

Membership alteration

If a completed health declaration is	s attached, please st	aple it and tick th	nis box		Membe							
Please complete this panel fully for all alterations					nur	mber L						
						Billings	group cod	e				
TitleInitialsSurna	me											
Effective date of alteration / /	Wage (deduction	To GRP	To MBR	N/a		oup Intact a	advised	Y	′es	No [N/a	а
Origin Phone In person	Corresponden	ce Group			st track ID ernal only)							
Name of person you received advice fr	om											
Please indicate the alteration(s) req	uired and provide t	he information	request	ed (Please	e tick)							
Reinstate membership	Reinstate with	continuous mem	nbership									
Cancellation	Cancellation reaso	n (Please tick on	ie of the b	oxes prov	vided)							
	Gone overseas	Deceased	Sus	pension	Gon	ne to ar	nother in	surer 🗌	Othe	er reas	on	
Name change	Current name			Ne	w title							
	New name			Init	ials							
Self/spouse reversal	If you have indicate	d yes for self-spo	ouse reve	rsal pleas	e comple	ete the	name cl	nange al	bove			
(Medical declaration may need to be completed)	New group name			_New gro	oup code	9						
Date leaving company / /	New plan	New Billi	ng Methc	d (Pvt on	ly)	Emp	loyee ni	umber				
Reason for transfer						Emp	loyee st	art date	- /	/		
Address change												
Common												
Invoice address												
Individual	Member name											
Contact details						_						
Member name		Pvt				Cell						
		Bus			E	mail						
Member name		Dut										
Membername		Pvt										
		Bus				Email 🕒						
Change plan (Medical declaration and healthy	From star											
lifestyle reward questionnaire may need to be completed)	From plan											

Add members	(Medical declaration may need to be completed)
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Full name	Date of birth	Male/female

Address (if different from the policyholder)

Delete members

Full name

Date of birth

Address (if different from the policyholder)

Male/female

Reason eg over 21, suspended, gone overseas, deceased, etc

Miscellaneous and messages

EXPLAIN THE CONDITIONS WHICH WILL NOW APPLY TO THE MEMBERSHIP

Indicate below the conditions you have explained to the policyholder

Situation	Condition	Explained to member					
Transfer or transfer with upgrade	Qualifying existing conditions	Decline					
Upgrade only	Qualifying existing conditions for higher cover	Decline					
Child added within 3 months of birth	Qualifying existing conditions	Cover					
	Commence claiming	Immediate					
Member added over 3 months old	Qualifying existing conditions	Decline					
	Commence claiming	Immediate Wait					
Southern Cross Agent's declaration	I confirm that I have advised the applicant fully on the benefits alteration(s) to the membership. I further confirm that I have gi Agreement with Southern Cross including the Conditions of Me or policy manual, and that I have fully explained the provisions of advice on matters in which I am authorised under the terms of	ven no advice that breaches the terms of my Agency embership as stated in the appropriate brochure of policy changes to the applicant. I have only given					
Southern Cross Agent's signature	Name/Agent's number						
Plan required	Members to be covered	Self Spouse Child Adult child					

Plan required

I have had explained to me, and understand the conditions of cover relating to these changes. •

- I understand that if cover ceases through the scheme, any special concessions offered may not continue.
- I confirm all information given is true and correct for all those named on this application, that all applicants are 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.

In relation to the persons named in this form, 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);

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.

Policyholder's name

Policyholder's signature

Today's date