Southern Cross Health Society

Health insurance application

For office use only

Membership number

PLEASE COMPLETE THIS FORM IN FULL

Print using a black or blue pen only. Please initial any corrections you make.

A child can only be named as a dependant on its parent's policy, and must be under the age of 21 years.

THIS SECTION IS TO BE COMPLETED BY THE APPLICANT ONLY.

☐ **Yes** **Health insurance eligibility:** Are you and all family members named in this application New Zealand citizens, holders of a resident visa or otherwise entitled to publicly funded health and disability services as determined by the Ministry of Health?

If not, please don't proceed. Contact your Southern Cross representative or visit moh.govt.nz/eligibility

1. YOUR DETAILS

Health insurance plan _____ **Start date** _____

Applicant

Title _____ First name _____ Surname _____

Date of birth _____ Previous member ☐ Yes Biological sex* ☐ Male ☐ Female

Physical address _____
Street number Street Suburb Town/city

Postal address _____
(if different from above) Street number Street Suburb Town/city

Home phone ☐☐ ☐☐☐☐☐☐☐ Mobile phone ☐☐☐☐ ☐☐☐☐☐☐☐

Personal email _____ ☐ (Tick preferred) Work email _____ ☐ (Tick preferred)

Partner/Spouse

Title _____ First name _____ Surname _____ Date of birth _____

Previous member ☐ Yes Biological sex* ☐ Male ☐ Female Mobile phone ☐☐☐☐ ☐☐☐☐☐☐☐

Dependant1 Title _____ First name _____ Surname _____

Date of birth _____ Biological sex* ☐ Male ☐ Female

Dependant 2 Title _____ First name _____ Surname _____

Date of birth _____ Biological sex* ☐ Male ☐ Female

Dependant 3 Title _____ First name _____ Surname _____

Date of birth _____ Biological sex* ☐ Male ☐ Female

*For actuarial purposes and to apply our Healthy Lifestyle Rewards we need to know your biological sex. In most cases biological sex is that assigned at birth – however if you are intersex or have had surgical gender reassignment please go to www.southerncross.co.nz/inclusive for additional information to assist you to answer this question. To help us build better relationships, based on understanding and respect, at any time you have the option to advise us or update the gender you identify with (male, female or gender diverse). We understand that your biological sex may be different to your gender identity.

SALES TO COMPLETE

Sales person's name

Sales code

Group name

Billing code ☐☐☐☐☐☐☐☐☐☐ Policy transfer ☐

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Campaign code

Previous policy number

Terms C ☐ L ☐ Start / / Additional info attached ☐

2. YOUR HEALTHY LIFESTYLE QUESTIONS

If you are already taking steps to maintain good health we would like to reward you†. If you wish to apply for a Healthy Lifestyle Reward please complete the following.

	Applicant	Partner/Spouse	Other dependants 18 years or older Dependant 1	Dependant 2
Have you been a **non**-smoker continually for the last 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you eat at **least 5** servings# of fruit and veges a day?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you exercise **30 mins** or more, at **least 5 days** a week?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Biological sex* FEMALE Do you drink **2 or less units**‡ of alcohol a day (14 per week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Biological sex* MALE Do you drink **3 or less units**‡ of alcohol a day (21 a week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
For office use only. Eligible for healthy lifestyle reward?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

† Please note: If you qualify for the Healthy Lifestyle Reward it will only be applied from age 21. If you are a member of a subsidised employer's work scheme you will not receive a Healthy Lifestyle Reward personally, but your health will be taken into account in your group's premium.
#A serving is about a handful.
*To apply our Healthy Lifestyle Rewards we need to know your biological sex. In most cases biological sex is that assigned at birth – however if you are intersex or have had surgical gender reassignment please go to www.southerncross.co.nz/inclusive for additional information to assist you to answer this question.
‡A unit is 100ml wine or 330ml beer or 30ml spirit.

3. HEALTH CONDITIONS

Have you **or any family member named** in this application ever displayed evidence of, or had any sign or symptom and/or consulted a provider of health care regarding, any of the following? (*We will need to contact you if all the questions below are not answered.*) **Please initial any corrections you make.**

If you answer **yes** to any of the below you must complete section 5.

