NOW HEALTH INTERNATIONAL

WorldCare application form: Individuals and families

For company use – intermediary details and stamp

Intermediary company:	Fax number:
	Email address:
Contact name:	Official stamp:
Telephone number:	

Please complete this form in BLOCK CAPITALS or apply online at www.now-health.com.

Failure to disclose all material facts (i.e. misrepresentation) may lead to **Us** voiding **Your Plan** and/or non-acceptance and/or reduced payments of future claims. A material fact is one which is likely to influence the assessment or acceptance of this application. If **You** are unsure whether a fact is material, **You** should disclose it.

Please keep a record of all information **You** supply to **Us** in connection with this application.

Please enclose any medical reports or test results with **Your** application if they are available. **We** may ask **You** to complete a further medical questionnaire if **We** need more information. All the information **You** provide will be treated in strict confidence.

We rely on the information that **You** provide in this form (i.e. **Your** representations) to decide whether or not to accept **Your** application, and whether or not **We** need to apply special terms. Special terms are exclusions or conditions that **We** may apply to **Your** cover. If **You** submit a claim for the **Treatment** of any existing condition which **You** did not tell **Us** about here or did not tell **Us** everything about, **We** may refuse to pay that claim. **We** also have the right to void **Your Plan**, or **We** may impose special terms on **Your Plan** which **We** will apply retrospectively. Please take the greatest care to ensure that this application form is completed fully and accurately.

If, after completing **Your** application form and before the latest of either **Our** written acceptance, payment of premium or **Your Start Date**/**Entry Date**, anything occurs which affects the information **You** provided in this form, such as a change in **Your** state of health or the state of health of any of **Your Dependants**, **You** must tell **Us** in writing about the change.

Please send **Your** completed application form to **Us** via **Your** intermediary, or direct to Now Health International (Europe) Limited, Suite G3/4, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom. **You** can also scan and email it to EuropeSales@now-health.com or fax it to +44 (0) 1276 602120.

Section 1: Name of Planholder

First name(s):	Family name:
What do **You** like to be called?	

*(If **Your** full name is John Andrew Smith, **You** might like to be called John or Mr Smith or Andy. **We** will address all correspondence to **You** in this way.)*

Section 2: Planholder details

Address:				
Email address:				
Preferred telephone number *(including country code)*:				
Is this **Your**	Mobile ☐	Home ☐	Work ☐	*If **You** would like SMS notifications, please tell us **Your** mobile number:*
Gender:	Male ☐	Female ☐		Date of birth (dd/mm/yyyy): / /
Country of Residence:				Nationality:
Height (cm/ft):				Weight (kg/lbs):
Occupation:				Occupation industry:

Section 3: Spouse and Dependant details

Spouse details	
First name(s):	Family name:
What does he/she like to be called?	
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they like to be called?				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Country of Residence:				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to **Planholder**:				
Occupation (ages 16+):				

Section 4: Start Date

Date on which **You** wish **Your** Now Health International **Plan** to start (dd/mm/yyyy): / /

Cover cannot start until **You** have accepted all of **Our** terms and conditions following **Our** receipt of this application form and **We** have received the correct premium. **You** can apply for cover to start at a future date within 60 days of completion of this application form.

Section 5: Document delivery settings

How would **You** like **Your Plan** documents delivered? In **Your** online secure portfolio area ☐ Printed and delivered to **You** by post ☐

As an international organisation, **We** are aware of the impact that printing and shipping has on the environment. **We** are committed to reducing **Our** carbon footprint by printing on sustainably sourced materials and ask **You** to access **Your** documents online only. **We** will print them however, if **You** tick the appropriate box above. Regardless of which option **You** choose, **You** will always receive a physical membership card.

Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to WorldCare **Benefit Schedule**. Please indicate **Your Plan** choice, **Excess,** and any additional options.

