Southern Cross Health Society

Health insurance medical declaration

Membership number ☐☐☐☐☐☐☐☐

1. POLICY DETAILS

Policyholder name _____ Date of birth _____

Plan name _____

Please note this is a new declaration and all medical history must be disclosed, including that already known to Southern Cross Health Society.
Please also note that you may be contacted by Southern Cross should we require further details regarding any information you provide on this form.

Best contact method and details _____

2. REASON FOR COMPLETING MEDICAL DECLARATION

☐ Upgrade plan (complete all sections below except 4) Is the cover for all members covered by the policy being updated? ☐ Yes ☐ No

☐ Add member(s) (complete all sections below except 3) ☐ Add member(s) **and** upgrade plan (complete all sections below)

☐ Transfer to another policy **and** upgrade plan

New membership number (if known) ☐☐☐☐☐☐☐☐

(Complete all sections below except 4 and include the membership number of the policy you are transferring to. Please note transfers can only be actioned on the authority of the policyholder of the policy onto which you wish to transfer).

☐ Leaving an employer scheme (answer all sections below except 3 and 4)

3. UPGRADE PLAN

New health insurance plan (please include any/all additional modules) _____

Excess (if applicable) _____

If you are not sure which plan you would like to move to please contact us on 0800 800 181.

4. ADD MEMBER(S) Please complete only for members being added to this policy

If there is not enough space on this form please supply the details on a separate sheet.

☐ Yes ☐ No Is the member you are seeking to add to this policy a New Zealand citizen, holder of a resident visa or otherwise entitled to free public healthcare for all services as determined by the Ministry of Health?

If not, please do not proceed. Contact your Southern Cross representative.

For any adult members being added to the policy please provide their best contact method and details .

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Relationship to policyholder _____ Phone number _____

Title _____ First name _____ Surname _____ Date of birth _____ Male/female

Relationship to policyholder _____ Phone number _____

Title _____ First name _____ Surname _____ Date of birth _____ Male/female

Relationship to policyholder _____ Phone number _____

5. 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.

* Please note the Healthy Lifestyle Reward only applies to those with less than two years of membership who do not receive an employer subsidy for their policy.

	Policyholder	Spouse/Partner	Other dependants 18 years or older: Dependant 1	Other dependants 18 years or older: Dependant 2
Are you a **non**-smoker?† †*Have not smoked at all over the past 12 months.*	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you eat at least 5 servings of fruits and vegetables a day?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you do 30 minutes of moderate physical activity on 3 or more days of the week?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
WOMEN: Do you drink 2 **or less** glasses of alcohol a day (14 per week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
MEN: Do you drink 3 **or less** glasses of alcohol a day (21 per 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 ☐

6. YOUR 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.	Women: Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, or endometriosis	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.	Men: Prostate condition including abnormal PSA tests, urinary symptoms, or signs or testicular lump(s) or pain	Yes ☐	No ☐
23.	Skin disorders including skin cancer, skin lesions under surveillance, eczema, rosacea or acne	Yes ☐	No ☐
24.	Men and Women: 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.	Women: Recurrent miscarriage(s) and/or infertility	Yes ☐	No ☐
29.	Any symptoms, signs or conditions not already disclosed	Yes ☐	No ☐

Is any person named on the application

30.	Currently taking any medication or under regular medical treatment or supervision	Yes ☐	No ☐
31.	Currently awaiting the completion or results of any medical investigation or diagnostic genetic test	Yes ☐	No ☐
32.	Intending to seek or currently seeking any medical advice, examination or procedure	Yes ☐	No ☐

7. YOUR HEALTH

For yourself and each of your family members named in this form, please provide all the following details of the LAST time they consulted their GP/family doctor. If there is not enough space on this form please supply the details on a separate sheet.

Policyholder 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 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 ______

8. DETAILS OF THE HEALTH CONDITIONS

If you have answered yes to any of the questions in Section 6, please provide details below. If there is not enough space on the form please supply the details on a separate sheet. Please list each condition for each person separately.

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? ______

9. DECLARATION

Please read carefully before signing. Failure to make this declaration truthfully may invalidate the policy.

