For new applications, start using nibAPPLY. It's easier, faster and saves time!

Ultimate Health / Ultimate Health Max Application

This form can also be used to request changes to any existing underwritten nib products excluding Major Medical policies.

nib

Policy number

Adviser number

This application is for:
◯ A new policy ◯ Replacing an existing policy ◯ Reducing an excess ◯ Adding an option
◯ Adding an additional person over 4 months of age. If adding a child less than 4 months please call 0800 123 642.
◯ Increasing cover from Ultimate Health to Ultimate Health Max

1.0 Details of person(s) to be insured (applicants)

1.1 Personal details – first applicant

Policyowner ◯ Yes ◯ No

Applying to be insured? ◯ Yes ◯ No

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr
◯ Other:

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Height (cm) Weight (kg)

Have you smoked any form of tobacco, e-cigarettes, vaping or any other substance in the last 12 months?
◯ Yes ◯ No

Are you a permanent New Zealand resident/citizen or Australian citizen residing in New Zealand?
◯ Yes ◯ No

If "No", are you eligible for publicly funded health services?
◯ Yes ◯ No (unfortunately nib cannot offer you health insurance at this time)

Eligibility criteria can be found on Ministry of Health website under "Guide to eligibility for publicly funded health services". Please note, it is your responsibility to remain eligible while your policy is in force.

Contact details

Preferred phone number

Email

1.2 Personal details – second applicant (if applicable)

Policyowner ◯ Yes ◯ No

Applying to be insured? ◯ Yes ◯ No

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Title ◯ Mr ◯ Mrs ◯ Ms ◯ Miss ◯ Dr
◯ Other:

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Height (cm) Weight (kg)

Have you smoked any form of tobacco, e-cigarettes, vaping or any other substance in the last 12 months?
◯ Yes ◯ No

Are you a permanent New Zealand resident/citizen or Australian citizen residing in New Zealand?
◯ Yes ◯ No

If "No", are you eligible for publicly funded health services?
◯ Yes ◯ No (unfortunately nib cannot offer you health insurance at this time)

Eligibility criteria can be found on Ministry of Health website under "Guide to Eligibility for publicly funded health services". Please note, it is your responsibility to remain eligible while your policy is in force.

Contact details

Preferred phone number

Email

All correspondence will be sent to the email address of the policyowner(s) where a valid email address is provided.
A valid email address is required in order to be eligible for nib Ultimate Health Travel Insurance (not available if replacing existing nib cover).

Address details (physical)

Street number

Street name

Suburb

Town / City

Postcode

Address details (mailing – if different)

Street / PO Box number

Street name

Suburb

Town / City

Postcode

Note: The policyowner(s) must be 16 or over.

Adviser – please attach an nib illustration.

Note: Additional applicants cannot be policyowners.

1.3 Personal details – applicants under age 16

Note: A parent or legal guardian must sign the declaration for all applicants under age 16. The parent / legal guardian must be eligible for publicly funded health services.

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Gender ◯ Male ◯ Female

Date of birth d d m m y y y y

If child is 12 years or above please complete the following:

Height (cm) Weight (kg)

1.4 Personal details – applicants aged 16 and over

Note: All applicants aged 16 and over must sign the declaration.

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Height (cm) Weight (kg)

Have you smoked any form of tobacco, e-cigarettes, vaping or any other substance in the last 12 months?
◯ Yes ◯ No

Are you a permanent New Zealand resident/citizen or Australian citizen residing in New Zealand?
◯ Yes ◯ No

If "No", are you eligible for publicly funded health services?
◯ Yes ◯ No (unfortunately nib cannot offer you health insurance at this time)

Eligibility criteria can be found on Ministry of Health website under "Guide to eligibility for publicly funded health services". Please note, it is your responsibility to remain eligible while your policy is in force.

