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 ☐ *	Member Phone Number *
For more information, refer to the Information Brochure, *www.firefighters.org.nz*	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.

I apply for Membership and agree to the terms and conditions of the Mutual Fund Healthcare 99.

SIGNED * DATE *

FOR OFFICE USE ONLY – EFFECTIVE DATE

Approved by: Date:

03/24/15

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:

Signature of Applicant - Date

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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