I hereby declare as follows

1. That the information I have disclosed is true and complete;
2. That any further information I disclose to Southern Cross between the date I sign this medical declaration form and the date I receive an updated Membership Certificate from Southern Cross is, at the time of disclosure, true and complete. I undertake to advise Southern Cross of any health condition or event that may affect me or any of the other people covered by this policy, or any other relevant information that may affect the policy, between the date I sign this form and the date I receive an updated Membership Certificate from Southern Cross.
3. I accept the terms and conditions (including the limitations and exclusions) of the policy.
4. I accept that cover for any pre-existing conditions may be limited and will be confirmed in an updated membership certificate.
5. I understand that premiums may change with market variations and will change when any person covered by this policy enters a different age band.

Privacy – Declaration

1. I understand that:
   a) the information Southern Cross collects in this form and in the wider declaration process will be used to consider and process the change being requested and, if approved, consider the specific terms that apply to the policy, to administer the policy and for marketing purposes.
   b) if any of the information requested as part of this form is not provided, it may delay the change being made or result in Southern Cross not effecting the change requested.
   c) the people covered by this policy are entitled to have access to, and request correction of, any of their personal or health information held by Southern Cross.
2. I authorise Southern Cross to collect from, and to disclose to:
   - my husband/wife/partner (if covered by this policy);
   - any person(s) nominated in writing by me;
   - third parties such as health services providers and medical authorities (including ACC and Ministry of Health), group administrators, agents, contractors, suppliers and other business partners;

   information relating to people covered by this policy and I authorise these parties to disclose to Southern Cross and receive from Southern Cross this information, in accordance with the Southern Cross Privacy Statement.

   I authorise Southern Cross to collect information from a previous Southern Cross health insurance and/or Critical Illness policy (including previous application(s), membership certificate(s) and/or claims.)

In relation to any other people covered by this policy, I confirm that:

- I am authorised to complete this form on their behalf;
- I am authorised to disclose to Southern Cross and to receive from Southern Cross their personal and health information and I have made each of them aware of the terms of Southern Cross' full Privacy Statement (contained on Southern Cross' website);
- I have made each of them aware of the contents of this form; and
- each of these people have authorised me to give the acknowledgements, undertakings and authorities set out above on their behalf.

Management of this and other personal and health information provided to Southern Cross is subject to the terms of the Southern Cross Privacy Statement. For an up to date copy of the full Southern Cross Privacy Statement, please refer to your Policy Document, visit our website at www.southerncross.co.nz/society or contact Member Services on 0800 800 181.

Financial strength rating

Southern Cross Medical Care Society (trading as Southern Cross Health Society) has an A+ (Strong) financial strength rating given by Standard & Poor's (Australia) Pty Limited.

The rating scale is:

AAA (Extremely Strong)	AA (Very Strong)	A (Strong)
BBB (Good)	BB (Marginal)	B (Weak)
CCC (Very Weak)	CC (Extremely Weak)	SD or D (Selective Default or Default)
R (Regulatory Action)	NR (Not Rated)	

Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

Full details of the rating scale are available at www.standardandpoors.com. Standard & Poor's is an approved rating agency under the Insurance (Prudential Supervision) Act 2010.

10. YOUR SIGNATURE

Thank you

We will review the details you have provided and advise you in writing of the specific terms applying to your policy. If you are not satisfied with the upgrade or change or you wish to remove the new person named on the medical declaration during the first 14 days after receiving your new membership certificate, you can revert to the plan you held immediately prior to the change and any premium adjustments will be made accordingly. You can only revert to your previous plan or remove the addition if you have not made a claim under the policy during this period and if you are entitled to do so (those leaving an employer scheme are not able to revert back to their previous plan/entitlements).

Policyholder's signature _____ **Date** _____/_____/_____

FOR OFFICE USE ONLY

Concession type

SB ☐	PC ☐	NC ☐	NU ☐	NW ☐	
Member	Code	Exclusions	Member	Code	Exclusions

Underwriter's name _____ **Underwriter's signature** _____ **Date** _____/_____/_____