Southern Cross Health Insurance

Health insurance medical declaration

IMPORTANT: Please note that all medical history must be disclosed in this form, including that already known to Southern Cross, whether you have provided that information in writing or orally.

Membership number | | | | | | | | |

1. POLICY DETAILS

Policyholder name _____ Date of birth _____

Plan name _____

Please also note that you may be contacted by Southern Cross should we require further details regarding any information you provide on this form.

Best contact method and details _____

2. REASON FOR COMPLETING MEDICAL DECLARATION

☐ Upgrade plan (complete all sections below except 4 and 5) Is the cover for all members covered by the policy being updated? ☐ Yes ☐ No

☐ Add member(s) (complete all sections below except 3) ☐ Add member(s) **and** upgrade plan (complete all sections below)

☐ Transfer to another policy **and** upgrade plan

New membership number (if known) | | | | | | | | |

☐ Leaving an employer scheme (answer all sections below except 3 and 4)

(Complete all sections below except 4 and 5 and include the membership number of the policy you are transferring to. Please note transfers can only be actioned on the authority of the policyholder of the policy onto which you wish to transfer).

3. UPGRADE PLAN

New health insurance plan (please include any/all additional modules) _____

Add Cancer Cover Plus (if applicable) _____

*If you or anyone on your policy is aged 60 or over, you cannot add Cancer Cover Plus. For more help and advice on your options, please contact us.

Excess (if applicable) _____

If you are not sure which plan you would like to move to please contact us on 0800 800 181.

4. ADD MEMBER(S) Please complete only for members being added to this policy

If there is not enough space on this form please supply the details on a separate sheet.

☐ Yes ☐ No Is the member you are seeking to add to this policy a New Zealand citizen, holder of a resident visa or otherwise entitled to free public healthcare for all services as determined by the Ministry of Health?

If not, please do not proceed. Contact your Southern Cross representative.

If you have Cancer Cover Plus and the person you're adding to your policy is aged 60 or over, they're not eligible for Cancer Cover Plus. If having cover is important to you or your family, you could consider our Cancer Assist plan, or purchase separate policies for you and your family. For more help and advice on your options you can call one of our team on 0800 800 181.

For any adult members being added to the policy please provide their best contact method and details.

Is this application to replace existing health insurance cover?

☐ Yes ☐ No **If yes**, it's important you understand the differences in our benefits versus your existing policy, including any pre-existing conditions you may currently be covered for, before you cancel that policy as different policies have different benefits, exclusions and coverage. You should take the time to read through the policy and consider whether it is right for you, and take independent advice about whether you should change your policy to a Southern Cross policy. If you decide to go ahead, but change your mind, you have until 14 days after the date you receive the policy document and membership certificate to contact us, have the change cancelled and receive a refund of premiums paid in relation to your new cover.

Title _____ First name _____ Surname _____ Date of birth _____

Biological sex* ☐ Male ☐ Female Relationship to policyholder _____ Phone number _____

Title _____ First name _____ Surname _____ Date of birth _____

Biological sex* ☐ Male ☐ Female Relationship to policyholder _____ Phone number _____

Title _____ First name _____ Surname _____ Date of birth _____

Biological sex* ☐ Male ☐ Female Relationship to policyholder _____ Phone number _____

Title _____ First name _____ Surname _____ Date of birth _____

Biological sex* ☐ Male ☐ Female Relationship to policyholder _____ Phone number _____

*For actuarial purposes we need to know your biological sex. In most cases biological sex is that assigned at birth – however if you are intersex or have had surgical gender reassignment please go to www.southerncross.co.nz/inclusive for additional information to assist you to answer this question. To help us build better relationships, based on understanding and respect, at any time you have the option to advise us or update the gender you identify with (male, female or gender diverse). We understand that your biological sex may be different to your gender identity.

5. YOUR HEALTHY LIFESTYLE QUESTIONS

If you are already taking steps to maintain good health we would like to reward you†. If you wish to apply for a Healthy Lifestyle Reward please complete the following.

