(s).
3. 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.
4. 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 the policy commences with Accuro Health Insurance.
5. Declare that any information supplied in this application, whether written by me/us or not, is true and accurate and that I am/we are authorised, where any person insured is less than 16 years of age, to act on their behalf.
6. Have read and understand this declaration and authorisation and its applicability to the Privacy Act 1993 and Health Information Privacy Code 1994 (see below for further information).
7. Understand the nature of the plan(s) chosen and believe they meet my/our requirements.
8. Understand that, upon issuance of the membership certificate, I/we have fourteen (14) days to cancel my/our plan(s) (14-day free-look period) and that, subject to no claims having been made, I/we will receive a full refund.
9. Understand that, if the application is approved, cover will start from the date stated on the membership certificate issued by Accuro Health Insurance.
10. For the purpose of assessing this application and any future claims, authorise Accuro Health Insurance to request and obtain information and records about me/us and any other people in this application. I/We authorise the following people to give you any such information and records:
    - » Any doctor, medical specialist, health agency, hospital, the Accident Compensation Corporation or other relevant person, including another Insurer or person relating to any other insurance held by me/us.

Privacy Act 1993 and the Health Information Privacy Code 1994

Each person applying for this Accuro Health Insurance plan should please note the following:

1. This application allows Accuro Health Insurance to collect and use information supplied in relation to the nib Ultimate Health application.
2. The intended recipient of that personal information is Accuro Health Insurance.
3. You have the right to access and request corrections subject to the provisions of the Privacy Act 1993. This information will be held at our head office.
4. While Accuro Health Insurance intends to treat this information as confidential, there are some situations where we may need to disclose your personal information to a third party.
5. By signing this declaration, you authorise the disclosure of the personal information of each member named in this plan (including any dependants) to third parties and any other member named in the plan:
    a) for statistical purposes (where not individually identified)
    b) for evaluation and assessment of claims under the policy that results from this application
    c) for providing on-going client service and information
    d) for any other matter related to the policy.
6. By signing this declaration, you also authorise Accuro Health Insurance or any agency authorised by Accuro Health Insurance to give and obtain your personal information, including your medical records, from other insurers and from medical practitioners. You agree this may include information relating to any other insurance applied for or obtained or claims previously made by you.

Important information

1. This form represents an application by each person named below to become a member of Accuro Health Insurance and relates only to the plan(s) indicated.
2. Anything in this declaration purporting to the singular may, by inference, include the plural.
3. Accuro Health Insurance is the trading name of the Health Service Welfare Society Limited (as registered under the Industrial and Provident Societies Act 1908). By making this application, you are accepting the rules of the Society, including obligations therein, and understand that the rules may subsequently be changed. If you would like a copy of the current rules before making this application, please do not hesitate to ask.
4. Accuro Health Insurance is also a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008.
5. The Board of Directors of the Society reserves the right, at all times, to vary the terms and conditions and benefits of plans however it deems appropriate.
6. This application forms the basis of any contract that eventuates and must be filled in truthfully and accurately. Applicants are obliged, beyond that which is requested, to volunteer information that would have a material impact on the cover offered. If you have doubts, you should disclose the information to Accuro Health Insurance for determination of significance. If you fail to provide or misstate material information, Accuro Health Insurance may at its discretion decline your request, cancel any upgrade/change applied for, void your plan(s) from inception or decline any claim that you may make.
7. Premiums are subject to change on 21 days' notice.

I/We acknowledge the information provided in this declaration, including in relation to my/our privacy, and accept the terms and conditions (including the limitations and exclusions) of the policy.

Main member's name in full

Signature Date signed: DD / MM / YY

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

Signature Date signed: DD / MM / YY

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

Signature Date signed: DD / MM / YY

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

Signature Date signed: DD / MM / YY

Please be aware that you are required to advise Accuro Health Insurance of any new signs/symptoms or health condition for any applicant that arises between the date you sign the application form and the date the policy commences.

Financial strength rating

Accuro has achieved a **B+** (Stable) AM Best financial strength rating.