Preferred phone number

Email

Applicant details

Base hospital cover: ◯ Ultimate Health ◯ Ultimate Health Max
◯ Other:

Excess: ◯ Nil ◯ $250 ◯ $500 ◯ $1,000
◯ $2,000 ◯ $4,000 ◯ $6,000

Option: ◯ Specialist Option
◯ non-PHARMAC Plus Option: (not available under Ultimate Health)
◯ $20,000 ◯ $50,000 ◯ $100,000
◯ $200,000 ◯ $300,000
◯ Serious Condition Financial Support Option: (including legacy trauma Options)
Amount:
◯ Other:
Other Options may be available under your selected base hospital product. Contact nib for further information.

Surname

First name(s)

Date of birth d d m m y y y y

Gender ◯ Male ◯ Female

Height (cm) Weight (kg)

Have you smoked any form of tobacco, e-cigarettes, vaping or any other substance in the last 12 months?
◯ Yes ◯ No

Are you a permanent New Zealand resident/citizen or Australian citizen residing in New Zealand?
◯ Yes ◯ No

If "No", are you eligible for publicly funded health services?
◯ Yes ◯ No (unfortunately nib cannot offer you health insurance at this time)

Eligibility criteria can be found on Ministry of Health website under "Guide to eligibility for publicly funded health services". Please note, it is your responsibility to remain eligible while your policy is in force.

Preferred phone number

Email

Note: If there is not enough space for details of relevant persons to be insured, please complete an additional application form for those persons.

2.0 Premium payment details (new applications only)

If the payment date and the start date of your policy are not in the same payment cycle, you may pay a double deduction. Change requests for existing nib policies will retain the current payment method and frequency, unless otherwise requested.

Note: Please select your preferred payment type and choose the relevant payment frequency from the following:

2.1 Direct Debit

Please also complete the Direct Debit Authority on page 12

◯ **Weekly** ◯ **Fortnightly**

(not available for credit cards)

Please select a day of the week for payments to be deducted:

◯ Mon ◯ Tue ◯ Wed ◯ Thu ◯ Fri

Note: Weekend days cannot be selected

◯ **Monthly** ◯ **Quarterly** ◯ **Half yearly** ◯ **Yearly**

Please select a day between the 1st and 28th for payments to be deducted:

Date d d

(unless otherwise specified the payment date will be in line with the commencement date)

2.2 Credit Card

◯ **Credit card**

Select this payment type if you would like to pay by credit card. nib will contact you to arrange your credit card payments. Please note, nib will accept payments that are either monthly, quarterly, half yearly, and annually for Visa and Mastercard only.

2.3 Commencement date

The commencement date is the date the application is received by nib or an alternative date nominated by you or us. The nominated commencement date is subject to the following provisions:

- no later than six weeks from the date this application is signed;
- no earlier than the date the application is received by us; and
- the application is accompanied by a valid, signed Direct Debit Authority or credit card information.

Nominated commencement date d d m m y y y y

3.0 Serious Condition Financial Support

Only complete this section if you are applying for the Serious Condition Financial Support Option or equivalent Option under any other underwritten products. **Note:** This Option is only available to applicants aged 16 years or over.

Have any of your birth parents, brothers or sisters suffered from a stroke, bowel cancer, breast cancer, prostate cancer, heart condition, high blood pressure, raised cholesterol, diabetes, Huntington's disease, motor neurone disease, haemochromatosis, polycystic kidney disease or any other hereditary disorder? (If "Yes", please give details below) ◯ Yes ◯ No

Applicant name	Relationship	Condition	At what age did the family member suffer the condition?	Has this family member died before age 60?
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No

4.0 Health conditions

Better reworded as – Important: This is a material part of your application and is to be completed in respect of all applicants named in the section above. **You must disclose details of any sign, symptom, treatment or surgery of any medical condition. When in doubt, disclose.** Refer to the Declarations in Section 9 for the importance of full disclosure and the potential consequences if you do not provide all relevant information including that nib may cancel your policy with effect from the start date of cover. If you experience any change in health before you receive your acceptance certificate, you must let us know. **Please answer YES (in the right column) if any of the below conditions apply to one or more of the applicants named above.**

