POLICE HEALTH PLAN
APPLICATION FORM

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Office use only

Please Note: This document collects personal information about you so Police Health Plan Limited can consider your membership. The information is received by Police Health Plan Limited, PO Box 12344, Wellington 6144, who will hold this information. You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

MEMBER DETAILS

Mr / Mrs / Ms / Miss	First names *(please state all names in full)*	
D.O.B DD / MM / YYYY	Last name	

I apply for membership of the Police Health Plan with the following level of cover: *(Tick applicable option)*

Comprehensive ◯ **Basic** ◯ **Surgical** ◯ **Voluntary Excess:** ◯ *(for surgical claims)* *Circle if applicable* **$500 | $1000**

IMMEDIATE FAMILY INFORMATION

Details of all your immediate family members requiring Health Plan:

Name(s) First	Last	D.O.B DD / MM / YYYY	Gender *Please circle*	Relationship to member	NZ Resident *Please circle*	Cover Required Comprehensive / Basic / Surgical	Voluntary Excess *Circle if applicable*
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000

Are you or any of your family applying for Police Health Plan transferring from another medical insurance scheme?

No ◯ **Yes** ◯ Please provide proof of current medical policy including insurer, policy type and policy renewal date.

MEDICAL DECLARATION (CONFIDENTIAL)

Have you or any other enrolling family member:

1. Been admitted to hospital for treatment in the last two years? **Yes** ◯ **No** ◯
2. Displayed 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 disease 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 of any kind? **Yes** ◯ **No** ◯

If you have answered yes to any of the above questions – please identify the question and give full details below.
Continue on a separate page if required.

Q.	Name	Illness / Symptom / Operation	Treatment	Doctor or Hospital	Date

GENERAL DECLARATION

Police Health Plan Ltd is a member of Health Funds Association of New Zealand (HFANZ). On behalf of its members, HFANZ manages an Integrity Registry for the purposes of detecting and preventing fraud and other serious probity concerns. The Integrity Registry is operated by PricewaterhouseCoopers. Police Health Plan Ltd may collect, use and disclose personal and health information about you for the purposes of the Integrity Registry. You can access and correct information held on the Integrity Registry. Contact Police Health Plan Ltd or HFANZ Integrity Registry Privacy Officer, Health Funds Association of New Zealand, PO Box 25161, Wellington 6146.

1. I declare that:
   1.1 All entries on this form are true and correct;
   1.2 Any false answer may forfeit all right to any benefits from Police Health Plan Limited (Health Plan).
2. I agree:
   2.1 to be bound by Health Plan Rules; and
   2.2 that the information may be exchanged between Health Plan, NZ Police Association, Police Welfare Fund Limited and associated bodies (including Police Welfare Insurances Ltd, General Insurances Ltd and Police Welfare Fund Mortgages Ltd) for providing information on services and statistical, processing and underwriting purposes.
3. I understand that:
   3.1 if I have agreed to take advantage of a discounted premium by selecting a voluntary excess, I agree to pay this excess amount towards any surgical procedures I may require.
   3.2 if I select a voluntary excess and then choose to switch to a lower or no-excess option, a 90-day stand-down period will apply before the lower or no-excess option commences, and all conditions that were existing under the previous higher voluntary excess, will still incur that excess, regardless of when any procedure on this condition is carried out.
4. I authorise Health Plan to seek any further medical information as and when required.

Print Name		**Signature**		**Date**	/ /

Financial Strength Rating: *A M Best Co. has assigned a Financial Strength Rating of A- (Excellent) and an Issuer Credit Rating of "a-" to Police Health Plan Limited. The outlook for both ratings is stable. The ratings reflect the captive membership base, low expense ratio and good asset quality.*

A M Best Co.'s Financial Strength Rating Scale: *Secure: A++, A+ (Superior); A, A- (Excellent); B++, B+ (Good). Vulnerable: B, B- (Fair); C++, C+ (Marginal); C, C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Suspended)*

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