



For office use only

Critical Illness policy number

1. YOUR DETAILS

Please complete this form in full. Print using a black or blue pen only. Please initial any corrections you make. This section is to be completed by the applicant only.

Are you an existing Southern Cross member?

Yes Please fill in your Southern Cross membership number and continue

No If you are applying for a Southern Cross health insurance policy as well as a Critical Illness policy please continue, and ensure that you attach this form to your Southern Cross health insurance application form.

CRITICAL ILLNESS MAXIMUM

(Please note the Critical Illness Maximum selected will apply for you and each family member named in this application).

\$20,000 Critical Illness Maximum

\$50,000 Critical Illness Maximum

\$100,000 Critical Illness Maximum

APPLICANT DETAILS

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Height (cm) _____ Weight (kg) _____

Have you smoked tobacco during the last 12 months? Yes No

Physical address _____
Street number _____ Street _____ Suburb _____ Town/city _____

Postal address _____
(if different from above) Street number _____ Street _____ Suburb _____ Town/city _____

Home phone Work phone Extn

Mobile phone E-mail _____

Dependant 1

Title _____ First name _____ Surname _____ Date of birth _____ Male/female (Please circle)

Height (cm) _____ Weight (kg) _____

Have you smoked tobacco during the last 12 months? Yes No

Dependant 2

Title _____ First name _____ Surname _____ Date of birth _____ Male/female

Height (cm) _____ Weight (kg) _____

Have you smoked tobacco during the last 12 months? Yes No

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Rep code

Billing code

Effective date / /

2. YOUR HEALTH

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

	Applicant	Dependant	Other dependant
a. Diabetes or high blood sugar (excluding gestational diabetes)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Cancer or any malignancy which includes carcinoma, sarcoma, Hodgkin's disease, Leukaemia, Lymphoma, breast lump or melanoma (excluding other skin lesions)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Stroke, brain haemorrhage, heart attack, angina, heart related chest pain or any other circulatory or heart conditions (excluding controlled high blood pressure)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Any chronic condition of the kidney or bladder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. Any chronic condition of the liver including cirrhosis and Hepatitis B or C	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
f. Chronic lung or other chronic respiratory disorders including emphysema or chronic bronchitis (excluding controlled asthma)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
g. Any injury or disorder of the central nervous system (brain, spinal cord or nerves) including, Multiple Sclerosis, paralysis, Dementia, Motor Neurone Disease or Parkinson's Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you wish to add any detail use the space below _____

2. Have you or **any family member** named on the application had two or more natural parents, brothers or sisters (living or dead) whom have been diagnosed before the age of 55 with:

	Applicant	Dependant	Other dependant
a. Bowel cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Breast or Ovarian cancer (females only)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

3. Have you or **any family member** named on the application had any of your natural parents, brothers or sisters (living or dead) ever suffer from:

	Applicant	Dependant	Other dependant
Huntington's Chorea, Motor Neurone Disease, Parkinson's Disease, Dementia, Heart disease, Polycystic kidney disease, Stroke, Diabetes or Muscular Dystrophy or any hereditary or familial disease or disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered **YES to question 2 or 3**, please provide the condition and the age the relative developed symptoms and their relationship to the applicant and/or family member below. If there is not enough space on the form please provide the details on a separate sheet.

3. PAYMENT METHOD

Direct debit

Weekly Fortnightly Monthly

Recurring credit card

Monthly Annually

4. YOUR DECLARATION

Please read carefully before signing.

I hereby declare as follows

1. That the information I have disclosed is true and complete.
2. That any further information I disclose to Southern Cross between the date I sign this application and the date I receive a Critical Illness 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 named in this application, or any other relevant information that may affect the policy, between the date I sign this application and the date I receive a Critical Illness Certificate from Southern Cross.
3. I accept the terms and conditions (including the limitations and exclusions) of the policy.
4. I accept that a three month no claim period exists from the policy start date unless specifically waived at enrolment.
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.

Privacy – Application Details

1. I understand that:
 - (a) the information Southern Cross collects in this application will be used:
 - to consider the eligibility for cover of people named in this application;
 - to consider the specific terms applying to the policy and any associated benefits (including the exclusion of cover for any pre existing conditions);
 - for administration purposes such as billing and claims management; and
 - for marketing purposes.
 - (b) if any of the information requested as part of this application is not provided, it may delay the application being processed, or result in Southern Cross not providing the people named in this application with cover or associated benefits.

(c) The people named in this application 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 named in this application);
- 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 named in this application 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, disclose and to use, personal and health information relating to the people named in this application, from their Southern Cross insurance policy (including their Southern Cross insurance application, Membership Certificate and claims history) for those purposes as set out in the Privacy – Application Details at (1) and you and each of the people named in this application authorise this collection and disclosure to those parties as set out above in Privacy – Application Details at (2).

In relation to any other people named in this application, I confirm that:

- I am authorised to complete this application on their behalf;
- I am authorised to disclose to Southern Cross and to receive from Southern Cross their personal and health information;
- I have made each of them aware of the contents of this application; and
- each of the people named have authorised me to give the acknowledgements, undertakings and authorities set out in the Privacy – Application Details at (1) and (2) 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/society or contact Member Services on 0800 800 181.

5. FINAL CHECK LIST

Please make sure you have completed everything in the check list before sending this form to Southern Cross.

FORM SIGNED ALL QUESTIONS IN SECTION 2 ANSWERED PREMIUM PAYMENT FORM SIGNED

6. YOUR SIGNATURE

Thank you for your application

We will review your application and advise you in writing of the specific terms applying to your policy and the policy start date. If you are not satisfied with the policy during the first 14 days after receiving it, you can cancel the policy and we will provide a full refund of all premiums paid.

Applicant's signature _____ Date ____/____/____

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Member	Code	Exclusions	Quoted by Sales	Loaded rate
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Underwriter's signature _____ Date ____/____/____