4.1 Whole body

 4.1.1. Nerves Have you ever had nerve conditions? Including multiple sclerosis, paralysis, Bell's palsy or any other nerve conditions.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.1.2. Glands Have you ever had glandular fever? Including pituitary gland disease, adrenal gland disease, pineal gland disease, thymus disease, thyroid disorder or any other glandular condition.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.1.3. Skin Have you had any skin conditions? Including benign skin lesion, mole or solar keratosis, eczema, psoriasis, acne, folliculitis, dermatitis, allergic reaction, skin reaction from a chemical sensitivity or any other skin condition.	◯ Yes ◯ No *If Yes, please answer question 6.1*
 4.1.4. Bone and muscle Have you ever had any pain, injury or disease of your muscles, joints, tendons or bones? Including gout, arthritis, osteoporosis, chronic fatigue, bone inflammation or osteomyelitis, occupational overuse syndrome, tendonitis, back injury, facial injury, fractured bone, joint injury or any other bone and muscle conditions.	◯ Yes ◯ No *If Yes, please answer question 6.2*
 4.1.5. Diabetes blood sugar Have you ever had any type of diabetes or any abnormal blood sugar results? Including type 1 diabetes, type 2 diabetes, abnormal blood sugar levels, insulin resistance or gestational diabetes.	◯ Yes ◯ No *If Yes, please answer question 6.3*
 4.1.6. Blood and veins Have you ever had any blood or bleeding disorder, haemorrhoids or varicose veins? Including anaemia, haemophilia, blood clotting disorder, rectal bleeding or any other blood and vein conditions.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.1.7. Cancer Have you ever had any type of cancer?	◯ Yes ◯ No *If Yes, please answer question 5*
 4.1.8. Ulcer, abscess or tumour Have you ever had any ulcers, tumours, lumps, cysts, abscesses or any other conditions?	◯ Yes ◯ No *If Yes, please answer question 5*

4.2 Head

 4.2.1. Brain Have you ever had any brain condition, seizures or head injury or symptoms of dizziness? Including epilepsy, febrile convulsion, dizzy spells, migraines, multiple sclerosis, stroke, Parkinson's disease, TIA (mini stroke), head injury, neurological disease, paralysis or other brain conditions.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.2.2 Eyes Have you ever had any eye conditions? Including blindness, cataracts, conjunctivitis, glaucoma, iritis, uveitis, choroiditis, chorioretinitis, keratoconus, macular degeneration, retinal detachment, blepharitis, ptergum, lazy eye, corneal abrasion, corneal ulceration or other eye problems.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.2.3. Mouth Have you ever had any mouth or teeth conditions? Including Impacted or unerupted teeth or other mouth or oral problem (do not declare routine / orthodontic dental treatment).	◯ Yes ◯ No *If Yes, please answer question 6.4*
 4.2.4 Ear, nose and throat Have you ever had any ear, nose or throat conditions? Including sinusitis, recurrent sore throat, tonsillitis, ear infections, or hay fever or any other ear, nose or throat conditions.	◯ Yes ◯ No *If Yes, please answer question 5*

4.3 Chest

 4.3.1 Blood pressure and cholesterol Have you ever had any high blood pressure or raised cholesterol?	◯ Yes ◯ No *If Yes, please answer question 6.5*
 4.3.2 Heart conditions Have you ever had any heart conditions? Including heart murmur, rheumatic fever, hole in the heart, heart valve disease, angina, arrhythmia or abnormal heart beat, heart attack, heart failure or heart surgery, any other heart disease or disorder.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.3.3 Lungs and breathing Have you ever had any lung condition, asthma or breathing disorders? Including asthma, TB (tuberculosis), emphysema, chronic obstructive airway disease (COAD), bronchitis, pneumonia, sleep apnoea, nodules on the lung, other lung, chest or breathing problem.	◯ Yes ◯ No *If Yes, please answer question 6.6*

