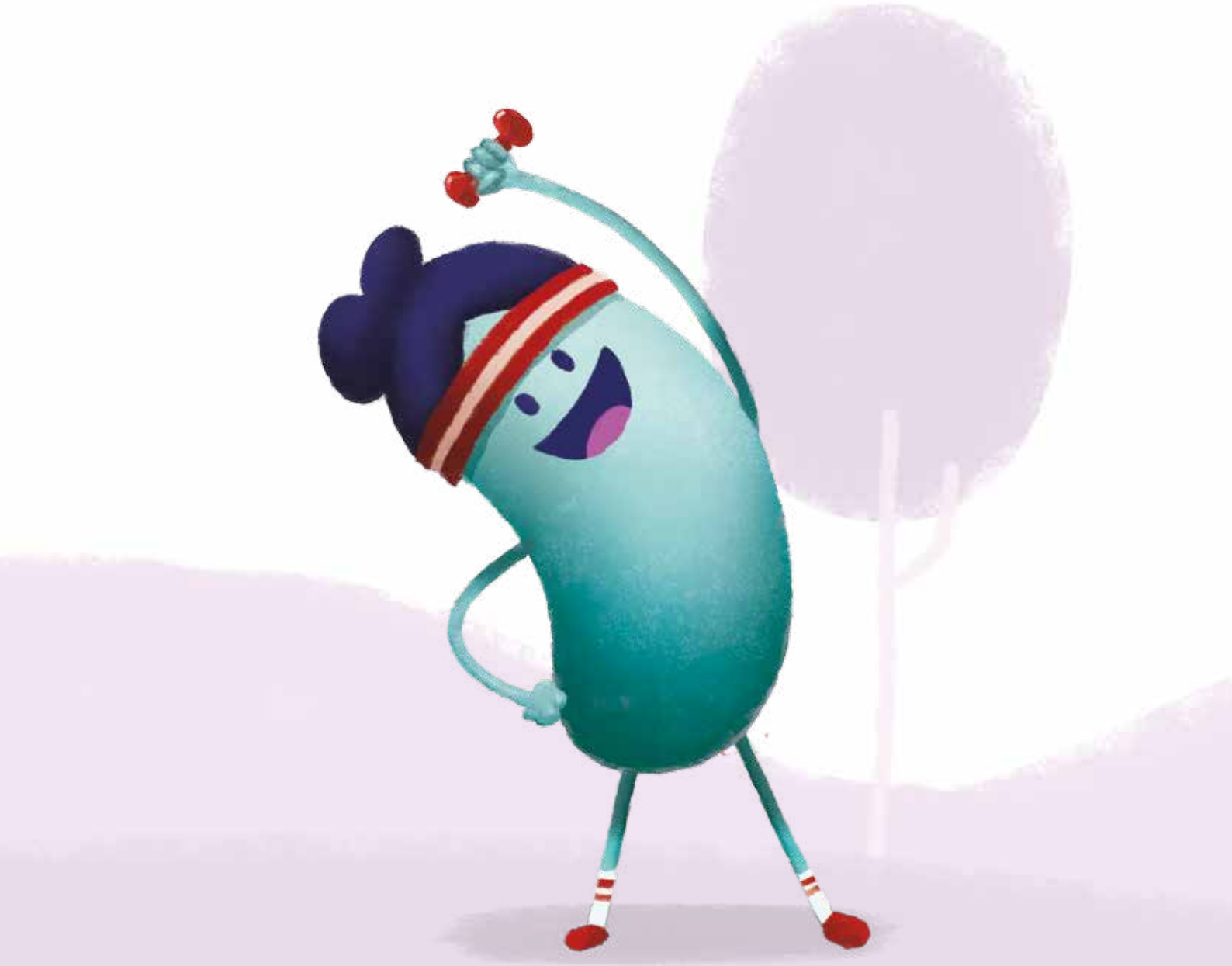
Everyday for Everyone Cover

Policy Document



Warehouse Money

Contents

Introduction

Thank you for trusting a Warehouse Money product to insure your good health. This Policy document explains what your Policy covers. It should be read in conjunction with all the documents that form part of your Contract of Insurance.

It is important you read the information carefully to ensure you know what you are covered for, what you need to tell us, how to make a Claim and any other terms and conditions of your Policy. However you should always contact us before undergoing any Health Service (see Claims on page 9).

Unless specified, this Policy document only describes Everyday for Everyone Cover as at the date of issue of this Policy document. This Policy document can be amended from time to time in accordance with its terms.

Who offers this Cover

Everyday for Everyone Cover is administered and underwritten by nib nz limited. Only nib can approve and accept your Policy, and will be responsible for the administration of your Policy.

nib is solely responsible for all Claims under this Cover, and in no circumstances will TW Financial Services Operations Limited (including its related companies) be liable if nib refuses to pay a claim.

In this policy, "we", "us" and "our" means nib nz limited.