Question number

1.	Accidents or injuries which have required, or could require treatment *(State* **left or right** *side in Section 5)*	Yes ☐	No ☐
2.	Allergic condition including hay fever	Yes ☐	No ☐
3.	Asthma, chronic bronchitis or any other disease or disorder of the lungs	Yes ☐	No ☐
4.	Congenital conditions, diagnosed genetic disorders and/or developmental disorders	Yes ☐	No ☐
5.	Hernia – If yes, what type:	Yes ☐	No ☐
6.	Stomach, bowel, or digestive disorder including ulcers, polyps, irritable bowel syndrome or gastric reflux	Yes ☐	No ☐
7.	Rectal or anal condition including haemorrhoids, or bleeding from bowel or rectum	Yes ☐	No ☐
8.	Abdominal or pelvic pain	Yes ☐	No ☐
9.	Back pain or condition including neck/cervical, thoracic, lumbar and sacral spine	Yes ☐	No ☐
10.	Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis	Yes ☐	No ☐
11.	Heart disease or disorder including shortness of breath, chest pain, angina or coronary artery disease	Yes ☐	No ☐
12.	High blood pressure and/or high cholesterol	Yes ☐	No ☐
13.	Blood or bleeding disorder including anaemia or B12 deficiency	Yes ☐	No ☐
14.	Vascular or arterial disorders including varicose veins	Yes ☐	No ☐
15.	Diabetes, gout, thyroid or other glandular disorders	Yes ☐	No ☐
16.	Liver or gall bladder condition including hepatitis	Yes ☐	No ☐
17.	Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, miscarriage, endometriosis, or infertility	NA ☐ Yes ☐	No ☐
18.	Ear, nose or throat condition including ear infections, sinusitis, or tonsillitis	Yes ☐	No ☐
19.	Eye disease or disorder including cataracts	Yes ☐	No ☐
20.	Jaw, mouth or teeth condition including wisdom teeth and/or over or under bite	Yes ☐	No ☐
21.	Kidney or bladder condition including stones, urinary incontinence or pelvic floor disorder	Yes ☐	No ☐

22. Prostate condition including abnormal PSA tests, urinary symptoms, or signs or testicular lump(s) or pain NA ☐ Yes ☐ No ☐

23. Skin disorders including skin cancer, skin lesions under surveillance, eczema, rosacea or acne Yes ☐ No ☐

24. Breast lumps (benign or cancerous) or breast pain or any other breast condition Yes ☐ No ☐

25. Cancerous and pre-cancerous conditions, cysts or tumours Yes ☐ No ☐

26. Neurological or nerve condition including headaches, migraines or stroke Yes ☐ No ☐

27. Psychiatric or psychological condition including anxiety, stress or depression Yes ☐ No ☐

28. Any symptoms, signs or conditions not already disclosed Yes ☐ No ☐

Is any person named on the application

29. Currently taking any medication or under regular medical treatment or supervision Yes ☐ No ☐

30. Currently awaiting the completion or results of any medical investigation or diagnostic genetic test Yes ☐ No ☐

31. Intending to seek or currently seeking any medical advice, examination or procedure Yes ☐ No ☐

4. YOUR HEALTH

For yourself and each of your family members named in this application, please provide all the following details of the LAST time they consulted their GP/family doctor. **Please initial any corrections you make.**

Applicant

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Partner/Spouse

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 1

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 2

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 3

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Please fill out a separate sheet for any additional dependants

5. DETAILS OF THE HEALTH CONDITIONS

If you have answered YES to any of the questions in section 3, please provide details below. If there is not enough space on the form please supply the details on a separate sheet. *(Use a separate field for every condition of each person).*

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

Question number ______________ **Person's name** ______________________________

Details of condition, sign or symptom ______________________________

____

When did the condition, sign or symptom first start? ______________________________

When did you last have the condition, sign or symptom? ______________________________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________________________

____

____

5. DETAILS OF THE HEALTH CONDITIONS (CONTINUED)

Question number ______________ **Person's name** ______________

Details of condition, sign or symptom ______________

When did the condition, sign or symptom first start? ______________

When did you last have the condition, sign or symptom? ______________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

Question number ______________ **Person's name** ______________

Details of condition, sign or symptom ______________

When did the condition, sign or symptom first start? ______________

When did you last have the condition, sign or symptom? ______________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

Question number ______________ **Person's name** ______________

Details of condition, sign or symptom ______________

When did the condition, sign or symptom first start? ______________

When did you last have the condition, sign or symptom? ______________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ______________

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CHECKLIST

HLR ☐ PEC concessions ☐ Standard business ☐ Previous policy ______________

Member	Code	Exclusions	Member	Code	Exclusions

Underwriter's name ______________ **Underwriter's signature** ______________ **Date** ____/____/____

6. SCHEME DETAILS

If you are eligible to join a Southern Cross employer's work scheme or association scheme please complete the following:

Company or association _____ Employee no _____

Branch/department _____ Occupation _____

Employed from _____/_____/_____ Address _____

7. PAYMENT OPTION

Please complete the appropriate form. Billing and payment options vary from scheme to scheme, please check which options are available to you.