Choice of **Plan**

Benefit	**Essential**	**Advance**	**Excel**	**Apex**
Maximum annual limit	USD 3m/ EUR 2.4m/GBP 1.9m	USD 3.5m/ EUR 2.8m/GBP 2.2m	USD 4m/ EUR 3.2m/GBP 2.5m	USD 4.5m/ EUR 3.6m/GBP 2.8m
In-Patient and **Day-Patient** care	▶	▶	▶	▶
Organ Transplant	▶	▶	▶	▶
Cancer Treatment	▶	▶	▶	▶
Acute **Medical Conditions** during **Pregnancy** and childbirth	▶	▶	▶	▶
Evacuation and **Repatriation**	▶	▶	▶	▶
Day-Patient or **Out-Patient** surgery	▶	▶	▶	▶
Out-Patient Medical Practitioner fees	▶	▶	▶	▶
Rehabilitation	▶	▶	▶	▶
Congenital cover	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental **Treatment**	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
Please choose	☐	☐	☐	☐

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency	USD ☐	EUR ☐	GBP ☐

Plan Excess

If **You** would like to change from the Standard **Excess** to one of the other options, please tick the appropriate box. Please note that the **Plan Excess** is per **Insured Person**, per **Medical Condition**, per **Period of Cover**.

	Essential	**Advance**	**Excel**	**Apex**
Standard **Excess**	Nil	USD 100/ EUR 80/GBP 60	USD 100/ EUR 80/GBP 60	USD 100/ EUR 80/GBP 60
Optional **Excess**				
Nil	N/A	☐	☐	☐
USD 50/EUR 40/GBP 30	N/A	☐	☐	☐
USD 250/EUR 200/GBP 155	N/A	☐	☐	☐
USD 500/EUR 400/GBP 310	N/A	☐	N/A	N/A
USD 1,000/EUR 800/GBP 625	☐	☐	N/A	N/A
USD 2,500/EUR 2,000/GBP 1,550	☐	☐	N/A	N/A
USD 5,000/EUR 4,000/GBP 3,125	☐	N/A	N/A	N/A
USD 10,000/EUR 8,000/GBP 6,250	☐	N/A	N/A	N/A
USD 15,000/EUR 12,000/GBP 9,375	☐	N/A	N/A	N/A

Additional options

	Essential	**Advance**	**Excel**	**Apex**
USA elective **Treatment** – Area 1 rates	☐	☐	☐	☐
10% **Co-Insurance** on **Out-Patient Treatment** – 5% Discount	N/A	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment** – 10% discount	N/A	☐	☐	☐
Out-Patient Per Visit **Excess*** – same as the USD 50/EUR 40/GBP 30 per medical condition excess price point	N/A	☐	☐	☐
Out-Patient Charges – 24% loading	☐	N/A	N/A	N/A
Out-Patient Charges – Option 2 – 50% loading	☐	N/A	N/A	N/A
Africa Area of Coverage restriction – 10% discount	☐	☐	☐	☐

* **We** have a network of medical providers who will settle **Out-Patient** claims directly with **Us**. If **You** choose this option, **You** can access the **Out-Patient Direct Billing** network but **You** must pay the first USD 25/EUR 20/GBP 15 of any **Eligible Out-Patient** claim. Not available with the WorldCare Essential **Out-Patient** Charges additional option.

Section 7: Method and frequency of premium payment

Please note that if the payment **You** are to make now is based on an indicative quote the amount due may change once **We** have reviewed this application. **You** will need to both agree and pay the revised premium before cover can start. Please select the frequency and payment type **You** would like to pay **Your** premiums in. Please note that quarterly premiums have a 3% surcharge and monthly premiums have a 5% surcharge.

	Annually	Semi-annually	Quarterly	Monthly
Cheque	☐	N/A	N/A	N/A
Credit card	☐	☐	☐	☐
Bank transfer	☐	N/A	N/A	N/A

Cheque: Please make **Your** cheque payable to Now Health International (Europe) Limited and attach it to this application form.
Credit card: **We** accept Visa, MasterCard and American Express. We will contact you to take the required payment.
Bank transfer: Please make sure **You** tell **Us Your** family name in the transfer details and send it to the appropriate bank account below:

	USD account	EUR account	GBP account
Bank	Citibank	Citibank	Citibank
Bank account name	Now Health Intl (Europe) Ltd	Now Health Intl (Europe) Ltd	Now Health Intl (Europe) Ltd
Address	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom
Account no.	12682281	12682214	12682249
Sort code	18-50-08	18-50-08	18-50-08
Swift code	CITIGB2L	CITIGB2L	CITIGB2L
IBAN no.	GB11CITI18500812682281	GB74CITI18500812682214	GB02CITI18500812682249