Contract of Insurance

Your Contract of Insurance consists of:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document); and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any).

In descending order of priority if there is any inconsistency.

Words in capitals

Some words in this document (including capitalised terms) have a specific meaning which applies to Everyday for Everyone Cover. Please refer to the Glossary of important terms on page 14.

This is an important document

Please keep this Policy document and the other documents that form part of your Contract of Insurance in a secure place for future reference.

How to contact us

WM Health Connect provides 24 hour access to your Policy and Claims details at **wmhealth.co.nz/portal**

Email us for general enquiries at **contactus@wmhealth.co.nz**

Email us for claims at **claims@wmhealth.co.nz**

Go to **warehousemoney.co.nz**

Call us on **0800 801 810**

Our opening hours are **Monday to Friday 8.00am to 5.30pm**. We are closed on public holidays.

General terms of Cover

Applying for a Warehouse Money health insurance Cover

All applications for a Warehouse Money health insurance Cover must meet the criteria stated under 'Who is covered' on page 5.

We may at our discretion refuse to accept an application until such time as the required information is provided or until the Premiums for the minimum period relevant to the applicant have been paid.

Subject to the terms of this Policy document and the Health Funds Association of New Zealand Inc. Health Insurance Industry Code we may, at our discretion, refuse an application to purchase a Warehouse Money health insurance Cover as an Insured Person, as described below.

- We have the right to refuse an application to join a Cover that has been closed for sale.
- We have the right to refuse an application to combine a Cover currently for sale with a Cover that has been closed for sale.
- We have the right to refuse an application to move a Cover that has been closed for sale to a Cover currently for sale.
- We have the right to refuse an application(s) to move to another Warehouse Money or nib Cover.

If we refuse an application, we will provide a reason for the refusal to the applicant.

Electronic communication

The Policyowner and the Insured Person must maintain valid email addresses at all times. They must advise us immediately of any change to their email addresses.

The Policyowner and the Insured Person agree:

- to us sending all communications to them in connection with this Policy electronically, including via email to a single nominated email address, and WM Health Connect. This includes Policy documents and notices under this Policy. The single nominated email address will be the email address the Policyowner provides us at time of application, as updated by the Policyowner from time to time
- to sending to us all communications in connection with this Policy via email or through WM Health Connect.

Any reference to notice in writing in this Policy means written notice sent electronically.

If you do not agree to receive Policy communications electronically, we can send paper copies of communications to you. There may be an administration fee for this service. Please contact us for more details.

Duty of disclosure

The Policyowner and all Insured Persons had a legal duty to disclose everything they knew (or ought to have known) which would have influenced the decision of a prudent insurer whether to accept the Policyowner's application, and if so, on what terms.

All information given by, or on behalf of, the Policyowner or any Insured Person must be true, correct and complete.

The Insured Person must have told us about any changes to the information given to us before any Commencement Date, Effective Date or Join Date (as applicable) of this Policy. If the Insured Person failed to do so, or if any of the above information was not disclosed to us or was not true, correct and complete, we can cancel this Policy or alter the terms and conditions of cover provided under this Policy from the Commencement Date, Effective Date or Join Date (as applicable) and not pay any Claims after those dates.

We may retain all the Premiums paid, and any Claims paid by us after those dates may be recovered from the Policyowner or the Insured Person.

Code of practice

This Policy complies with the Health Funds Association of New Zealand Inc. Health Insurance Industry Code. The Policyowner or any Insured Person can obtain a copy of nib's financial statements for the last reported financial year by submitting a request via WM Health Connect or by sending an email to **contactus@wmhealth.co.nz**

Period of cover

Your Everyday for Everyone Cover (as shown on the Acceptance Certificate or Renewal Certificate, whichever is the later) starts from the Commencement Date, Effective Date or Join Date (as applicable). This is subject to any applicable Waiting Period.

14-day free-look period

A 14-day free-look period applies to all Warehouse Money health insurance Covers.

The Policyowner can receive a full refund of Premiums if they decide to cancel the Policy within the first 14 days – providing no Claims have been made during that time, and that the cancellation is requested in writing. This period starts the day after we send you your Contract of Insurance. During this time, should you decide the Policy doesn't meet your needs, please email confirmation to us at **contactus@wmhealth.co.nz** and we will cancel the Policy and refund the full Premiums paid, providing no Claims have been made.

Health cover reviews

It is the Policyowner and all Insured Persons' responsibility to understand what is covered and what is not covered by their health insurance Policy. We recommend you review your health insurance at least once each year. We are happy to discuss your Cover – you are welcome to submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810**.

Recognised providers

Claims are only eligible for Health Services carried out by a Recognised Provider.

We will pay for Benefits under Everyday for Everyone Cover and Everyday for Everyone Extension Cover if the Insured Person attends a Recognised Provider, who must:

- meet all the minimum criteria outlined by us relating to their education, qualifications and active membership of any governing body specified by us;
- be in Private Practice; and
- be recognised by us.