INDIVIDUAL AND ASSOCIATION MEMBERS PAYMENT OPTIONS

Direct debit – complete direct debit authority

☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Annually

Recurring credit card – complete recurring credit card authority

☐ Monthly ☐ 3 Monthly ☐ 6 Monthly ☐ Annually

EMPLOYER'S WORK SCHEME MEMBERS PAYMENT OPTIONS

Salary/wage deduction

☐ Weekly ☐ Fortnightly ☐ Monthly

Direct debit

☐ Weekly ☐ Fortnightly ☐ Monthly

Recurring credit card

☐ Monthly ☐ 3 Monthly ☐ 6 Monthly

☐ **Fully subsidised group – payment method not applicable**

8. 您的声明

请在签署前仔细阅读。未如实做出此项声明可能会导致本保险无效。

1. 我申请成为南十字医疗保险协会的会员(以下简称“南十字医疗保险”)，并同意接受南十字医疗保险规则的约束。

我声明如下

1. 我提供的信息是真实完整的。
2. 在我签署本申请之日到我收到南十字医疗保险单期间提供给南十字医疗保险的任何进一步信息都是真实和完整的。我保证在签署本申请之日到我收到南十字医疗保险单期间，向南十字医疗保险提供可能会影响我或本申请中提及姓名的任何其他人的任何健康状况或事件，或可能会影响本保单的任何相关信息。
3. 我接受本保险的条款和条件(包括限制和排除条款)。
4. 我明白，保费可能会随市场行情而发生变化，并会随着本申请内指名的任何人进入不同年龄组别时而发生变化。

隐私声明-申请详情

1. 我明白：
   (a) 南十字医疗保险收集的有关本申请表和申请过程中的任何信息将用于考虑及处理我的健康保险申请。如果获得批准，将适用保单中的具体条款，并按市场营销目的来执行本保单。
   (b) 如果未提供本申请要求的任何信息，可能会延迟申请的处理，或导致南十字医疗保险不为本申请提名人提供保险或相关好处。
   (c) 本申请提名人有权接触，并要求更改南十字医疗保险持有的任何个人或健康信息。
2. 本人授权南十字医疗保险向以下任何人收集并披露我的信息：
   - 我的丈夫/妻子/伴侣 (如果是本申请的提名人)；
   - 我书面提及的任何人；
   - 健康服务提供商和医疗当局(包括意外事故伤害赔偿局和卫生部)、团体管理人、代理商、承包商、供应商和其它商业伙伴等第三方；

   根据南十字医疗保险隐私声明，我授权这些缔约方向南十字医疗保险披露并从南十字医疗保险接收有关本申请表提名人的信息。

我授权南十字医疗保险收集以前的南十字医疗保险的健康保险和/或危重病保单(包括以前的申请、保单和/或报销)。

就有关本申请的任何提名人，我确认：

- 我有权以他们的名义填写本表格；
- 我有权向南十字医疗保险披露并接收个人及健康信息并使他们每个人都认识到南十字医疗保险的完整隐私声明(南十字医疗保险网站所载)；
- 我使他们每个人都了解此申请；
- 每个提名人授权我以他们的名义确认、承诺和执行以上各项。

提供给南十字医疗保险的本申请管理和其它个人及健康信息受南十字医疗保险隐私声明条款的约束。南十字医疗保险隐私声明全文的最新副本，请参阅保险单，或浏览我们的网站 www.southerncross.co.nz/privacy 或致电 0800 800 181，联系会员服务。

财务实力评级

南十字医疗保健协会(营业名称为南十字医疗保险协会)具有由标准与普尔(澳大利亚)有限公司评定的A+(强)财务实力。

评级标准是：

AAA(极强)	AA(很强)	A(强)
BBB(好)	BB(中)	B(弱)
CCC(很弱)	CC(极弱)	SD或D(选择性违约或违约)
R(管制行动)	NR(未评级)	

“AA”到“CCC”评级通过添加加号(+)或减号(-)来显示主要评级类别中的相关级差。

www.standardandpoors.com提供评级标准的全部详情。标准与普尔是根据《2010年保险(监管)法》批准的评级机构。

感谢您的申请

我们将审查您的申请并书面通知您有关适用于您的保险的特定条款和保险开始日期。如果您在收到保险的14天内不满意，您可以取消本保险。我们将提供所有保险费的全额退款。您只有在此期间没有提出过报销才可以这样做。

申请人签名 _____ **日期** _____/_____/_____

9. YOUR SIGNATURE

Thank you for your application

We will review your application and advise you in writing of the specific terms applying to your policy and the policy start date. If you are not satisfied with the policy during the first 14 days after receiving it, you can cancel the policy and we will provide a full refund of all premiums paid. You can only do this if you have not made a claim under the policy during this period.