The rating scale is: **A++**, **A+** (Superior), **A**, **A-** (Excellent), **B++**, **B+** (Good), **B**, **B-** (Fair), **C++**, **C+** (Marginal), **C**, **C-** (Weak), **D** (Poor), **E** (Under Regulatory Supervision), **F** (In Liquidation), **S** (Suspended).

For more rating information, see **www.ambest.com/ratings/guide.pdf**

It is important that Accuro Health Insurance receives your application within 45 days of you signing this form and the nib Ultimate Health application, or your application may become invalid.

Payment method form

accuro HEALTH INSURANCE
0800 222 876

Membership number	Main member name
Preferred first date of payment	Date DAY / MONTH / YEAR or ◯ as soon as possible

Invoice

Recurring payment frequency ◯ Monthly ◯ Quarterly ◯ Six-monthly ◯ Annually (receive one month free)

Credit/debit card

Recurring payment frequency ◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Quarterly ◯ Six-monthly ◯ Annually (receive one month free)

Name on card Expiry date on card MONTH / YEAR

Card type ◯ Visa ◯ Mastercard

Please note that we only accept Visa or Mastercard.
We do not accept other cards such as American Express or Diners Club.

For security reasons, please do not provide your credit card number. Once we receive this form, we will phone you to obtain this information. Please remember, when your credit/debit card expires, you will need to call us on 0800 222 876 to update your credit/debit card details.

I/We authorise the Health Service Welfare Society Ltd. (trading as Accuro Health Insurance), until further notice in writing, to charge my/our credit/debit card account with all amounts due on my/our Accuro Health Insurance account from time to time, on or after the payment due date.

Cardholder signature Date DAY / MONTH / YEAR

Direct debit authority (there is a discount for paying by direct debit)

Recurring payment frequency ◯ Weekly ◯ Fortnightly ◯ Monthly ◯ Quarterly ◯ Six-monthly ◯ Annually (receive one month free)

Name of account

Account number

To the manager:

Bank name

I/We authorise you until further notice in writing to debit my/our account with you all amounts that Health Service Welfare Society Ltd. (trading as Accuro Health Insurance and hereinafter referred to as the Initiator), the registered Initiator of the above Authorisation Code, may initiate by direct debit.

I/We acknowledge and accept that the Bank accepts this authority only upon the conditions listed on the reverse of this form.

AUTHORITY TO ACCEPT DIRECT DEBITS
(not to operate as an assignment or agreement)
Authorisation Code

0	3	3	0	2	8	8

(User number)

The following information will appear on your bank statement:

Payer particulars:	Accuro Health Insur
Payer code:	Health cover HSWS
Payer reference:	Your member number

Authorised signatures **Date signed:** DAY / MONTH / YEAR

For bank use only

Approved		Date received	Recorded by	Checked by	Bank stamp
3028					
09	2018				

Original
Retain at branch

Copy
Forward to Initiator if requested

Conditions of this authority to accept direct debit

1) **The Initiator:**

a) Undertakes to give notice of the commencement date, frequency and net amount at least 10 calendar days before the first Direct Debit is drawn (but not more than 2 calendar months). This notice will be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

Where the Direct Debit system is used for the collection of payments which are regular as to frequency, but variable as to amount, the Initiator undertakes to provide the Customer with a schedule detailing each payment amount and each payment date.

In the event of any subsequent change to the frequency or amount of the Direct Debit, the Initiator has agreed to give advance notice of at least 30 days before the change comes into effect. This notice must be provided in writing (including by electronic means and SMS where I/we have provided prior written consent (including by electronic means including SMS) to communicate electronically).

b) May, upon the relationship which 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.

c) May, upon receiving written notice (dated after the date of this Authority) from a bank to which I/we have transferred my/our account, initiate Direct Debits in reliance of that written notice and this Authority from the account identified in the written notice.

2) The Customer may:

a) At any time, terminate this Authority as to future payments by giving notice of termination to the Bank and to the Initiator by the means agreed by me/us, the Bank and 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 of alteration of 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 event 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 dispute lies 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 of information about Direct Debits on Bank statements; and
- Any variations between notices given by the Initiator and the amounts of Direct Debit.

e) The Bank is not responsible for, or under any liability in respect of the Initiator's failure to give notice in accordance with 1(a), 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 signed 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 its current fees for this service in force from time-to-time