Key information found on WM Health Connect and on the Warehouse Money website

WM Health Connect

WM Health Connect provides 24 hour access to:

- submit and track your Claims;
- view your Claims history;
- view your Policy details; and
- send a quick request to update your details or make enquiries about your Policy.

WM Health Connect can be found by visiting **wmhealth.co.nz/portal**

The website provides key information, including the Prosthesis Schedule and Claim forms. All the relevant information can be found by visiting **warehousemoney.co.nz**

Who is covered

This Policy provides Cover for an Insured Person who lawfully resides in New Zealand.

We may request to see originals or certified copies of all relevant documents (including proof of identity) for each Insured Person.

We reserve the right to cancel the Policy or the relevant Insured Person's Cover if the relevant person no longer meets the criteria above.

Dependent children

A Dependent Child will become subject to adult premium rates on the next Policy Anniversary Date after they reach age 21. We will automatically continue to cover that person on this Policy as an Insured Person and deduct the additional Premium based on their age for the Cover, from the same payment source and at the same frequency as this Policy, unless you advise us otherwise.

Unless otherwise approved by us, a person under 18 years of age is not eligible to be a Policyowner. A Dependent Child under age 18 must be accompanied on the Policy by at least one adult aged 21 or older as a Policyowner or have his or her parent or legal guardian as the Policyowner.

Who can view and change the policy

The Policyowner is the primary account holder and has full and total authority to make changes to the Policy and make Claims enquiries about anyone on the Policy. If the Policy has more than one Policyowner then all Policyowners must consent to any changes.

The Policyowner may add or remove an Insured Person from the Policy, and may add or remove Everyday for Everyone Cover and Everyday for Everyone Extension Cover, at a Policy Anniversary Date.

Before any changes can be made, the Policyowner must give us at least 30 days' prior notice by email.

An Insured Person can request to have themselves removed from the Policy at a Policy Anniversary Date (see Removing an Insured Person on page 6). Before any changes can be made, the Insured Person must give us at least 30 days' prior notice by email.

If we agree to any other change, we will make the requested change to this Policy on the same (or nearest equivalent) date in the month that corresponds to the date in the month of the Policy Anniversary Date, immediately after you request this change. For example, if the Policy Anniversary Date is 30 September and you request a change on 15 June, the Effective Date of the change will be 30 June. If we make the change on any other date, we will let you know.

Adding a partner, dependent child, parent or grandchild

The Policyowner can add their Partner, Dependent Child, parent or grandchild to this Policy. The Policyowner and any new Insured Person added must follow the relevant application process. Cover for a new Insured Person added will start from the Effective Date or Join Date (as applicable) shown on your Acceptance Certificate or Renewal Certificate (whichever is the later), subject to any applicable Waiting Periods. Please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810** for more details.

We will charge an additional Premium for each Insured Person added.

Removing an insured person

An Insured Person can be removed from this Policy at a Policy Anniversary Date:

- at the written request of that Insured Person. He or she has the option, within 30 days of removal, to arrange a separate Policy on terms determined by us without providing any evidence of his or her current state of health; or
- at the written request of the Policyowner (see above).

Changes in contact details

The Policyowner must notify us of all changes in contact details of the Insured Persons covered under the Policy.

To update your details at any time, please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810**.

Adding or removing Everyday for Everyone Extension Cover

Everyday for Everyone Extension Cover cannot be added to, or remain on, a Policy without Everyday for Everyone Cover.

The Policyowner can add the Everyday for Everyone Extension Cover to a Policy with Everyday for Everyone Cover for an additional Premium, by following the relevant application process. Please submit a request through WM Health Connect, email us on **contactus@wmhealth.co.nz** or call us on **0800 801 810** for more details.

The Premium will be adjusted from the next available billing date to reflect this change. This extension of Cover will start from the Effective Date shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

The Policyowner can only remove Everyday for Everyone Extension Cover at the next Policy Anniversary Date. The Policyowner must give us at least 30 days' prior notice in writing before the Cover can be removed.

We will process the change

Once we have accepted the changes, we will send the Policyowner a new Acceptance Certificate or Renewal Certificate (whichever is the later) that will show the changes.

Commencement of cover

Any Insured Person will be able to claim for the Benefits and/or Health Services provided by the Cover once Waiting Periods have been served and provided that all Premiums have been paid up-to-date.

Waiting periods

Waiting Period means a period of time after the Commencement Date, Effective Date or the Join Date (as applicable), for which no Claim will be paid for anything that happens during this period.

Waiting Periods vary according to the Benefit and/or Health Service being provided.

