

Change medical insurance

Use this form: To add or change your UniMed medical insurance cover benefit, or to update your dependants to your existing membership. If you are a member through your employer, any change will be subject to the rules of your company's arrangements. Send completed form to us at superlife@superlife.co.nz or post to us at P.O. Box 105262, Auckland City 1143.

SL00135 – 09.11.2016

Your details

Name:		SuperLife number:	<input type="text"/>
Email:		Date of birth:	<input type="text"/> / <input type="text"/> / <input type="text"/> (dd/mm/yyyy)
Home address:		Phone:	(<input type="text"/>) <input type="text"/>
		Post code:	<input type="text"/>

I want to (tick as appropriate)

☐ Change my existing plan

Please tick the medical plan you are applying for

- | | |
|--|---|
| <input type="checkbox"/> UniCare Plus | <input type="checkbox"/> Major Surgical + GP |
| <input type="checkbox"/> Major Surgical base plan | <input type="checkbox"/> Major Surgical + GP + dental 100 |
| <input type="checkbox"/> Major Surgical + specialists | <input type="checkbox"/> Major Surgical + GP + dental 400 |
| <input type="checkbox"/> Major Surgical + specialists + dental 100 | <input type="checkbox"/> Major Surgical + GP + specialists |
| <input type="checkbox"/> Major Surgical + specialists + dental 400 | <input type="checkbox"/> Major Surgical + GP + specialists + dental 100 |
| | <input type="checkbox"/> Major Surgical + GP + specialists + dental 400 |

☐ Change my excess for each hospital/surgical claim.

In respect of a hospital/surgical claim, I want an excess for each claim of:

- ☐ No excess. ☐ I will meet the first \$500 dollars. A discount to the premium applies if you elect the \$500 excess.
- ☐ Update my dependant(s) to my existing cover as listed below

Dependants' details - list all family members to be covered including you and any other existing dependants

Name	Sex (tick one)		Date of birth (dd/mm/yyyy)
	Male	Female	
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

Signature

I understand that the new cover starts when I am notified by SuperLife, but not before the date the premium is paid. I authorise the deduction of the required contributions from my bank account or from my pay or from my SuperLife Accounts as appropriate.

If you have increased your cover or added dependants you must also complete the UniMed form attached.

Your signature: _____ Date: / / (dd/mm/yyyy)