

Accuro linking form

Asteron Life application

This form is to be used to apply for health insurance from Accuro, using a Asteron Life application form. Completing this form allows Accuro to use the information you have already provided to Asteron Life. Please attach a copy of the Asteron life application. 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	<input type="radio"/> SmartCare+ Hospital and Surgical base plan <input type="radio"/> SmartCare Hospital and Surgical base plan <input type="radio"/> Other _____
Please choose the excess for the base plan	<input type="radio"/> \$0 <input type="radio"/> \$250 <input type="radio"/> \$500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,000 <input type="radio"/> \$4,000 <input type="radio"/> \$6,000 <input type="radio"/> \$8,000 <input type="radio"/> \$10,000
Would you like any additional plans?	<input type="radio"/> Specialist plan (Excess: <input type="radio"/> \$0 <input type="radio"/> \$250) <input type="radio"/> GP plan <input type="radio"/> Dental and Optical plan <input type="radio"/> Natural Health plan <input type="radio"/> Day to Day product
When would you like this policy to start?	DAY / MONTH / YEAR or <input type="radio"/> 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	
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Please note that your adviser will have authority to access your policy information.

3 Policy details

Title <input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Miss <input type="radio"/> Ms <input type="radio"/> Other (please specify):		Date of birth DAY / MONTH / YEAR
Full name of member		
Address		
Telephone		
Email		

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

Signed date of linking application	DAY / MONTH / YEAR
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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 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:

Allergies, nasal and/or sinus problems

Anaphylaxis, nasal obstruction, hay fever, sinusitis or recent and/or recurrent sinus infections? No Yes (please complete section 4.1)

Dental problems (This includes any oral surgery in relation to the below)

Wisdom teeth, impacted or unerupted teeth, cysts or gum disease? No Yes (please complete section 4.2)

To be completed by males only

Blood in the urine, slow urinary stream, problems with passing urine, disease or disorder of the testicles, bladder, urethra or prostate, sexual dysfunction or abnormal prostate tests? No Yes (please complete section 4.3)

To be completed by females only

Breast disease or disorder, breast lumps, cysts or breast pain, gynaecological disorder of any kind, endometriosis, polycystic ovarian syndrome, irregular, heavy or painful menstrual bleeding, current symptoms of menopause, ovarian or hormonal problems, complications of pregnancy, abnormal smear(s), painful intercourse and/or prolapse? No Yes (please complete section 4.3)

Other conditions

Any other illness, accident, injury, condition, complaint, disability, medication or disorder not already declared on the Asteron Life application form or this linking form, including any that have arisen in the time between signing the Asteron Life application and this form? No Yes (please complete section 4.4)

4.1

Allergies, nasal and/or sinus problems

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

4.2 Dental problems

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

4.3 Male/female specific

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 <input type="radio"/> This condition is on-going	DAY / MONTH / YEAR <input type="radio"/> This condition is on-going
How frequent and severe are/were the occurrences or attacks of the condition?	_____ per month/per year (delete one) <input type="radio"/> Mild <input type="radio"/> Severe <input type="radio"/> Moderate <input type="radio"/> Other	_____ per month/per year (delete one) <input type="radio"/> Mild <input type="radio"/> Severe <input type="radio"/> Moderate <input type="radio"/> Other
Have you had any investigations and/or received any treatment?	<input type="radio"/> Yes <input type="radio"/> No If yes , please provide details regarding type of investigations, treatment and/or medication:	<input type="radio"/> Yes <input type="radio"/> No If yes , please provide details regarding type of investigations, treatment and/or medication:
Have you been referred to a specialist?	<input type="radio"/> Yes <input type="radio"/> No If yes , when and what was the outcome?	<input type="radio"/> Yes <input type="radio"/> No If yes , when and what was the outcome?

Declaration and authorisation to obtain and use information

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

- Understand and agree that the information I/we have provided in the Asteron Life 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 Asteron Life application is deemed to have been provided directly by me to Accuro Health Insurance.
- I/We confirm and declare that there has been no change in my/our health since I/we made the Asteron Life application or I/we have provided Accuro Health Insurance with details of the change(s).
- 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.
- 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.
- 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.
- 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).
- Understand the nature of the plan(s) chosen and believe they meet my/our requirements.
- 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.
- Understand that, if the application is approved, cover will start from the date stated on the membership certificate issued by Accuro Health Insurance.
- 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:

- This application allows Accuro Health Insurance to collect and use information supplied in relation to the Asteron Life application.
- The intended recipient of that personal information is Accuro Health Insurance.
- 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.
- 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.
- 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:
 - for statistical purposes (where not individually identified)
 - for evaluation and assessment of claims under the policy that results from this application
 - for providing on-going client service and information
 - for any other matter related to the policy.

- 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

- 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.
- Anything in this declaration purporting to the singular may, by inference, include the plural.
- 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.
- Accuro Health Insurance is also a registered financial service provider under the Financial Service Providers (Registration and Dispute Resolution) Act 2008.
- 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.
- 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.
- 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

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 Asteron life application, or your application may become invalid.