The following Waiting Periods apply to each Insured Person:	
Preventative and General Dental Treatment (for example: examinations, scale & cleans, fluoride treatments, fillings, basic extractions (excluding wisdom teeth) and X-ray)	2 months
Physiotherapy	2 months
GP Consultations.	2 months

The following Waiting Periods apply to each Insured Person:	
Optical Appliances (for example: prescription spectacles and contact lenses)	6 months
Dietitian or Nutritionist Consultations.	2 months

Waiting Periods when adding Everyday for Everyone Extension Covers

For Insured Persons adding Everyday for Everyone Extension Cover, the Waiting Periods noted above for the Everyday for Everyone Extension Cover apply from the Effective Date shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

Transfer to a new Policy

If for any reason an Insured Person needs to transfer to a new Policy with the same level of Cover, the Waiting Period applies from the Commencement Date, Effective Date or Join Date (as applicable) of the original Policy.

Maintaining continuous cover

It is important to maintain continuous Cover to ensure you are able to continue to Claim Benefits and to avoid having to re-serve Waiting Periods if you decide to re-join later.

- If the Policy falls into arrears of Premium, all Insured Persons on the Policy will be unable to Claim.
- After 90 days of non-payment of Premium the Policy will be terminated.
- Once the Policy has been terminated all Insured Persons listed on the Policy will have to re-serve Waiting Periods if they decide to re-join later.
- It will be at nib's discretion to determine whether the Insured Persons listed on the Policy will be covered for any Claims requested under the Policy during a period of non-payment.

Cancelling the Policy or removing Everyday for Everyone Cover (and Everyday for Everyone Extension Cover) from the Policy

Unless otherwise permitted by us, any cancellation of a Policy or removal of Everyday for Everyone Cover (and Everyday for Everyone Extension Cover) from a Policy must be authorised in writing by the Policyowner.

The Policyowner can only cancel the Policy or remove Everyday for Everyone Cover (and Everyday for Everyone Extension Cover) from the Policy at the next Policy Anniversary Date. The Policyowner must give us at least 30 days' prior notice.

Termination of the policy or cover

We may terminate an Everyday for Everyone Cover Policy and/or Cover for an Insured Person:

- if the Premiums are in arrears by more than 90 days after the due date for payment; or
- if the last Insured Person covered by this Policy dies; or
- if any Insured Person breaches the terms of the Policy; or
- if any information provided by, or on behalf of the Policyowner or any Insured Person when arranging this Policy, or when making any changes to it, is false, incorrect or incomplete; or
- an Insured Person covered by the Policy has obtained or attempted to obtain an advantage, monetary or otherwise, whether for the Insured Person or for any other Insured Person, to which they are not entitled under this Policy document; or
- an Insured Person has engaged in offensive or intimidating behaviour towards our employees.

If we terminate this Policy and/or Cover for an Insured Person, any Premiums paid may be retained by us. If we have already made any Claims payments for a health service that took place after our right to terminate arose, we may, in some circumstances, recover these from the Policyowner.

Your premiums

Premiums must be up-to-date to keep the Policy active so that the Insured Persons listed on the Policy can Claim Benefits.

- Where the Premium rate change takes effect during the period of advance payment, the change will not come into effect until the next Premium falls due.
- Premiums can be paid in advance for up to a maximum of 12 months.

Available payment methods and frequency

Payment periods are set out below and must be paid in advance, unless otherwise permitted by us:

- where Premiums are paid by direct debit from a bank, building society, credit union cheque or savings account – weekly, fortnightly, monthly, quarterly, half yearly and yearly;
- where Premiums are paid by credit card payment from a MasterCard, Visa or Diners – monthly, quarterly, half yearly and yearly.

nib direct debit service agreement

- We will comply with the terms and conditions of our direct debit authority.
- Any information about the nominated account will remain confidential, except where required to complete direct debits with the financial institution.
- When the due date is not a working day, we will debit the account on the first working day after the due date.

It is the Policyowner's responsibility to:

- ensure the nominated account can accept direct debits;
- ensure there are enough funds available in the account to make the payment on the due date;
- tell us if the account details change, or if the account is transferred or closed;
- arrange a different payment method if we cancel the direct debit arrangements;
- ensure all account holders of the nominated account sign the direct debit authority form; and
- update us if the credit card details change, for example: new expiry date.

The Policyowner can change the direct debit arrangements in line with the terms and conditions of our direct debit authority, at least 10 calendar days before the next due date.

The Policyowner must give instructions to stop or alter the direct debit details in writing.

We reserve the right to cancel direct debit arrangements if the nominated financial institution dishonours direct debits, and to arrange a different payment method with the Policyowner.

The details of the direct debit arrangement are contained in the direct debit authority form which the Policyowner submits to us. We will rely on those details to process payments until told otherwise.

Not all accounts held with a financial institution are available to be drawn on under the bulk electronic clearing system. The Policyowner should check with their financial institution if they are unsure whether their account can facilitate direct debits.

The Policyowner may cancel or stop a drawing with their financial institution.

If the Policyowner has a direct debit inquiry, or believes a debit has been made incorrectly, please contact us immediately by submitting a request through WM Health Connect, emailing us on **contactus@wmhealth.co.nz** or calling us on **0800 801 810**.