	Applicant	Partner/Spouse	Other dependants 18 years or older Dependant 1	Dependant 2
Have you been a **non**-smoker continually for the last 12 months?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you eat at **least 5** servings# of fruit and veges a day?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Do you exercise **30 mins** or more, at **least 5 days** a week?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Biological sex* FEMALE Do you drink **2 or less units**‡ of alcohol a day (14 per week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Biological sex* MALE Do you drink **3 or less units**‡ of alcohol a day (21 a week)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
For office use only. Eligible for healthy lifestyle reward?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

†Please note: If you qualify for the Healthy Lifestyle Reward it will only be applied from age 21. If you are a member of a subsidised employer's work scheme you will not receive a Healthy Lifestyle Reward personally, but your health will be taken into account in your group's premium. The Healthy Lifestyle Reward will not apply to the premium for Cancer Cover Plus, if you have chosen to add this cover to your policy.
#A serving is about a handful.
*To apply our Healthy Lifestyle Rewards we need to know your biological sex. In most cases biological sex is that assigned at birth – however if you are intersex or have had surgical gender reassignment please go to www.southerncross.co.nz/inclusive for additional information to assist you to answer this question.
‡A unit is 100ml wine or 330ml beer or 30ml spirit.

6. YOUR HEALTH CONDITIONS (if you're only adding Cancer Cover Plus, complete section 7)

Have you **or any family member named** in this application ever displayed evidence of, or had any sign or symptom and/or consulted a provider of health care regarding, any of the following? Remember all health conditions must be disclosed in this form, including that already known to Southern Cross. (We may need to contact you if all the questions below are not answered). **Please initial any corrections you make**.

If you answer **yes** to any of the below you must complete section 9.

Question number

1.	Accidents or injuries which have required, or could require treatment (State **left or right** side in Section 5)	Yes ☐ No ☐
2.	Allergic condition including hay fever	Yes ☐ No ☐
3.	Asthma, chronic bronchitis or any other disease or disorder of the lungs	Yes ☐ No ☐
4.	Congenital conditions, diagnosed genetic disorders and/or developmental disorders	Yes ☐ No ☐
5.	Hernia – If yes, what type:	Yes ☐ No ☐
6.	Stomach, bowel, or digestive disorder including ulcers, polyps, irritable bowel syndrome or gastric reflux	Yes ☐ No ☐
7.	Rectal or anal condition including haemorrhoids, or bleeding from bowel or rectum	Yes ☐ No ☐
8.	Abdominal or pelvic pain	Yes ☐ No ☐
9.	Back pain or condition including neck/cervical, thoracic, lumbar and sacral spine	Yes ☐ No ☐
10.	Bone, muscle or joint disorder, disease or injury including rheumatism or arthritis	Yes ☐ No ☐
11.	Heart disease or disorder including shortness of breath, chest pain, angina or coronary artery disease	Yes ☐ No ☐
12.	High blood pressure and/or high cholesterol	Yes ☐ No ☐
13.	Blood or bleeding disorder including anaemia or B12 deficiency	Yes ☐ No ☐
14.	Vascular or arterial disorders including varicose veins	Yes ☐ No ☐
15.	Diabetes, gout, thyroid or other glandular disorders	Yes ☐ No ☐
16.	Liver or gall bladder condition including hepatitis	Yes ☐ No ☐
17.	Gynaecological or menstrual disorder including heavy or painful periods, any abnormal smears, miscarriage, endometriosis, or infertility	NA ☐ Yes ☐ No ☐
18.	Ear, nose or throat condition including ear infections, sinusitis, or tonsillitis	Yes ☐ No ☐
19.	Eye disease or disorder including cataracts	Yes ☐ No ☐
20.	Jaw, mouth or teeth condition including wisdom teeth and/or over or under bite	Yes ☐ No ☐

21. Kidney or bladder condition including stones, urinary incontinence or pelvic floor disorder — Yes ☐ No ☐

22. Prostate condition including abnormal PSA tests, urinary symptoms, or signs or testicular lump(s) or pain — NA ☐ Yes ☐ No ☐