4.4 Abdomen

 4.4.1 Upper digestive system Have you had any heartburn or chest pain with an unknown cause? Including indigestion, gastric reflux, helicobacter pylori (H pylori), difficulty with swallowing, chest pain with cause unknown, heartburn or other digestive problem.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.2 Digestive system Have you ever had any bowel issues, gallbladder, appendix, pancreas or other intestinal condition? Including appendicitis, constipation, diarrhoea, ulcer, pancreatitis, diverticulitis, coeliac disease, lactose intolerance, other gastro-intestinal problem or abdominal pain with cause unknown.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.3 Liver Have you had any liver conditions or any hepatitis? Including fatty liver, hepatitis, jaundice, cirrhosis of the liver, liver transplant or other liver problem.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.4 Hernia Have you had any type of hernia? Including hiatus hernia, inguinal hernia, umbilical hernia, incisional hernia, femoral hernia, epigastric hernia or other hernia.	◯ Yes ◯ No *If Yes, please answer question 6.7*
 4.4.5 Kidney Have you had any kidney conditions or urinary reflux? Including kidney stones and infections, polycystic kidney disease, nephrotic syndrome, kidney failure, or other kidney condition.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.6 Urinary system Have you had any bladder, urinary or urinary tract condition, or abnormal urine test results? Including urinary tract infection, urinary reflux, ureteral stricture, bladder disease or disorder, ureters disorder, urethra disorder, blood in the urine, protein in the urine or other urinary tract infections.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.7 Female anatomy Have you ever had any cervix, uterus, ovarian or vaginal conditions? Including endometriosis, heavy or painful periods, or abnormal smears, or abnormal mammogram results, or pregnancy complications?	◯ Yes ◯ No *If Yes, please answer question 6.8*
 4.4.8 Male anatomy Have you ever had any prostate, urinary flow, testicular or penile conditions? Including increased urinary frequency or urgency, slow urinary stream or problems passing urine, sexual dysfunction likely to require treatment, testicular disorder, Hypospadias, Epispadias or other conditions.	◯ Yes ◯ No *If Yes, please answer question 5*
 4.4.9. Other Any other illness, injury, condition, medical treatment, surgery, or medication not covered above? Are you awaiting any tests not covered above?	◯ Yes ◯ No *If Yes, please answer question 5*

5.0 Health questions – standard

Please provide details below if you have answered **YES** to any of the above questions in section 4. If you need more space please attach another sheet to the form, or alternatively please provide the answers in section 7.

Question number ______ **Applicant name** ______

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had?

e. When did you last have treatment?

f. What tests and investigations have you had and what were the findings?

Question number ______ **Applicant name** ______

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had?

e. When did you last have treatment?

f. What tests and investigations have you had and what were the findings?

Question number ______ **Applicant name** ______

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had?

e. When did you last have treatment?

f. What tests and investigations have you had and what were the findings?

Question number ______ **Applicant name** ______

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had?

e. When did you last have treatment?

f. What tests and investigations have you had and what were the findings?

Question number ______ **Applicant name** ______

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had?

e. When did you last have treatment?

f. What tests and investigations have you had and what were the findings?

6.0 Health questions

If you need more space please attach another sheet to the form, or alternatively please provide the answers in section 7.

6.1 Skin

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If skin lesions or moles, please indicate if they have been removed?

g. If skin lesions or moles, please identify the histology? (mark one box only)
◯ Malignant ◯ Benign ◯ Pre-malignant ◯ Unknown

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If skin lesions or moles, please indicate if they have been removed?

g. If skin lesions or moles, please identify the histology? (mark one box only)
◯ Malignant ◯ Benign ◯ Pre-malignant ◯ Unknown

6.2 Bone and muscle

Applicant name:

a. Name of your condition?

b. Body area affected (please advise left or right or if back, which part of the back was affected)?

c. When did you first have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. Have you had any metalware or fixation devices implanted which are still in place?

f. What tests, scans, x-rays or investigations have you had and what were the findings?

g. Are you awaiting any further treatment or investigations?

Applicant name:

a. Name of your condition?

b. Body area affected (please advise left or right or if back, which part of the back was affected)?

c. When did you first have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. Have you had any metalware or fixation devices implanted which are still in place?

f. What tests, scans, x-rays or investigations have you had and what were the findings?

g. Are you awaiting any further treatment or investigations?