Important information about your premiums and benefits

The Premiums are calculated according to the rates applying from time to time for the Policy selected.

No changes will be made to your individual Policy alone, based upon the individual claims experience of your Policy.

The Premiums and the Benefits for this Policy are not guaranteed. We may alter the Premium rates and/or Benefits and/or the terms of cover (including 'What is not covered' and 'Glossary of important terms') during the life of the Policy, but only in the following circumstances and only to the extent necessary to take these circumstances into account:

- if the law that applies to the Policy changes (including changes in taxation); or
- if our costs increase as a result of medical inflation, as determined by us; or
- in order to increase the level of cover under a Benefit or to add a new Benefit; or
- to allow for an unexpected and significant increase in the type and/or level of claims under the Policy, which are not sustainable long term and which threaten its commercial viability; or
- to align this Policy with a newer version of the same type of Policy we subsequently offer with similar (but not necessarily the same) Premiums and/or Benefits; or
- to take into account unexpected and severe public health threats e.g. a pandemic.

We will give the Policyowner 30 days' prior written notice of any alteration. The Policyowner retains the right to cancel this Policy at any time.

We want to ensure your valuable cover continues if a deduction advice is returned to us due to a failure to deliver to the nominated email address.

In these circumstances, we will continue to make deductions in accordance with our Premium rates until we are advised otherwise and the Policyowner authorises us to stop the deductions.

Claims

- Benefits will only be paid for Claims which meet nib's criteria.
- We reserve the right to recover any money paid in error, obtained fraudulently, or by any other means contrary to the Policy or law.
- The Insured Persons will not be paid any Benefits if the Premiums are not paid up-to-date (see Your Premiums on page 8).
- Claims are only eligible for Health Services carried out by a Recognised Provider.
- No payment will be greater than 100% of the actual costs of the Health Service.

How to make a Claim

How to make a claim

- Submit your Claim through WM Health Connect: **wmhealth.co.nz/portal**
- Visit **warehousemoney.co.nz** for a Claim form.
- Email us at **claims@wmhealth.co.nz**
- Call us on **0800 801 810.**
- The Policy number must be quoted for all Claims.
- Any Claims must have all the relevant information submitted with the Claim form (see Supporting documentation for Claims below).

Supporting documentation for Claims

Supporting documentation for Claims must be:

- made in a format approved by us;
- submitted with a fully completed Claim form; and
- supported by Recognised Provider invoices and/or Recognised Provider itemised receipts and/or itemised receipts on the Recognised Provider's letterhead or showing the Recognised provider's official stamp and GST number. Please retain the originals as we retain the right to request to view the originals at any time.

If we require further information in order to assess the Claim, all necessary requests must be complied with.

We recommend all Claims be submitted within 12 months of the relevant treatment date, as no inflation adjustments apply.

The Claim must relate to an Insured Person. Reimbursement must be to a Policyowner or Insured Person, regardless of whether any other person has paid the account or bill.

In cases where the Insured Person is deceased, Claim payment can only be made to a remaining Policyowner or the deceased Insured Person's estate.

The Policyowner and each Insured Person must comply with this Policy in full before any Claim is paid.

If any Premium is outstanding on this Policy at the date we accept a Claim, we will withhold payment of the Claim until all outstanding Premium(s) have been paid.

Medical report or assistance

If the Policyowner or an Insured Person needs assistance to complete the Claim form, or we request a medical report with the Claim form, these will be at the Policyowner's expense.

If we request additional information in order to assess the Claim, this will be at our expense.

Rapid refund and method

We will aim to process Claims within two working days of receipt of the Claim form, unless further information is required.

Typically we refund the Policyowner directly. If we are refunding the Policyowner by direct credit, please ensure your bank details are accurate on the Claim form. We will only refund to a nominated New Zealand bank account in New Zealand dollars.

Everyday for Everyone Cover

This section lists and defines the Benefits we provide under this Cover, and should be read in conjunction with all other parts of your Contract of Insurance. All Claims are subject to our general terms (see General terms of Cover on page 4 and What is not covered on page 11).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the Cover selected.

What is covered

Everyday for Everyone Cover does not cover any hospital related services. It provides cover for the Health Services outlined below.

We will refund 70% of each cost incurred under the Benefits up to the Benefit Limits. Waiting Periods apply to all Benefits (see Waiting Period on page 6).

1 Dental Benefit

This Benefit covers the cost of Dental Treatment performed by a registered Dental Practitioner or oral surgeon, including examinations, cleaning and scaling, fillings, basic extractions (excluding wisdom teeth), and dental/oral X-rays.

Benefit limit

- The maximum we will pay for this Benefit is $350 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for treatments covered under the school dental service or general dental benefit scheme.
- Benefits are not payable for extraction of wisdom teeth. Cover may be available under a Warehouse Money hospital Cover if the Policyowner has selected that Cover.
- Benefits are not payable for any additional costs relating to gold or other exotic materials.
- Benefits are not payable for any procedures such as orthodontic work, periodontic and endodontic treatment.