23. Skin disorders including skin cancer, skin lesions under surveillance, eczema, rosacea or acne — Yes ☐ No ☐

24. Breast lumps (benign or cancerous) or breast pain or any other breast condition — Yes ☐ No ☐

25. Cancerous and pre-cancerous conditions, cysts or tumours — Yes ☐ No ☐

26. Neurological or nerve condition including headaches, migraines or stroke — Yes ☐ No ☐

27. Psychiatric or psychological condition including anxiety, stress or depression — Yes ☐ No ☐

28. Any symptoms, signs or conditions not already disclosed — Yes ☐ No ☐

Is any person named on the application

29. Currently taking any medication or under regular medical treatment or supervision — Yes ☐ No ☐

30. Currently awaiting the completion or results of any medical investigation or diagnostic genetic test — Yes ☐ No ☐

31. Intending to seek or currently seeking any medical advice, examination or procedure — Yes ☐ No ☐

7. HEALTH CONDITIONS RELATED TO CANCER COVER PLUS

If you choose to add Cancer Cover Plus to your policy, please answer all questions, even if you are repeating answers from section 6. **Please initial any corrections you make**. If you answer **yes** to any of the below you must complete section 9.

Remember all health conditions must be disclosed in this form, including that already known to Southern Cross.

Question 4 relating to your family history will only be used to assess cover for Cancer Cover Plus.

Question number

1. Have you or any family member (18 years or older) named in this application smoked any substance, including e-cigarettes, during the last 12 months? — Yes ☐ No ☐

2. Have you or any family member named in this application ever displayed evidence of, or had any sign or symptom or suffered from, sought medical advice/treatment, or intend to seek medical advice/treatment for any of the following:

2.1. Cancer or any malignancy which includes carcinoma, Hodgkin's disease, leukaemia, lymphoma, breast lump, melanoma or metastasised skin lesion (excluding other superficial skin lesions)? — Yes ☐ No ☐

2.2. Hepatitis B or Hepatitis C? — Yes ☐ No ☐

3. Have you or any family member named in this application ever displayed evidence of, or had any sign or symptom or suffered from, sought medical advice/treatment, or intend to seek medical advice/treatment for any of the following:

3.1 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 test? — Yes ☐ No ☐

3.2. FEMALES ONLY Breast disease or disorder, breast lumps, cysts or breast pain, gynaecological disorder of any kind, blood in the urine, slow urinary stream, problems with passing urine, 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. — Yes ☐ No ☐

4. Have your natural parents or siblings (living or dead) or the natural parents or siblings (living or dead) of any family members named in this application been diagnosed before the age of 55 with any of the following?

4.1. Colorectal cancer — Yes ☐ No ☐

4.2. Breast or Ovarian cancer — Yes ☐ No ☐

4.3. Prostate cancer — Yes ☐ No ☐

5. Are you or any family member named in this application aware that you (or they) have a genetic predisposition for developing cancer? — Yes ☐ No ☐

6 Are you or any family members named in this application:

6.1. Currently taking any medication or under regular medical treatment or supervision — Yes ☐ No ☐

6.2. Currently awaiting the completion or results of any medical investigation or diagnostic genetic test — Yes ☐ No ☐

6.3 Intending to seek or currently seeking any medical advice, examination or procedure — Yes ☐ No ☐

8. YOUR HEALTH

For yourself and each of your family members named in this application, please provide all the following details of the LAST time they consulted their GP/family doctor. **Please initial any corrections you make.**

Applicant

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Partner/Spouse

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 1

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 2

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Dependant 3

Person's name _____

Time of consultation ☐ past week ☐ past month ☐ past 3 months ☐ past 6 months ☐ past year ☐ over a year

Reason for consultation _____

Treatment/medication received _____

Outcome _____

Please fill out a separate sheet for any additional dependants.

9. DETAILS OF THE CONDITIONS

If you have answered yes to any of the questions in Section 6 and/or 7, please provide details below. If there is not enough space on the form please supply the details on a separate sheet. Please list each condition for each person separately.

Remember all health conditions must be disclosed in this form, including that already known to Southern Cross.

If you have answered YES to section 7, question 4, please include **in each case** (i) the relationship of the person diagnosed with the condition (the "Diagnosed") to you/the relevant family member named in the application (ii) what condition the Diagnosed was diagnosed with (iii) how old the Diagnosed was when they were diagnosed with the condition.

