Change of plan form

Please fill out this form if you would like to make a change to your existing policy. We will contact you to complete any further documentation that may be required.

1.0 About your policy

Name	Policy number								

Note: If your address has changed in the last 12 months, please update your details below:

Contact details

Name

Phone

Email Address

All correspondence will be sent to the email address of the policyowner(s). A valid email address must be provided.

2.0 Adding a family member

If you would like to add any family members to your policy please provide their details below:

Note: Family members will be added with the same level of cover as what is currently stated on your policy unless otherwise specified in section 2.1 *with the exception of Serious Condition Lump Sum Option which is fully underwritten and only available to members 16 years or over.*

Partner's name	Date of birth	d	d	m	m	y	y	y	y	Gender assigned at birth ◡ Male ◡ Female
Child one's name	Date of birth	d	d	m	m	y	y	y	y	Gender assigned at birth ◡ Male ◡ Female
Child two's name	Date of birth	d	d	m	m	y	y	y	y	Gender assigned at birth ◡ Male ◡ Female
Child three's name	Date of birth	d	d	m	m	y	y	y	y	Gender assigned at birth ◡ Male ◡ Female

2.1 Policy details

Note: If you would like to change or upgrade your policy please tick the appropriate box below:

Insured person's name:

◡ Add Specialist Option ◡ Add GP Option

◡ Add Dental, Optical, and Therapeutic Option

◡ Add Proactive Health Option

◡ Other _____

◡ Add Serious Condition Lump Sum Option:
(This Option requires the completion of a full application form.)

◡ Add Non-PHARMAC Plus Option:

◡ $20,000 ◡ $50,000 ◡ $100,000

◡ $200,000 ◡ $300,000

◡ Change the excess on your policy to:

◡ nil ◡ $250 ◡ $500

◡ $1,000 ◡ $2,000 ◡ $4,000

◡ $6,000

Insured person's name:

◡ Add Specialist Option ◡ Add GP Option

◡ Add Dental, Optical, and Therapeutic Option

◡ Add Proactive Health Option

◡ Other _____

◡ Add Serious Condition Lump Sum Option:
(This Option requires the completion of a full application form.)

◡ Add Non-PHARMAC Plus Option:

◡ $20,000 ◡ $50,000 ◡ $100,000

◡ $200,000 ◡ $300,000

◡ Change the excess on your policy to:

◡ nil ◡ $250 ◡ $500

◡ $1,000 ◡ $2,000 ◡ $4,000

◡ $6,000

See over page...

2.1 Policy details

Note: If you would like to change or upgrade your policy please tick the appropriate box below:

Child's name:

- Add Specialist Option
- Add GP Option
- Add Dental, Optical, and Therapeutic Option
- Add Proactive Health Option
- Other _____

- Add Serious Condition Lump Sum Option:
  (This Option requires the completion of a full application form.)

- Add Non-PHARMAC Plus Option:
  - $20,000
  - $50,000
  - $100,000
  - $200,000
  - $300,000

- Change the excess on your policy to:
  - nil
  - $250
  - $500
  - $1,000
  - $2,000
  - $4,000
  - $6,000

Child's name:

- Add Specialist Option
- Add GP Option
- Add Dental, Optical, and Therapeutic Option
- Add Proactive Health Option
- Other _____

- Add Serious Condition Lump Sum Option:
  (This Option requires the completion of a full application form.)

- Add Non-PHARMAC Plus Option:
  - $20,000
  - $50,000
  - $100,000
  - $200,000
  - $300,000

- Change the excess on your policy to:
  - nil
  - $250
  - $500
  - $1,000
  - $2,000
  - $4,000
  - $6,000

3.0 Privacy Act 2020 and Health Information Privacy Code 2020

Collection and use

This form collects each applicant's and insured person's personal and health information. nib will use the information it collects to:

- determine each applicant's and insured person's eligibility for the policies and options applied for, and
- administer the policies, and
- promote and/or market our current and future health and related services and health related products of nib's business partners, and
- consider claims and provide the benefits and health related services under the policies.

Insurance law requires each applicant and insured person to comply with his or her duty of disclosure to nib when applying for insurance. To the extent nib collects personal and health information under that duty, the supply of it to nib is mandatory. If any applicant or insured person fails to provide information required by the duty of disclosure, nib may decline the application or, if nib has issued a policy, it may have the right to cancel the policy retrospectively.

Intended recipients

In providing our health and related services and using personal information, we may collect information from or disclose personal information to:

- nib and its related companies and business partners, and
- all other co-applicants named in this application and all insured persons, and
- any applicant's insurance adviser or other individual who a person has granted authority to access information on their behalf, and
- at claim time:
  - all necessary health service providers
  - any of nib's contractors or service providers assisting it with administering and meeting each applicant's and insured person's claim

Each applicant and insured person authorises the collection of information from and the disclosure of information to the intended recipients named for the purposes set out above.

Access and correction

The accuracy of personal information is important to us. We will take reasonable steps to ensure a person's information is accurate, complete and up-to-date. We rely on the applicant and/or insured person to advise of any changes to their contact details and any other personal information. Each applicant and insured person has the right to access and correct their personal and health information held by nib. nib nz limited, 48 Shortland Street, Auckland collects and holds the personal and health information.

Signature

We are signing this application on behalf of all the children under the age of 16 and are authorised to do so.

Full name of applicant(s)	Today's date	Signature
Policyowner name	d d m m y y y y	
Policyowner name	d d m m y y y y	

Note: If you do not have a Direct Debit operating please complete and return the Direct Debit form which is at the end of this document. Please sign this form and email it to **grouphealth@nib.co.nz**

nib nz limited, PO Box 91 630, Victoria Street West, Auckland 1142, Auckland, Email: **grouphealth@nib.co.nz**

nib Direct Debit Authority

Your personal details

Policy Number:

Office use only: STB ☐

Policyholder name:

Note: You're setting up a direct debit authority which will be payable either monthly, quarterly, half yearly or annually depending on your group arrangement. We will tell you the date and amount of your first payment, and your payment frequency, when we confirm your updated policy details.

Account information

Name of my account to be debited (acceptor)

Name of my bank:

Bank	Branch	Account	Suffix

Initiator's Authorisation Code

0	6	5	4	4	8	3

Approved

5448 | 11/17

From the acceptor to [insert name of acceptor's bank] **(my bank):**

I authorise you to debit my account with the amounts of direct debits from nib with the authorisation code specified on this authority in accordance with this authority until further notice.

I agree that this authority is subject to:

- The bank's terms and conditions that relate to my account, and
- The specific terms and conditions listed below.

Account Holders signature/s

Authorised signature/s:

X

Date D D / M M / Y Y Y Y

Specific conditions relating to notices and disputes

I may ask my bank to reverse a direct debit up to 120 calendar days after the debit if:

- I don't receive a written notice of the amount and date of each direct debit from the initiator, or
- I receive a written notice but the amount or the date of debiting is different from the amount or the date specified on the notice.

The initiator is required to give a written notice of the amount and date of each direct debit in a series of direct debits no later than the date of the first direct debit in the series. The notice is to include:

- the dates of the debits, and
- the amount of each direct debit.

If the bank dishonours a direct debit but the initiator sends the direct debit again within 5 business days of the dishonour, the initiator is not required to give you a second notice of the amount and date of the direct debit.

If the initiator proposes to change an amount or date of a direct debit specified in the notice, the initiator is required to give you notice:

- no less than 30 calendar days before the change, or
- if the initiator's bank agrees, no less than 10 calendar days before the change.

Please return completed form to: **grouphealth@nib.co.nz**