



POLICE HEALTH PLAN LIMITED POLICY AMENDMENT FORM

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Office use only

Please Note: This form collects personal information about you and your family so Police Health Plan Limited can consider the requested amendments to your membership. The information is received and held by Police Health Plan Limited (contact details above). You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

SECTION A - CURRENT PRIMARY POLICY HOLDER DETAILS

Family Name		First Name(s)	Membership No.
Current address			
		Day-time phone number:	()

SECTION B - ADDITIONS TO POLICY (please complete the medical declaration on reverse in all cases)

	First name(s)	Title	Sex M/F	Family name	Relationship to Policyholder	D.O.B	NZ Resident?	Cover required (please tick)		
								Comprehensive	Basic	Surgical
1							Yes / No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2							Yes / No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3							Yes / No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4							Yes / No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION C - DELETIONS FROM POLICY

	First Name(s)	Title	Sex M/F	Family Name	Relationship to Policyholder	D.O.B
1						
2						
3						
4						

SECTION D - UPGRADING / DOWN-GRADING COVER

	First Name(s)	Title	Sex M/F	Family Name	Relationship to Policyholder	D.O.B	New level of cover required (please tick)		
							Comprehensive	Basic	Surgical
1							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you require a new bank authority form if paying by Bank Direct Credit?

YES NO

Please sign declaration on reverse



MEDICAL DECLARATION

Has/have any of the applicant/s

- 1 Been admitted to hospital for treatment in the last two years? YES NO
- 2 Evidence or recent symptoms of arthritis, asthma, bronchitis, bunions, deafness, diabetes, duodenal ulcer, eye problems (e.g. short sighted), gynaecological disorders, haemorrhoids, hernia, heart disease, high blood pressure, infertility, obesity, psychiatric or nervous disorders, rheumatism, squint, tonsillar disease, varicose veins, or any other illness which may require treatment in the future? YES NO
- 3 Been under medical treatment for any condition (such as those described in question 2), or been receiving continuing medications? YES NO

If you have answered YES to any of the above questions - please identify the question and give full details below. Use a separate piece of paper if required.

No.	Member	Operation, Treatment or Illness	Treatment Given	Doctor or Hospital	Date

- 4 Are new enrolling members transferring from another medical insurance scheme? YES NO
(If yes, please provide proof of current medical cover)

Name of Insurer & policy type Policy Renewal Date / /

DECLARATION

I declare that: all entries on this form are true and correct; and any false answer may forfeit all right to any benefits from Police Health Plan (the Plan). I agree to be bound by the Plan Rules and that the information may be exchanged between the Plan, NZ Police Association, Welfare Fund Limited and associated bodies for statistical, marketing and processing purposes. I authorise the Plan to seek any further medical information as and when required.

Print Name Signature of Policy Holder

Date / /

ALL CLAIMS WILL BE PROMPTLY SETTLED BY DIRECT CREDIT. CHEQUES ARE NOT ISSUED

Please tick below which account is preferred.

Credit Union Account? Other Bank

You will still receive a reimbursement schedule (Remittance Advice) advising full details of payment