



**Please complete this form in full.** Print using a black or blue pen only.  
Please initial any corrections you make. To have Critical Illness you must also have a Southern Cross health insurance policy (excluding HealthEssentials).

For office use only

Critical Illness  
policy number

--	--	--	--	--	--	--	--	--	--

## REASON FOR COMPLETING APPLICATION

### New Critical Illness policy

If you are an existing Southern Cross member please fill in your membership number and complete sections 1 to 8.

--	--	--	--	--	--	--	--	--	--

### Adding a partner and/or dependant(s)

Please fill in your Critical Illness policy number and complete sections 2 to 8.

--	--	--	--	--	--	--	--	--	--

### Change level of cover

If increasing, please fill in your Critical Illness policy number and complete sections 3 to 8.  
If decreasing, please fill in your Critical Illness policy number and complete sections 3 and 5 to 8.

--	--	--	--	--	--	--	--	--	--

## 1. YOUR DETAILS

The policyholder must be 18 or over.

Title \_\_\_\_\_ First name \_\_\_\_\_ Surname \_\_\_\_\_ Date of birth \_\_\_\_\_

Physical address \_\_\_\_\_  
Street number Street Suburb Town/city Postcode

Postal address \_\_\_\_\_  
(if different from above) Street number Street Suburb Town/city Postcode

Home phone 

--	--

--	--	--	--	--	--	--	--

 Work phone 

--	--

--	--	--	--	--	--	--	--

 Extn 

--	--	--	--

Mobile phone 

--	--	--	--

--	--	--	--	--	--	--	--

 E-mail \_\_\_\_\_

Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kgs Biological sex\*  Male  Female

## 2. ADD PARTNER AND/OR DEPENDANTS

A child can only be named as a dependant on their parents' policy, and must be under the age of 21 years.

**Partner** Title \_\_\_\_\_ First name \_\_\_\_\_ Surname \_\_\_\_\_

Date of birth \_\_\_\_\_ Biological sex\*  Male  Female Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kgs

Mobile phone 

--	--	--	--

--	--	--	--	--	--	--	--

**Dependant 1** Title \_\_\_\_\_ First name \_\_\_\_\_ Surname \_\_\_\_\_

Date of birth \_\_\_\_\_ Biological sex\*  Male  Female Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kgs  
(only if 18 years or older) (only if 18 years or older)

**Dependant 2** Title \_\_\_\_\_ First name \_\_\_\_\_ Surname \_\_\_\_\_

Date of birth \_\_\_\_\_ Biological sex\*  Male  Female Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kgs  
(only if 18 years or older) (only if 18 years or older)

\* To establish your cover under your Critical Illness policy we need to know your biological sex. In most cases biological sex is that assigned at birth – however if you are intersex or have had surgical reassignment please go to [www.southerncross.co.nz/inclusive](http://www.southerncross.co.nz/inclusive) for support to help you answer this question.

## FOR OFFICE USE ONLY

Sales person's name

Sales code

Billing code

--	--	--	--	--	--	--	--	--	--

Effective date

	/		/	
--	---	--	---	--

### 3. LEVEL OF COVER

Select your Critical Illness level of cover or change your level of cover.

\$20,000     \$50,000     \$100,000     \$200,000     \$300,000

If you are increasing the Critical Illness level of cover, please continue to section 4.

If you are decreasing the Critical Illness level of cover, please continue to section 5.

Please note the Critical Illness level of cover selected will apply to everyone covered by the policy (except for anyone over 65 years old). Any exclusions (as set out in your Critical Illness Certificate) affecting you or any dependant covered by the policy prior to any increase or decrease to your Critical Illness level of cover will remain. If you increase your Critical Illness level of cover, your new Critical Illness level of cover will only apply from 3 months after the date the increase takes effect and your previous Critical Illness level of cover will continue to apply for any critical illness that developed before the date of the increase. If you decrease your Critical Illness level of cover, your new Critical Illness level of cover will apply immediately from the date of the decrease and your new Critical Illness level of cover will apply for any critical illness that developed before the date of the decrease.

