

## MEDICAL INSURANCE APPLICATION FORM

I am applying for a Medical Insurance Policy as **(Tick box)**:  a Member or  a Dependent  
*(\*Dependent means the spouse, child or grandchild of a Member)*

### Applicant's details

*(\*If you are applying as a Dependent of a Member, please also complete the "Applicant's Member's Details" section below. Dependent must have the same Medical Insurance Policy as Member)*

Membership number *(if the applicant is a Manchester Unity Member)*:

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Medical Insurance Policy requested (Tick)

- Basic Plan
- Premier Plan
- Wellness Plan

### Optional Extras (Tick) (You must have a Medical Insurance Policy to take these options)

- Dental
- Optical
- Wellness
- Hospital stay
- Category (Select from A, B, C, D, E, F)

### Premium Payment Frequency

*(\*Tick frequency for payment of your Premium Amount. All Premium Amounts are payable by direct debit)*

- Fortnightly   
  Monthly   
  3-monthly   
  Annually

### Applicant's Member's Details *(\*Only complete if you are applying as a Dependent)*

Membership number:

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Phone Number: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

# PRE-EXISTING CONDITION INFORMATION

## A) Hospital admissions (Other than childbirth)

Have you at any time been admitted to a Hospital, private surgical centre or day surgery unit?

Yes

No

If yes, please provide details below:

**Treatment/Investigation/Operation**

**Year of Admission**

**Hospital/Doctor**

---

---

---

---

---

---

---

---

---

---

---

---

## B) Injury/Employment related conditions (including details of all claims you have lodged with ACC, or other approved accident insurers).

Have you undergone diagnostic tests, required medical treatment or undergone surgery

Yes

No

If yes, please provide details below:

**Treatment/Investigation/Operation**

**Year ACC Approved**

**Hospital/Doctor**

---

---

---

---

---

---

---

---

---

---

---

---

## C) Future Treatment/Diagnosis/ Surgery

Have you been advised that you may require, or have an expectation you may need, diagnostic tests/treatment/surgery in the future?

Yes

No

If yes, please provide details below:

**Treatment/Investigation/Operation**

**Approximate date of future treatment**

**Hospital/Doctor**

---

---

---

---

---

---

---

---

---

---

---

---

## D) Regular Medication

Have you taken in the past, or are currently taking, any form of medication on a regular basis?

Yes

No

If yes, please provide details below:

**Name of Medication**

**Duration of Medication**

**Hospital/Doctor**

---

---

---

---

---

---

---

---

---



**Additional Information**

Please state any additional information that may be relevant to your application for medical insurance cover under the Policy:

---

---

---

---

**Rating disclosure:**

Manchester Unity was assigned a financial strength rating BB- by Fitch Ratings on 20 March 2019. Fitch Ratings' scale is available for inspection on Manchester Unity's website.

**Applicant's declaration - please read and sign this statement:**

I have completed this application truthfully and accurately and disclosed all information that may be relevant to the insurance cover I am applying for. I understand that Manchester Unity relies on the information I provide to determine whether to provide cover; that (on acceptance) this application will form part of the Policy; and that if I fail to complete this application truthfully and accurately, and/or fail to disclose all relevant information, then Manchester Unity may choose to void the Policy from the beginning; cancel the Policy; refuse to pay any claim under the Policy and/or alter the Policy by adjusting the Premium Amount and/or the cover.

Applicant's signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Applicant's Member's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(\*If a Dependent of a Member is the Applicant, the Member must also sign)*

**Send your completed application form and direct debit authority to:**

Manchester Unity Friendly Society, PO Box 5083, WELLINGTON 6140

**Office use only:**

Policy start date: \_\_\_\_\_

Premium Amount: \_\_\_\_\_

Telephone: 0800 101 842

Website: [www.manchesterunity.org.nz](http://www.manchesterunity.org.nz)