MEMBERSHIP APPLICATION FORM

Office use only

1 SELECT APPLICATION

I apply for membership of the:

New Zealand Police Association ◯ *(Tick)*

Police Welfare Fund ◯ *(Tick)*

Please also complete the separate Health Plan Application and Life Insurance Benefit Nomination

Police and Families Credit Union ◯ *(Tick)*

We will be in touch to complete your Police and Families Credit Union application

2 FILL IN YOUR APPLICATION DETAILS

Mr / Mrs / Ms / Miss

First names *(all names in full)*

Last name

Preferred name

Date of birth *(dd/mm/yyyy)* / /

Gender: Male | Female *(Circle one)*

Postal Address

Floor / Level / C/o

Address

Suburb

City/Town

Postcode

Residential Address *(if different from postal address)*

Floor / Level / C/o

Address

Suburb

City/Town

Postcode

Home phone

Work phone

Mobile phone

Preferred email *(Preferred email to contact you on)*

Alternative email

APPLICANT'S PROFESSIONAL INFORMATION:

NZ Police employment: ◯ Constabulary ◯ Police Employee ◯ Authorised Officer *(Please tick relevant type)*

Contract Type: ◯ Permanent ◯ Temporary *(Tick one, casual contracts are excluded)*

Number of hours worked per week

Police QID

Date hired by NZ Police / /

Police location of work

Police position

3 READ AND ACCEPT CONDITIONS

CONDITIONS FOR MEMBERSHIP OF NEW ZEALAND POLICE ASSOCIATION AND POLICE WELFARE FUND LIMITED

I apply for membership of the New Zealand Police Association (NZPA)/Police Welfare Fund Limited and declare the information in this application is true and correct.

RULE COMPLIANCE AND SUBSCRIPTION PAYMENTS

1 I agree to:
- 1.1 Abide by the Rules, as amended from time to time, of the NZPA and Police Welfare Fund Limited (including Police Wefare Fund Insurances Ltd, Police Welfare Fund General Insurances Ltd, Police Health Plan Ltd and Police Welfare Fund Mortgages Ltd).
- 1.2 Pay any subscriptions or fees pursuant to my membership when they are due.
- 1.3 The NZPA and Police Welfare Fund Limited commencing subscription deductions from my salary following graduation from the Royal New Zealand Police College or 6 months after entering the RNZPC, whichever is the lesser, provided that I have not notified the Police Welfare Fund Limited or NZPA, in writing, of my intentions to cease membership.
- 1.4 The NZPA and Police Welfare Fund Limited altering my subscription deductions from my salary following notice of subscription changes and/or amendments to fees for products and services I have purchased.

REPRESENTATION

2 Pursuant to the rules and policies of the NZPA, I authorise them to act as my representative in matters relating to my employment, including but not limited to:
- 2.1 The negotiation and enforcement of (an) employment agreement(s)/contract(s), whether individual or collective;
- 2.2 Consultation on any matter or policy which may, or is likely to, impact on my employment;
- 2.3 Any proceedings related to my employment;
- 2.4 Receiving personal information about me from my employer, including receiving information prior to that information being conveyed to me (e.g. any pending disciplinary allegations and investigation).

3 In the event that there is a legal issue arising from my employment, I understand and agree that, in accordance with it's rules and policy, NZPA will make the final determination in respect to the progression and NZPA representation of that issue.

4 I agree with the following ratification procedure for any collective employment agreement contract(s) which the NZPA may negotiate on my behalf: the proposed settlement will be accepted if supported by the majority of votes cast in accordance with the NZPA Rules by those relevant eligible members of the NZPA voting for the purpose of ratifying a settlement.

5 I understand I can withdraw my authorisation to be represented by the NZPA prior to any proposed settlement being reached in negotiations with my employer for a collective employment agreement/contract; or with regard to any other matter at any stage.

PRIVACY ACT CONDITIONS

6 I agree that the information in this application may be used by all of the bodies I have applied for membership of and any third party in providing additional related or unrelated services to me.

7 I authorise any person or company to provide the bodies in condition 1, including Police Welfare Fund Insurances Ltd, Police Welfare Fund General Insurances Ltd, Police Health Plan Ltd and Police Welfare Fund Mortgages Ltd, with any information requested by them in connection with any services provided by the bodies, or the Police and Families Credit Union (PFCU).