SIGN HERE **Applicant's signature** _____ **Date** _____/_____/_____

Southern Cross Health Society

Direct debit authority

Fill in the required details clearly in BLOCK CAPITALS and make sure that you have given us your signature and contact phone number.

Members of an employer work scheme - your deduction date and frequency may be according to your current pay cycle.

To ensure your correct bank account is debited, **please enclose a deposit slip for the bank account you have nominated.** Then simply send this to us in the postage paid envelope provided.

We will automatically adjust the deduction amount when changes happen to your policy and notify you in advance of the deduction date. You don't have to fill in another form.

This information is being collected by Southern Cross Medical Care Society for administration purposes, including billing. You have the right of access to, and to request correction of, any personal information held by us.

If you need any further information just call us toll-free on **0800 800 181** and one of our Member Services team will help you.

YOUR DETAILS

Membership or policy number

Group code (for office use only)

Please read Conditions of the Authority overleaf.

Name of policyholder _____ Daytime phone no _____

1. Please choose **one of the following** deduction frequencies and specify the deduction date.

☐ Weekly
☐☐ Day ☐☐ Month

☐ Fortnightly
☐☐ Day ☐☐ Month

☐ Monthly
☐☐ Day ☐☐ Month

Note: 1. Enter the date that you want the direct debit deduction cycle to start deducting money from your bank account.

2. Direct debit deductions can only occur on a week day (not Saturday/Sunday). Should the date fall on a public holiday, deduction will occur on the next available business day.
3. Southern Cross is required to give you **10 days notice** in writing prior to your first deduction. An invoice/statement will be sent to you 10 days prior to the deduction. To meet this requirement, please ensure we receive this form **at least 15 days** prior to your nominated deduction date.
4. If Southern Cross is unable to meet the 10 day notice requirement, your deduction will occur on the next deduction date according to your deduction frequency. The first deduction may include more than one bill period.

2. Bank account details

Name of bank account holder _____

Please provide your bank/branch number, account number and suffix of the account to be debited in the spaces below.

BANK/BRANCH NUMBER

ACCOUNT NUMBER

SUFFIX

Bank/branch _____

AUTHORITY TO ACCEPT DIRECT DEBITS
Not to operate as an assignment or agreement

AUTHORISATION CODE
1200357
(user number)

I/We authorise you until further notice in writing to debit my/our account with all the amounts which Southern Cross Medical Care Society, Level 1, Ernst & Young Building, 2 Takutai Square, Auckland 1010 (hereafter 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 authority only on the conditions overleaf.

Information to appear on my/our Bank Statement

S	O	U	T	H	E	R	N	C	R	O	S	S

PAYER PARTICULARS

PAYER CODE

H	E	A	L	T	H	S	O	C

PAYER REFERENCE

SIGN HERE **Authorised signature(s)** _____ **Date** _____

FOR BANK USE ONLY

APPROVED	DATE RECEIVED	RECORDED BY	CHECKED BY	BANK STAMP

Southern Cross
Health Society

CONDITIONS OF THE AUTHORITY TO ACCEPT DIRECT DEBITS

1. The Initiator:
   (a) Undertakes to give written notice to me/us of the commencement date, frequency and amount of the Direct Debit at least 10 calendar days (but no more than 2 calendar months) before the first Direct Debit is drawn. Where the Direct Debit System is used for the collection of payments which are regular as to frequency, but variable as to amounts, the Initiator undertakes to provide me/us 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 written notice at least 30 days before that change comes into effect.
   (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 this 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 payment by giving written notice of termination to both 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 or alteration of a Direct Debit back to the Initiator through the Initiator's Bank, PROVIDED such a request is made not more than 120 days from the date when the Direct Debit was debited to his/her 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 accounts 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 any 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) The Bank accepts no responsibility or liability for the accuracy of the information about Direct Debits on Bank Statements.
   (e) The Bank is not responsible for, or under any liability in respect of:
      – any variations between notices given by the Initiator and the amounts of the Direct Debits on Bank Statements.
      – 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 of 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 its current fees for the service in force from time to time.