NEW ZEALAND FIREFIGHTERS WELFARE SOCIETY

HEALTHCARE 99 APPLICATION FORM

Healthcare 99 is a mutual fund not an insurance scheme

Private Bag 31999 LOWER HUTT Telephone 0800 OK FIRE Fax 0800 65 3475
thesec@firefighters.org.nz *www.firefighters.org.nz*

CONTACT DETAILS

Name of Member *	Welfare Society Membership Number *
Select either (please tick one) Option A ☐ or Option B ☐ * or Option A1 ☐ or Option B1 ☐ For more information, refer to the Information Brochure, *www.firefighters.org.nz*	Member Phone Number * Email Address *

DETAILS (names known as)

Spouse/Partner	Date of Birth *
Child	Date of Birth *
Child	Date of Birth *
Child	Date of Birth *
Child	Date of Birth *
Child	Date of Birth *

MEMBERS BANK ACCOUNT DETAILS FOR REFUNDS

Bank ☐☐ Branch ☐☐☐☐ Account Number ☐☐☐☐☐☐☐ Suffix ☐☐☐ *

DECLARATION

List Pre-existing and congenital conditions below. *

Name	Condition	Treatment
Name	Condition	Treatment
Name	Condition	Treatment
Name	Condition	Treatment
Name	Condition	Treatment

I declare that the applicants listed below have received medical treatment for ther pre-exiting conditions during the last 5 years. *

Name	Condition	Date	Treatment Cost

POINTS TO NOTE

Pre-existing medical conditions and congenital conditions are excluded.

All entries marked with an * must be filled in.

FOR OFFICE USE ONLY – EFFECTIVE DATE

Approved by: Date:

Please Turn Over

HEALTHCARE 99

Declaration & Agreement

1 I / We declare that:

- I / We agree that the quotation shall be the basis of the contract between myself / us and Healthcare 99 and I / We am / are willing to accept the terms, conditions and exclusions of Heathcare 99.
- The answers and information given and on any attachment are in every respect correct.
- I / We authorise the disclosure of personal information held by any party regarding any claim regarding my / our existing or previous insurances.
- I / We agree to Healthcare 99 releasing to other parties personal information regarding any claim.

PLEASE READ AND ANSWER THESE QUESTIONS FULLY

2 **Have you or any other person to be covered under this Healthcare 99 Benefit**

- Has any insurer declined, cancelled, required withdrawal, imposed special terms on you or ever refused a claim?

Details:

- Is there any further information that may affect the acceptance of membership to Healthcare 99 *(eg bankruptcy, insolvency, criminal activity or associations or convictions or any other circumstances giving greater than normal risk of loss. Note this is not an exhaustive list)*

Details:

I understand that on being approved for membership, I will accept the Rules of the Society as being binding upon me. I hereby give authority for the Society to have deducted from my wages, salary or other payments as the case may be, the contributions payable to the Society and any levies which may from time to time be imposed and subsequently ratified at the Annual General Meeting of the Welfare Society.

I will not be a full member until my first contribution fee is received by the office of the Welfare Society.
Once this form is submitted if I do not have a payroll number I will received a direct debit form from the office which I will complete and return to the office of the Welfare Society so my full membership can be confirmed.

TICK THIS BOX TO AGREE ☐ DATE *

All claims submitted are subject to reimbursement at the sole discretion of the Healthcare 99 Committee.

ALL IN-HOSPITAL PROCEDURES MUST HAVE PRIOR APPROVAL OF THE CLAIMS MANAGER

HEALTHCARE 99 IS NOT AN INSURANCE SCHEME