8 I acknowledge that:
- 8.1 The information now given in my application or supplemented at any future time is being collected in connection with my membership of and the provision of services by the bodies referred to in condition 1 and, if applicable, the PFCU;
- 8.2 That information and any supplement to it may be exchanged between the bodies referred to in condition 1 or the PFCU without any further authority from me; and
- 8.3 The information will be held by those bodies and, if applicable, the PFCU, subject to my rights of access to, and correction of, that information as provided in the Privacy Act 1993.

I have read, understood and accept all the Conditions for Membership of New Zealand Police Association and Police Welfare Fund Limited and the Privacy Act Conditions relevant to the bodies that I have applied for membership of.

Print Name **Signature** **Date** / /

POLICE WELFARE FUND MEMBERS – PLEASE COMPLETE HEALTH PLAN APPLICATION AND LIFE INSURANCE BENEFIT NOMINATION.

Once completed, send to New Zealand Police Association: membership@policeassn.org.nz | New Zealand Police Association, PO Box 12344, Wellington 6144

51868-09-18

POLICE HEALTH PLAN
APPLICATION FORM

Office use only

Please Note: This document collects personal information about you so Police Health Plan Limited can consider your membership. The information is received by Police Health Plan Limited, PO Box 12344, Wellington 6144, who will hold this information. You may request access to, and correction of, this information according to the provisions of the Privacy Act 1993.

MEMBER DETAILS

Mr / Mrs / Ms / Miss

First names *(please state all names in full)*

D.O.B DD / MM / YYYY

Last name

I apply for membership of the Police Health Plan with the following level of cover: *(Tick applicable option)*

Comprehensive ◯ **Basic** ◯ **Surgical** ◯ **Voluntary Excess:** ◯ *Circle if applicable* **$500 | $1000**
(for surgical claims)

IMMEDIATE FAMILY INFORMATION

Details of all your immediate family members requiring Health Plan:

Name(s) First	Last	D.O.B DD / MM / YYYY	Gender *Please circle*	Relationship to member	NZ Resident *Please circle*	Cover Required Comprehensive / Basic / Surgical	Voluntary Excess *Circle if applicable*
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000
			M | F		Yes | No	◯ ◯ ◯	$500 | $1000

Are you or any of your family applying for Police Health Plan transferring from another medical insurance scheme?

No ◯ **Yes** ◯ Please provide proof of current medical policy including insurer, policy type and policy renewal date.

MEDICAL DECLARATION (CONFIDENTIAL)

Have you or any other enrolling family member:

1. Been admitted to hospital for treatment in the last two years? **Yes** ◯ **No** ◯
2. Displayed evidence or recent symptoms of arthritis, asthma, bronchitis, bunions, deafness, diabetes, duodenal ulcer, eye problems (e.g. short sighted), gynaecological disorders, haemorrhoids, hernia, heart disease, high blood pressure, infertility, obesity, psychiatric or nervous disorders, rheumatism, squint, tonsillar disease, varicose veins, or any other disease which may require treatment in the future? **Yes** ◯ **No** ◯
3. Been under medical treatment for any condition (such as those described in question 2), or been receiving continuing medications of any kind? **Yes** ◯ **No** ◯

If you have answered yes to any of the above questions – please identify the question and give full details below.
Continue on a separate page if required.

Q.	Name	Illness / Symptom / Operation	Treatment	Doctor or Hospital	Date

GENERAL DECLARATION

Police Health Plan Ltd is a member of Health Funds Association of New Zealand (HFANZ). On behalf of its members, HFANZ manages an Integrity Registry for the purposes of detecting and preventing fraud and other serious probity concerns. The Integrity Registry is operated by PricewaterhouseCoopers. Police Health Plan Ltd may collect, use and disclose personal and health information about you for the purposes of the Integrity Registry. You can access and correct information held on the Integrity Registry. Contact Police Health Plan Ltd or HFANZ Integrity Registry Privacy Officer, Health Funds Association of New Zealand, PO Box 25161, Wellington 6146.