6.3 Diabetes blood sugar

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. What is your last HbA1c (if known)?

g. Have you had any complications (if yes please advise what these are)?

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. What is your last HbA1c (if known)?

g. Have you had any complications (if yes please advise what these are)?

6.4 Mouth

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If wisdom teeth, how many wisdom teeth have been removed?

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If wisdom teeth, how many wisdom teeth have been removed?

6.5 Blood pressure and cholesterol

Applicant name:

a. Name of your condition?

b. Name current medications, if not on medication please advise of latest readings

Applicant name:

a. Name of your condition?

b. Name current medications, if not on medication please advise of latest readings

6.6 Lungs and breathing

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. Have you had any time off work or school, been hospitalised or had oral steroids for this condition in the last 2 years?

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. Have you had any time off work or school, been hospitalised or had oral steroids for this condition in the last 2 years?

6.7 Hernia

Applicant name:

a. Which types of hernia have you had?

b. Where was your hernia located?

c. What treatment have you had for your hernia (if surgery, please indicate if you have had Mesh inserted)?

d. When did you last have any treatment for your hernia, or signs of your hernia?

Applicant name:

a. Which types of hernia have you had?

b. Where was your hernia located?

c. What treatment have you had for your hernia (if surgery, please indicate if you have had Mesh inserted)?

d. When did you last have any treatment for your hernia, or signs of your hernia?

6.8 Female anatomy

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If abnormal cervical smears: If abnormal cervical smears:

- When was your last abnormal cervical smear?

  Date d d m m y y y y

- How many normal smear tests have you had since then?

Applicant name:

a. Name of your condition?

b. When did you first have the condition, signs or symptoms?

c. When did you last have the condition, signs or symptoms?

d. What treatment have you had and when did you last have any treatment?

e. What tests and investigations have you had and what were the findings?

f. If abnormal cervical smears: If abnormal cervical smears:

- When was your last abnormal cervical smear?

  Date d d m m y y y y

- How many normal smear tests have you had since then?

7.0 Additional notes and information

Applicant name: _____

Notes:

Applicant name: _____

Notes:

Applicant name: _____

Notes:

Applicant name: _____

Notes:

Applicant name: _____

Notes:

8.0 Business replacement

The Financial Markets Conduct Act requires advisers to exercise care, diligence and skill when providing clients with financial advice. That advice should include an accurate explanation of the differences between your existing and proposed policy/benefits, the advantages and disadvantages of switching, and the reasons why replacement is your best option.

Note: If your or a previously insured person's health has changed since the commencement date of the policy(ies) to be replaced, you may not be able to obtain the same acceptance terms. If the existing policy is with another insurer, you'll need to contact the old insurer directly to cancel the policy. We strongly suggest you do not cancel any existing policy until everything necessary has been disclosed to nib, the new policy has been issued and you are happy that you and any previously insured persons are appropriately insured.

Business replacement advice

Is this application for health insurance to replace any existing health insurance policy for any of the lives insured, or any health insurance policy that has been cancelled in the last six months? ◯ Yes ◯ No

Applicant to confirm

◯ I confirm that I have been provided with all the information and advice in relation to moving the health insurance for all lives insured to nib, or replacing an existing nib policy.

Adviser to confirm

I, _____ confirm that I have provided the applicant(s) all the necessary information and advice for them to make an informed decision to move their insurance to nib, or replace an existing nib policy. I confirm that this change is in the best interests of the applicant(s).

9.0 Important information and declaration

Commencement of cover

Cover commences under the nib health policy on the date shown on the Acceptance Certificate for the applicable:

- commencement date (new policy), or
- effective date (changes to policy), or
- join date (new person on policy)

subject to any waiting period referred to in the policy.

Cover commences under the nib travel policy in accordance with the terms of the policy – please read "When am I covered?" for more information. The start of your nib travel policy will be confirmed in your welcome pack (not available if replacing existing nib cover).