2 Physiotherapy Benefit

This Benefit covers the cost of Physiotherapy treatment.

Benefit limit

- The maximum we will pay for this Benefit is $100 for each Insured Person every Policy Year.

3 GP Consultations Benefit

This Benefit covers the cost of GP Consultations.

Benefit limit

- The maximum we will pay for this Benefit is $100 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any additional services performed in the GP's rooms.

Everyday for Everyone Extension Cover

Everyday for Everyone Extension Cover can be only purchased as an extension to Everyday for Everyone Cover (see Adding or removing Everyday for Everyone Extension Cover on page 6).

This section lists and defines the Benefits we provide under this extension and should be read in conjunction with all other parts of your Contract of Insurance. All Claims are subject to our general terms (see General terms of Cover on page 4 and What is not covered on page 11).

Your Acceptance Certificate or Renewal Certificate (whichever is the later) details the Cover selected.

What is covered

Everyday for Everyone Extension Cover does not cover any hospital related services. It provides cover for Health Services outlined below.

We will refund 70% of each cost incurred under the Benefits up to the Benefit Limits. Waiting Periods apply to all Benefits (see Waiting Period on page 6).

1 Optical Appliance Benefit

This Benefit covers the cost of prescription spectacles and contact lenses.

Benefit limit

- The maximum we will pay for this Benefit is $200 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for any examination and/or Consultation fees.
- Benefits are not payable for replacing a lens as part of the process of repairing spectacles or for sunglass tinting, coating or hardening of lenses.
- Benefits are not payable for goods purchased from suppliers outside of New Zealand (for example through a website based out of New Zealand).

2 Dietitian or Nutritionist Consultations Benefit

This Benefit covers the cost of Dietitian and Nutritionist Consultations.

Benefit limit

- The maximum we will pay for this Benefit is $150 for each Insured Person every Policy Year.

Additional terms

- Benefits are not payable for the cost any additional items in connection with a Dietitian or Nutritionist Consultation including (but not limited to) food, food substitutes, vitamins, supplements, videos, books or DVDs.

What is not covered

Benefits are not payable for any Health Services that are related to and/or any consequences of the following:

- Health Services not stated in this Policy document.
- Health Services provided during a Waiting Period.
- Health Services provided after the Benefit Limit has been reached.
- Incomplete Claims, Policy applications or Claims where false or inaccurate information is supplied.
- Providers who do not meet our criteria.
- Any services provided by a family member or relative (for example: Health Services).
- Expenses recoverable from any third party (for example: any other person, company or insurer).
- Services provided outside of New Zealand.
- Goods purchased outside of New Zealand (for example: goods ordered on the internet which are from another country).
- Acute Medical Conditions.
- Cosmetic procedures.
- Sleep problems and disorders (for example: snoring, insomnia and sleep apnoea).
- Allergies or allergic disorders (for example: allergy testing and desensitisation).
- Any Congenital, hereditary, or genetic Condition or chromosomal disorder (for example: birth defect), Marfan's syndrome, kyphosis, scoliosis, cystic fibrosis or pectus excavatum.
- Gene therapy and genetic testing.
- Health Services resulting from concerns of familial risk or familial predisposition only, in the absence of signs or symptoms that a Condition exists.
- Pregnancy (for example: ectopic, healthy or termination of), caesarean section, sterilisation or reversal of contraception, hormone therapy or intrauterine devices.
- Infertility, assisted reproduction or erectile dysfunction.
- Psychiatric, psychological, behavioural or developmental Condition (for example: depression, ADD, ADHD and eating disorders).
- Substance misuse (for example: misuse of alcohol and misuse of drugs).
- Self-inflicted injuries, or injuries arising from attempted suicide.
- Charges under the Crimes Act (for example: any medical Condition which is related in any way to the Insured Person being involved in an incident which results in the Insured Person being charged under the Crimes Act).
- Any form of risk management such as preventative treatment (except where provided for under the Dental Benefit or the Dietitian or Nutritionist Consultations Benefit).
- If an Insured Person sees the same Recognised Provider twice on the same day, only costs relating to the first visit will be payable.
- When Consultations do not occur face-to-face.
- Administration costs (for example: fax charges, after hours costs, over time, cancellation charges and prioritisation fees).
- Prescription charges.
- Any Health Services that are provided by health professionals not recognised by the Medical Council of New Zealand.
- Claims that do not meet our general terms (see General terms of Cover on page 4).

nib's obligations

We will:

- Treat Insured Persons as valued customers.
- Answer questions promptly and accurately at the first point of contact (whenever possible).
- Provide detailed health policy information and help the Policyowner and the Insured Persons understand what they are covered for.
- Deal with feedback and complaints in a timely and responsible manner.
- Keep the Policyowner and the Insured Persons informed regarding the process of their Claim (whenever possible).
- Comply with all aspects of the Health Funds Association of New Zealand Inc. Health Insurance Industry Code.
- Make every possible effort to resolve complaints to the Policyowner and the relevant Insured Person's satisfaction (whenever possible).
- Provide at least 30 days' written notification of Cover changes and at least 30 days' notification of a Premium increase.
- Meet the terms outlined in our direct debit authority.
- Provide a 14-day free-look period on all health Cover sales and Cover changes (providing no Claims are made during that time).
- Treat personal information with respect and in total accordance with the Privacy Act 1993, including the Health Information Privacy Code 1994.

