

EBS Standard Plan Application

By becoming an EBS subscriber, automatic access is obtained to the EBS Standard Plan, a prerequisite of belonging to the Society. Subscribers can elect (and are encouraged) to take up the EBS Hospital Cover option to have comprehensive medical protection. The form also allows you to include family members and incorporates an authority for payroll deductions. Please complete all the details of the sections relevant to you. Whatever your requirement, you must complete the name and address panels below.

I am a current EBS Health Care subscriber
 I am a new EBS Health Care applicant

MOE Employee Number (if applicable)

TYPE OF POLICY REQUIRED

EBS Standard Plan

Contributor
 Contributor & partner
 Contributor & child/ren
 Contributor & family

Plus EBS Hospital Cover – There are separate forms required for EBS Hospital cover. Please ask your EBS representative.

Sovereign
 Absolute
 Absolute spec/ tests
 Southern Cross
 Vip 1
 Vip 2
 AIG Life
 Tower

CONTRIBUTOR & FAMILY MEMBER DETAILS

Plan Type

	Title	Family Name	Given Names	Sex	Dob	Std / Hos	
Contributor						✓	
Partner							
Child 1							
Child 2							
Child 3							
Child 4							

If additional children are to be covered, please attach their details on a separate piece of paper.

CONTRIBUTOR: ADDITIONAL DETAILS

Residential address:

Post Code _____

Telephone: Private: _____ Work: _____ Mobile: _____

Worksite: _____ Email: _____

Union: _____

DECLARATION & COMMENCEMENT OF COVER (✓ as appropriate)

- The rate/new rate will be \$ _____ (EBS Standard Plan Only)
- I understand my **EBS Standard Plan** will commence from the date of my first salary deduction of premium.
- My employer cannot deduct contributions. Please send me a direct debit authority. I understand my **EBS Standard Plan** cover will commence from the date of the first direct debit of premium from my bank.
- I declare that I am a full financial member of the above named union. I have read the EBS Health Care Terms and Conditions brochure.

Contributor's Signature: _____ Date: ____/____/____



Authority to make EBS Health Care deductions from salary

Surname: _____ Given names: _____

Worksite: _____ This is a new authority. This replaces an existing authority.

I authorise you to deduct \$ _____ (or such other amount from time to time determined by EBS Health Care) from my salary.

Contributor's Signature: _____ Date: ____/____/____

Standard Plan Benefits

The Standard Plan offers a range of low-cost benefits such as doctors' visits, Bereavement support, Complimentary Medical and Sick Leave without pay provisions. The following is a brief outline of what the Standard Plan has to offer, please refer to our brochure for full conditions applicable to each benefit, or on our web page. www.ebs.org.nz

- **Bereavement** : \$1000 on the death of a subscriber, registered partner or child (including still birth).
- **Birth** : \$200 for each live child born to a contributor or partner.
- **Hospital Expenses** : 50% of the net cost to a maximum of \$700 a year each for contributor, partner and children (maximum total \$2100).
- **Standard \$500 Excess Refund** :** is available to linked and approved EBS Hospital Plans.
- **Medical Treatment** : 50% of the net cost of doctors' fees and prescription charges(\$10 per item limit applies)* to a maximum of \$750 a year each for contributor, partner and children (maximum total \$2250).
- **Major Diagnostic** : 50% of the net cost of CAT & MRI scans and Angiograms up to a maximum of \$600 a year for each contributor , partner and children (maximum total of \$1 800) providing subscriptions have been paid for six months prior to the date of the procedure.
- **Medical Appliance** : 50% of the net cost of specified items (eg.hearing aids.) to a maximum of \$300 a year each for contributor, partner and children (maximum total \$900).
- **Complementary Medical** : (e.g., homeopathic, fertility treatment) 50% of the net cost of specified expenses to a maximum of \$375 a year each for contributor, partner and children (maximum total \$1125).
- **Optical** : 50 percent of the net cost of glasses, multifocal or contact lenses to a maximum of \$200 a year for contributor, partner and children (maximum total \$600).- providing subscriptions have been paid for six months prior to the date of the optical examination.
"Please Note - The effective date for the optical benefit is the date of the eye examination, NOT the date the lenses/glasses are purchased or supplied."
- **Orthodontic** : 30 percent of orthodontic and associated fees to a maximum of \$750 per registered child The maximum benefit payable for the duration of the contributors' membership is \$1 500 (See Terms & Conditions and Orthodontic Guidelines for full details of benefits.)
- **Sick Leave Without Pay** : \$50 per week plus \$5 for each child up to a maximum of \$60 per week for 26 weeks.

*Entitlements cannot be aggregated to allow more than the annual maximum per adult or child.

** Hospital Cover excess is available to linked and approved EBS Hospital Cover Plans only.

Please note, Hospital Plan rates are additional to the Standard Plan rates.

RATES FOR EBS STANDARD PLAN AS AT 01 March 2008

AGE	CONTRIBUTOR			CONTRIBUTOR & PARTNER *			CONTRIBUTOR & CHILD/REN *			CONTRIBUTOR & FAMILY *		
	fortnightly	monthly	annual	fortnightly	monthly	annual	fortnightly	monthly	annual	fortnightly	monthly	annual
00-45	4.81	10.42	125.06	11.18	24.22	290.68	10.39	22.51	270.14	14.81	32.09	385.06
46-60	5.58	12.09	145.08	13.85	30.01	360.10	11.35	24.59	295.10	18.08	39.17	470.08
61-65	6.93	15.02	180.18	16.74	36.27	435.24	11.54	25.00	300.04	19.24	41.69	500.24
66-99	8.27	17.92	215.02	19.24	41.69	500.24	12.62	27.34	328.12	21.54	46.67	560.04

*EBS Standard Plan rates are based on the age of the contributor.

Please note that rates may change from time to time; check with your agent or EBS before making a decision.

Email us contact@ebs.org.nz or call our Helpline on: 0800 268 3763