Privacy Act 2020 and Health Information Privacy Code 2020

Collection and use

This Application 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 an 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.

nib Ultimate Health Travel Insurance (not available if replacing existing nib cover).

The applicants agree:

- to receive all travel insurance related documents electronically at the email address provided on this Application, and
- they have unrestricted rights of entry back into New Zealand, and
- to be repatriated to New Zealand if medically necessary as a result of a claim.

All information provided is true and complete

Each applicant and insured person declares that:

- all the information he or she has provided in this Application is true and complete, and
- where he or she has provided information on behalf of a co-applicant and/or an insured person, he or she has the authority to do so.

Signature(s)

Note: Before signing, please ensure you have answered all the questions and have read and understood section 9.0 'Important information and declaration' above.

Policyowner(s) and applicants age 16 or over

To be signed by all applicants aged 16 and over, including the policyowner(s).

Note: The Policyowner(s) must be age 16 and over. Policyowner(s) are also signing on behalf of all dependent children under age 16.

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

Sign here

Adviser details

Adviser number

Agreement number **B**

◯ Upfront ◯ Hybrid or ◯ Spread

Note: If left unmarked, upfront will be selected by default.

To speed up acceptance of this application, may we contact your customer direct for further information?

◯ Yes ◯ No

Name of Adviser

Phone

◯ The default process for all policy acceptance information is to be emailed to the client and a copy email to the Adviser. Please select here if you also want a hard copy of the Welcome Pack sent to you.

Financial strength rating

nib nz limited has an A- (Strong) financial strength rating given by S&P Global Ratings Australia Pty Ltd.

A- Strong	AAA (Extremely Strong) AA (Very Strong) A (Strong) BBB (Good)	B (Weak) CCC (Very Weak) CC (Extremely Weak)	SD or D (Selective Default or Default) R (Regulatory Action) NR (Not Rated)

Direct Debit Authority

Your personal details

Policy number:

Office use only: STB ☐

Policyholder name:

I would like to pay: ☐ Weekly ☐ Fortnightly ☐ Monthly ☐ Quarterly ☐ Half-yearly ☐ Annually

Preferred start date: D D / M M / Y Y Y Y

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: **newbusinessteam@nib.co.nz**

Checklist

Please check that you have completed the following:

- ◯ Answered all the questions
- ◯ Provided additional information in the appropriate questionnaire if a question requires more details
- ◯ Completed 'Business Replacement' section 8
- ◯ Carefully read and signed the 'Important information and declaration' section
- ◯ Relevant payment details completed
- ◯ If any information has been completed on a separate sheet, it must be attached to this application, signed and dated
- ◯ For Advisers: a nib illustration is attached to the application

Next steps for your application

We want to make your application as easy as possible. Below is an outline of the process.

If you have any questions, please contact your Financial Adviser or call us on **0800 123 nib** (0800 123 642)

Application sent to nib

Application received and assessed.

The date your application is received by us is the date your cover will commence (unless a later date has been stated in this application).

Premiums will be due from this date.

We assess your application to ensure you qualify for the cover you have applied for and the illustration is correct.

Is further information required?

In some instances, we require additional information to complete your application.

NO

Your policy is issued

You will receive your Welcome Pack including the policy document and Acceptance Certificate outlining any changes to the terms of your policy.

The 14-day free-look period

We understand the cover you have chosen needs to fit in with your overall financial and health needs. To allow you time to review your policy details and ensure it meets your needs, we provide a 14-day free-look period. During this time should you decide your policy doesn't meet your needs, please send written confirmation to us and we will cancel the policy and refund the full premiums paid, providing no claims have been made.

YES

We will contact your adviser or you directly and outline what the requirements are

As a general rule for health insurance, we rely on the information that you or your adviser provide us to be true, correct and complete, and we do not usually request medical information from your GP.

Confirmation of terms

On some occasions, an exclusion or an additional premium may be applied due to a pre-existing medical condition. If the terms are changed we will let you or your adviser know the new terms before issuing the policy.

nib nz limited, 48 Shortland Street, Auckland, Phone: 0800 639 642, Email: newbusiness@nib.co.nz

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