Policyowner and insured person's obligations

By taking out a Warehouse Money health insurance Policy with nib, the Policyowner and all Insured Persons agree to:

- Comply with this Policy in full.
- Be accurate and truthful in their health insurance application and Claims.
- Undertake to understand Waiting Periods and what they are covered for, and if unsure – ask us.
- Keep their health insurance Premiums up-to-date to ensure they remain covered.
- Meet the terms outlined in our direct debit authority.
- Provide all information reasonably required by us in relation to all Policies.
- Notify us as soon as reasonably possible for any change that may affect their Policy, and if unsure ask us.
- Comply with the duty of disclosure (see Duty of disclosure on page 4).
- Maintain valid email addresses at all times. They must advise us immediately of any change to their email addresses, and agree:
  - To us sending all communications to them in connection with this Policy electronically, including via email to a single nominated email address, and WM Health Connect. This includes Policy documents and notices under this Policy. The single nominated email address will be the email address the Policyowner provides us at time of application, as updated by the Policyowner from time to time.
  - To sending to us all communications in connection with this Policy via email or through WM Health Connect.

nib's privacy policy

We are committed to protecting the privacy and security of the personal information we collect. We have implemented measures to comply with our obligations under the Health Funds Association of New Zealand Inc. Health Insurance Industry Code and the Privacy Act 1993, including the Health Information Privacy Code 1994.

Our privacy policy explains how we may collect, use and disclose personal information. In addition to the parties listed in our privacy policy, nib may also disclose information provided by you, and any other information collected by nib as underwriter of the insurance policies, to TW Financial Services Operations Limited. However, in no circumstances will nib disclose any of your health information to TW Financial Services Operations Limited.

To read our current privacy policy, please go to **nib.co.nz/about-us/privacy-policy**

Feedback and complaints

Any questions? More information?

We know that customer feedback can help improve the quality of our service.

How to contact us:

- Submit a request thorough WM Health Connect at **wmhealth.co.nz/portal**
- Email **contactus@wmhealth.co.nz**
- Go to **warehousemoney.co.nz**
- Call us on **0800 801 810**, Monday to Friday 8:00am – 5.30pm.

We have a process for dealing with complaints to ensure they are heard

You are welcome to contact us on the details above to talk to the person who handled your enquiry or Claim, or to talk to a Team Leader or Manager.

Alternatively, you can email the Complaints Committee: complaints@wmhealth.co.nz

We will make every possible effort to resolve complaints to your satisfaction. In the event that you are not satisfied with the outcome, we will email a letter of "deadlock" which gives you the option to take your complaint to the Insurance & Financial Services Ombudsman (IFSO):

The Insurance & Financial Services Ombudsman
PO Box 10-845
Wellington 6143
Phone 0800 888 202
Email: info@ifso.nz

Need help?

- Submit a request through WM Health Connect by visiting **wmhealth.co.nz/portal**
- Email **contactus@wmhealth.co.nz**
- Go to **warehousemoney.co.nz**
- Call us on **0800 801 810,** Mon to Fri: 8:00am - 5.30pm.

Glossary of important terms

"ACC" means the Accident Compensation Corporation or any "Accredited Employer" as defined in the Accident Compensation Act 2001 or its successor under any subsequent legislation.

"Acceptance Certificate" means the most recent document entitled 'Acceptance Certificate' forwarded to the Policyowner by nib as part of the Contract of Insurance.

"Acute Medical Condition" means a sign, symptom or Condition that requires immediate, or within 48 hours, hospital admission for treatment or monitoring.

"Benefit" means an amount of money payable from nib to or on behalf of an Insured Person, in respect of approved expenses incurred by that Insured Person for treatment, in accordance with the Policy document and the Contract of Insurance.

"Benefit Limit" or **"Benefit Limits"** means the maximum amount we will pay for each Benefit for each Insured Person every Policy Year.

"Claim" or **"Claims"** means a request from an Insured Person for the payment of Benefits or a confirmation of future payment of Benefits, which complies with this Policy document.

"Commencement Date" means the start date of your Policy that is shown as 'Original policy commencement date' on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"Condition" means any illness, injury, ailment, disease, sickness, disorder or disability.

"Congenital" means a health anomaly or defect which is present at birth, whether it is recognised or not and whether it is inherited or due to external or environmental factors such as drugs or alcohol.