1. I declare that:
   - 1.1 All entries on this form are true and correct;
   - 1.2 Any false answer may forfeit all right to any benefits from Police Health Plan Limited (Health Plan).
2. I agree:
   - 2.1 to be bound by Health Plan Rules; and
   - 2.2 that the information may be exchanged between Health Plan, NZ Police Association, Police Welfare Fund Limited and associated bodies (including Police Welfare Insurances Ltd, General Insurances Ltd and Police Welfare Fund Mortgages Ltd) for providing information on services and statistical, processing and underwriting purposes.
3. I understand that:
   - 3.1 if I have agreed to take advantage of a discounted premium by selecting a voluntary excess, I agree to pay this excess amount towards any surgical procedures I may require.
   - 3.2 if I select a voluntary excess and then choose to switch to a lower or no-excess option, a 90-day stand-down period will apply before the lower or no-excess option commences, and all conditions that were existing under the previous higher voluntary excess, will still incur that excess, regardless of when any procedure on this condition is carried out.
4. I authorise Health Plan to seek any further medical information as and when required.

Print Name **Signature** **Date** / /

Financial Strength Rating: *A M Best Co. has assigned a Financial Strength Rating of A- (Excellent) and an Issuer Credit Rating of "a-" to Police Health Plan Limited. The outlook for both ratings is stable. The ratings reflect the captive membership base, low expense ratio and good asset quality.*

A M Best Co.'s Financial Strength Rating Scale: *Secure: A++, A+ (Superior); A, A- (Excellent); B++, B+ (Good). Vulnerable: B, B- (Fair); C++, C+ (Marginal); C, C- (Weak); D (Poor); E (Under Regulatory Supervision); F (In Liquidation); S (Suspended)*

51869-09-18

NZ POLICE GROUP LIFE INSURANCE
BENEFIT NOMINATION FORM

Enhancing the wellbeing of Police and their families

Office use only

A **I,** _____ *(Insured Person)*

hereby make the following nomination(s) in respect of *Benefits* payable under my NZ Police Constabulary Group Life Insurance Policy/NZ Police Employee Group Life Insurance Policy.

1. Membership Number

2. QID

B **POLICE CONSTABULARY WHO ARE POLICE WELFARE MEMBERS TO COMPLETE**

(For Police Constabulary who are not members of the Police Welfare Fund, the Partner *Life Benefit is excluded and you do not need to complete this section.)*

For all purposes of the *Partner Life Benefit* I nominate as my *Partner*:

Full Name of Partner

Address

The *Partner Life Benefit* is payable to the *Insured Person* named in A.

C **In respect of my *Life Benefit* I nominate**

i) The following mortgagee(s) to receive the amount(s) specified at time of my death.

	Full name of Mortgagee(s)	Address	Amount
(i)	Mortgagee:		$
	Mortgagee:		$

and/or

ii) The following person(s) to share in the *Life Benefit* in the percentages specified, after payment is made to any mortgagee(s) nominated in (i).

- *If you have completed (i), now specify the person(s) to whom any balance of* Life Benefit *should be paid. Whole percentages must be used.*
- *If (i) is not applicable, specify the person(s) to whom the entire* Life Benefit *should be paid. Whole percentages must be used.*

REFER TO INSTRUCTIONS ON OPPOSITE PAGE IF UNSURE

	Full name of Person(s)	Address	Percentage of *Life Benefit*
(ii)	Person:		%
	Person:		%
	Person:		%
	Person:		%
	All percentages must be whole and add up to exactly 100%	**TOTAL**	100%

Signature of *Insured Person* *(as in A)*

DATE / /

Witness *(must not be a person nominated in B or C above)*

Print Name:

DATE / /

Please note:
This document determines who receives what benefit under the NZ Police Constabulary/Police Employee Group Life Insurance policies.

It is held by the Policy Owner, Police Welfare Fund Insurances Limited, PO Box 12344, Wellington 6144.

Any questions about this form call the Policy Owner on ***0800 500 122 or Police Network extn: 44446***

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There is a separate Benefit Nomination Form for Police Life Insurance Extra (previously named Supplementary Life Insurance Plan) and Benefit nominations for this cover should be recorded on this separate Form. For one of these forms see www.policeassn.org.nz

Tear off this form, fold, staple and freepost back to the Police Welfare Fund.