### 4. YOUR HEALTH

	You	Partner	Dependant 1	Dependant 2
4.1 Have you or any family members (18 years or older) named in this application smoked tobacco or any substance during the last 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

4.2 Have you or any family member named in this application ever displayed evidence of, or had any sign or symptom or suffered from, sought medical advice/treatment, or intend to seek medical advice/treatment for any of the following:

	You	Partner	Dependant 1	Dependant 2
a. Diabetes or high blood sugar (excluding gestational diabetes)? There is very limited cover available under our Critical Illness policy if you have diabetes. Our Cancer Assist plan may be more suitable for you.	Yes <input type="checkbox"/> No <input type="checkbox"/>	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, Hodgkin's disease, leukaemia, lymphoma, breast lump, melanoma or metastasised skin lesion (excluding other superficial 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Hepatitis B or Hepatitis 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
d. Stroke, brain haemorrhage, heart attack, angina, heart related chest pain or any other circulatory or heart conditions (excluding well 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
e. Any condition of the kidney or bladder, or renal failure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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. Any condition of the liver including cirrhosis or liver failure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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. Lung or other respiratory disorders including emphysema or chronic bronchitis (excluding well 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
h. Any injury or disorder of the 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

4.3 Have you or any family member named in this application had any of your natural parents or siblings (living or dead) diagnosed before the age of 55 with any of the following? Please specify who, what and at what age in 4.9 below.

	You	Partner	Dependant 1	Dependant 2
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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
b. Breast 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
c. Ovarian 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

4.4 Have you or any family member named on this application had any of your natural parents or siblings (living or dead) suffer from any of the following? Please specify who, what and at what age in 4.9 below.

	You	Partner	Dependant 1	Dependant 2
Huntington's chorea, motor neurone disease, Parkinson's disease, dementia, heart disease, polycystic kidney disease, stroke, diabetes, 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"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

4.5 Are you or any family member named in this application aware that you (or they) have a genetic predisposition for developing cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.6 Are you or any family member named in this application currently awaiting the completion or results of any medical investigation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.7 Are you or any family member named in this application currently taking any medication or under regular medical treatment or supervision?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4.8 Are you or any family member named in this application currently intending to seek or currently seeking any medical advice, examination or procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>

4.9 If you answered YES to questions 4.2 to 4.8, please provide further information below. If there is not enough space on the form please provide the details on a separate sheet.

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

**FOR OFFICE USE ONLY**

Member name	Code	Exclusions

**Underwriter's name** \_\_\_\_\_ **Underwriter's signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**QUOTE DETAILS**

Member name	Smoker Yes <input type="checkbox"/> No <input type="checkbox"/>	Sales - Quoted loadings			Underwriting
		BMI	Family history	Or ERA advised	Total loading
	Yes <input type="checkbox"/> No <input type="checkbox"/>				
	Yes <input type="checkbox"/> No <input type="checkbox"/>				
	Yes <input type="checkbox"/> No <input type="checkbox"/>				

## 5. PAYMENT METHOD

### Direct debit

Weekly  Fortnightly  Monthly

### Recurring credit card

Monthly  Annually

## 6. YOUR DECLARATION

Please read carefully before signing. Failure to make this declaration truthfully may invalidate the policy.

### 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 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 that Southern Cross collects in this application and in the wider application process will be used to consider and process my application or to change the Critical Illness level of cover or add a family member for Critical Illness and, if approved, consider the specific terms that apply to my Critical Illness policy or my Southern Cross health insurance policy, to administer my Critical Illness policy and for marketing purposes.
  - (b) if any of the information requested as part of this application is not provided, it may delay the application or changes 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 partner (if named in this application);
  - any person(s) nominated by me;
  - third parties such as health services providers and medical authorities (including ACC and Ministry of Health), agents, contractors, suppliers and other business partners;information relating to people named in this application and authorise these parties to disclose to Southern Cross and receive from Southern Cross this information.

I authorise Southern Cross to collect, disclose and to use, personal and health information relating to the people named in this application, from information it holds regarding their Southern Cross health insurance and/or Critical Illness policy and/or Cancer Assist policy (including previous application(s), membership certificate(s) and/or claims).

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

- I am authorised to complete this application form 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 above on their behalf.

Once your application has been accepted, 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/privacy](http://www.southerncross.co.nz/privacy) or contact us on 0800 800 181.

### Financial strength rating

Southern Cross Medical Care Society (trading as Southern Cross Health Society) has an A+ (Strong) financial strength rating given by Standard & Poor's (Australia) Pty Limited.

The rating scale is:

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

Ratings from 'AA' to 'CCC' may be modified by the addition of a plus (+) or minus (-) sign to show relative standing within the major rating categories.

Full details of the rating scale are available at [www.standardandpoors.com](http://www.standardandpoors.com). Standard & Poor's is an approved rating agency under the Insurance (Prudential Supervision) Act 2010.

## 7. YOUR SIGNATURE

### Thank you for your application

We will review your application and advise you of the specific terms applying to your policy and the policy start date or changes to your policy. 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

## 8. FINAL CHECKLIST

Please make sure you have completed everything in the checklist before submitting this form to Southern Cross.

Application form signed  Payment form signed