Question number ____________ Person's name ____________

Details of condition, sign or symptom ____________

____

When did the condition, sign or symptom first start? ____________

When did you last have the condition, sign or symptom? ____________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ____________

____

Question number ____________ Person's name ____________

Details of condition, sign or symptom ____________

____

When did the condition, sign or symptom first start? ____________

When did you last have the condition, sign or symptom? ____________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ____________

____

Question number ____________ Person's name ____________

Details of condition, sign or symptom ____________

____

When did the condition, sign or symptom first start? ____________

When did you last have the condition, sign or symptom? ____________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ____________

____

____

Question number ____________ Person's name ____________

Details of condition, sign or symptom ____________

____

When did the condition, sign or symptom first start? ____________

When did you last have the condition, sign or symptom? ____________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ____________

____

Question number ____________ Person's name ____________

Details of condition, sign or symptom ____________

____

When did the condition, sign or symptom first start? ____________

When did you last have the condition, sign or symptom? ____________

What was the treatment (including investigations) and if medication was/is required, what was/is it? ____________

____

10. DECLARATION

Please read carefully before signing. Failure to make this declaration truthfully may invalidate the policy.

I hereby declare as follows

1. That the information I have disclosed in this Medical Declaration is true and fully complete (i.e. includes all medical history including that already known to Southern Cross).
2. That any further information I disclose to Southern Cross between the date I sign this medical declaration form and the date I receive an updated Membership Certificate from Southern Cross is, at the time of disclosure, true and complete. I undertake to advise Southern Cross of any health condition or event that may affect me or any of the other people covered by this policy, or any other relevant information that may affect the policy, between the date I sign this form and the date I receive an updated Membership Certificate from Southern Cross.
3. I accept the terms and conditions (including the limitations and exclusions) of the policy.
4. I accept that cover for any pre-existing conditions may be limited or excluded (whether or not disclosed in this document) and will be confirmed in an updated membership certificate.
5. I understand that premiums may change with market variations and will change when any person named on this application enters a different age band.
6. If I am completing this application electronically – I agree that electronic signatures shall be deemed original signatures for the purposes of this application and agree to not contest the admissibility or enforceability of the electronically signed copy of this application.

Privacy – Declaration

1. I understand that:
   a) the information Southern Cross collects in this form and in the wider declaration process will be used to consider and process the change being requested and, if approved, consider the specific terms that apply to the policy, to administer the policy and for marketing purposes.
   b) if any of the information requested as part of this form is not provided, it may delay the change being made or result in Southern Cross not effecting the change requested.
   c) the people covered by this policy are entitled to have access to, and request correction of, any of their personal or health information held by Southern Cross.
2. I authorise Southern Cross to collect from, and to disclose to:
   - my husband/wife/partner (if covered by this policy);
   - any person(s) nominated in writing by me;
   - third parties such as health services providers and medical authorities (including ACC and Ministry of Health), group administrators, agents, contractors, suppliers and other business partners;

   information relating to people covered by this policy and I authorise these parties to disclose to Southern Cross and receive from Southern Cross this information, in accordance with the Southern Cross Privacy Statement.

   I authorise Southern Cross to collect information from a previous Southern Cross health insurance policy and/or Cancer Assist policy and/or Critical Illness policy (including previous application(s), membership certificate(s) and/or claims.)

In relation to any other people covered by this policy, 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);
- I have made each of them aware of the contents of this form; and
- each of these people have authorised me to give the acknowledgements, undertakings and authorities set out above on their behalf.

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/privacy** 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.

11. YOUR SIGNATURE

Thank you

We will review the details you have provided and advise you in writing of the specific terms applying to your policy. If you are not satisfied with the upgrade or change or you wish to remove the new person named on the medical declaration during the first 14 days after receiving your policy document and membership certificate, you can revert to the plan you held immediately prior to the change and any premium adjustments will be made accordingly. You can only revert to your previous plan or remove the addition if you have not made a claim under the policy during this period and if you are entitled to do so (those leaving an employer scheme are not able to revert back to their previous plan/entitlements).

By ticking this box I confirm that I have read and agree to the Southern Cross Declaration.

TICK HERE ☐ **Applicant's signature** **Date** _____/_____/_____

FOR OFFICE USE ONLY

Concession type

Previous policy _____

SB ☐ PC ☐ NC ☐

Member	Code	Exclusions	Member	Code	Exclusions

Underwriter's name _____ **Date** _____/_____/_____