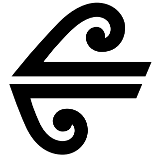
koruhealth
Healthcare Society

Application Form Children aged 19+



Instructions

Please complete this form neatly and send to:
Koruhealth, C/- Christchurch Engineering, PO Box 14005, Christchurch Airport, 8544 or Internal OCS mail, Koruhealth CHC15.

Need help filling out this form?
Telephone: 03 374 7621 / 378 2464 or extn 87621 / 86464   Email: KoruHealthAdmin@airnz.co.nz

Personal Details

Title: First name: Surname:

Home Address:
(including postcode)

Contact Numbers: Home: Mobile: Date of Birth:

Email Address: Preferred Contact Method: By Post By Email

Membership Details

Membership Type: Adult Child of current Air NZ employee ($18.00 a fortnight) Adult Child of Former Air NZ employee ($990.00 per annum)

Parent's Employee #:

Parent's First Name: Parent's Last Name:

Please ensure you include a copy of your birth certificate with this form if not previously listed on family policy.

Bank Details

Please specify whether you would like payments made into your parent's bank account or your own.

Payments to be made into parent's bank account or Payments to be made into my bank account

Adult child's bank account details:

Bank Account Number:
(eg 01-1234-1234567-00)

Account Name:

If supplying your bank account details, please ensure you include a bank deposit slip when sending this form.

Other Memberships

Are you a member of another medical scheme? No Yes Provider:

What type of cover do you have?

Signature

Signature of adult child:
I hereby certify that all the details I have entered are correct and I agree to be bound by the rules of KoruHealth:

Date:

Signature of parent member:
I hereby agree that I am responsible for payment of my dependent's fees:

Date:

NB: All benefits are subject to the absolute discretion of the Board and membership fees convey only the right to claim for specified expenses.

VERSION 4 August 2022