"Consultation" or **"Consultations"** means a necessary face-to-face meeting with a Recognised Health Professional for discussion or the seeking of advice, or conferring to evaluate the medical case and any treatment. A Consultation does not include the treatment itself. This does not include virtual consultation.

"Contract of Insurance" means the following:

- the Acceptance Certificate or Renewal Certificate (whichever is the later);
- this Policy document (or any subsequent document that replaces this document); and
- any application(s) completed by the Policyowner and all the Insured Persons covered under the Policy (if any) in descending order of priority if there is any inconsistency.

"Cover" means a defined group of Benefits which are payable to an Insured Person under their chosen level of health insurance, subject to the relevant rules.

"Dental Practitioner" means a nib Recognised Health Professional who is:

- in Private Practice and holds a current annual practicing certificate; and
- a member of the Dental Council of New Zealand (or its successor under any subsequent legislation).

"Dental Treatment" means treatment that is provided by a Dental Practitioner.

"Dependent Child" or **"Dependent Children"** means an Insured Person's child or children under the age of 21 years.

"Dietitian" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Dietitian Board in New Zealand (or its successor under any subsequent legislation).

"Effective Date" means the date that any changes made to your Policy take effect. The date is shown as 'Effective date' on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"GP" or **"General Practitioner"** means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Medical Council of New Zealand (or its successor under any subsequent legislation).

"Health Services" means Consultations, assessments, investigations or treatments of a sign, symptom or Condition provided by a Recognised Health Professional.

"Insured Person" means a person named as an 'Insured Person' in your Acceptance Certificate or Renewal Certificate (whichever is the later), and may, as applicable, include the Policyowner.

"Join Date" means the date when Cover commences when an Insured Person is added to this Policy shown on the Acceptance Certificate or Renewal Certificate (whichever is the later).

"nib" or **"we"** or **"us"** means nib nz limited.

"Nutritionist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practising certificate; and
- a member of the Nutrition Society of New Zealand (or its successor under any subsequent legislation).

"Optical Appliance" means spectacles or contact lenses used to correct sight which has been approved by nib and prescribed by an optometrist or ophthalmologist.

"Partner" means an Insured Person's spouse or a person who cohabits with the Insured Person in the nature of a marital, de-facto or civil union relationship.

"Physiotherapist" means a Recognised Health Professional who is:

- in Private Practice and holds a current annual practicing certificate; and
- a member of The Physiotherapy Board of New Zealand (or its successor under any subsequent legislation).

"Physiotherapy" means treatment provided by a Physiotherapist.

"Policy" or **"Policies"** means this contractual agreement between the Policyowner and nib as governed by the Contract of Insurance.

"Policy Anniversary Date" means the date 12 months after the Commencement Date and every 12-month anniversary of that date.

"Policy Year" means the 12 month period that commences on the Commencement Date and ends at 6am of the Policy Anniversary Date, and each successive 12 month period from a Policy Anniversary Date to the next Policy Anniversary Date.

"Policyowner" means a person who administers the Policy and whose name is on the Acceptance Certificate or Renewal Certificate (whichever is the later) as 'Policyowner(s)'. This means all Policyowners if there is more than one.

"Premium" means the amount of money the Policyowner is required to pay to nib in respect of a specified period of Cover for the Policy.

"Private Practice" means a practice (whether sole, partnership or group) which receives its primary income from the fees charged to its patients without subsidy or funding from the public health sector, and is recognised by nib.

"Recognised Health Professional" means any registered person who holds a current practising certificate in compliance with the Health Practitioners Competence Assurance Act 2003 (or its successor under any subsequent legislation) and is a member of the appropriate registration body, for example the Medical Council of New Zealand or the Dental Council of New Zealand and is recognised by nib.

"Recognised Private Hospital" means a private hospital, day surgery unit or private wing in a public hospital, within New Zealand that has been recognised by nib. It does not include any other type of medical facility.

"Recognised Provider" means a Recognised Health Professional, Recognised Private Hospital or other recognised medical facility that is recognised by nib.

"Renewal Certificate" means the most recent document entitled 'Renewal Certificate' forwarded to the Policyowner by nib in relation to the Policy.

"Waiting Period" or **"Waiting Periods"** means, in relation to a Benefit, a period of time after the Commencement Date, Effective Date or the Join Date, for which no Claim will be paid for a specific Benefit.

"WM Health Connect" means the online portal where the Policyowner(s) can access information about the Policy. At the date of this document, the address is www.wmhealth.co.nz/portal. This may be updated from time to time.

For credit cards and other insurance

Take a look online at **warehousemoney.co.nz** or just give us a call.

→ **Travel Insurance**
0800 801 811

→ **Credit Cards**
0800 801 808

warehousemoney.co.nz

Warehouse Money Health Insurance is promoted by nib nz limited. nib nz is a registered Financial Service Provider and member of the Insurance & Financial Services Ombudsman dispute resolution scheme.

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