Section 8: Claim reimbursement method

Please indicate how **You** would like to receive claim reimbursement payments. Bank transfer is the most secure and quickest method.
Cheque ☐ Bank transfer ☐

For bank transfer

Account holder's name:	Country:
Bank name:	
Bank address:	
IBAN or account no.:	
Routing code (e.g. Swift or sort code):	

Section 9: Insurance details

9.1 Do **You** currently have health insurance with another company? Yes ☐ No ☐

If yes, please give details:

9.2 Do **You** intend to continue with the existing insurance? Yes ☐ No ☐

Section 10: Health declaration

If **You** have more than five **Dependants**, please use a separate sheet of paper and attach it to this application.
You do not need to disclose matters related to common colds, **Vaccinations**, hayfever, uncomplicated fractures, or appendicectomy.

	Planholder	Dependant (Spouse)	Dependant 1	Dependant 2	Dependant 3	Dependant 4
10.1 Have **You** in the last five years ever undergone any **Surgical Procedure**, been a patient or been treated in a **Hospital**, clinic, sanatorium, nursing home or other medical institution where **You** were off work for more than one week, and/or received more than 10 days' **Treatment**?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.2 Are **You** currently taking any kind of medication (other than oral contraceptives), or is any **Treatment** or tests currently being performed or planned, or any day or **In-Patient** hospitalisation scheduled?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Have **You** ever suffered from, received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised for:

10.3 Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.5 Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Have **You** ever been tested positive for HIV, Hepatitis B or C?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.6 **Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.9 Diabetes, thyroid disorders or weight management problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.13 Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, major injury or **Medical Condition** not already noted above?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.14 Females only Have **You** ever suffered from any breast or gynaecological disorders?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.14, please provide details in the box below.

Name	Question number	Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future **Treatment**.

Section 11: Doctor's contact details

Please give details of **Your** current usual doctor or the one who is most familiar with **Your** medical history.

Medical Practitioner's details

Name:	Telephone number:
Address:	
Date of last attendance and reason:	

Section 12: Important notes

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Now Health International **Plan** terms, conditions and exclusions.

The premiums quoted have been calculated based on each person's age at the date of the quotation. Premiums may be subject to change if the age of any person increases prior to the actual **Start Date** of **Your** Now Health International **Plan**. Cover cannot start until **You** have accepted all of **Our** terms and conditions following **Our** receipt of this application form and **We** have received the correct premium.

The premiums quoted have been based on Your Body Mass Index being within normal limits.

Data protection
We and the **Underwriters** will collect certain information about **You** in the course of considering **Your** application and, if a **Plan** is issued to **You**, conducting **Our** relationship with **You**. This information will be processed for the purposes of underwriting **Your** insurance coverage, managing any **Plan** issued and administering claims. **Your** information may be passed to **Underwriters, Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the European Economic Area. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the European Economic Area. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

Now Health International may contact **You** with details of **Our** other products and services which may be of interest to **You**. **You** may be contacted by post, telephone or email if appropriate. If **You** do not wish **Us** to do this please tick this box ☐ .

Access to Medical Reports Act 1988
You have a right of access to, and correction of, information that **We** hold about **You**. Please contact **Us** if **You** would like to exercise either of these rights. Some of the information **We** collect about **You** may be classified as "sensitive" – that is information about racial or ethnic origin and physical or mental health. Data protection laws impose specific conditions in relation to sensitive information, including, in some circumstances, the need to obtain **Your** explicit consent before **We** process the information.

By signing this Application Form **You** consent to the processing and transfer of information (including sensitive information) described in this notice. Without this consent **We** will not be able to consider **Your** application.

Section 13: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a Now Health International **Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Plan**. I understand that the Application Form, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Plan** terms and conditions make up the contract between **Us** and all form part of the **Plan** Agreement. I am aware that cover shall be provided in accordance with the Agreement.

- I declare that the information given in this application is true and that disclosure in respect of each person included in this application is complete, even if some of the information provided is not in my own handwriting. I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Now Health International for the purpose of defrauding or attempting to defraud Now Health International. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Europe) Limited of any changes in the facts contained in this application form, such as a change in the state of health of any person named in it, before the latest of either written acceptance, payment of premium or the **Start Date/Entry Date**.
- For the purpose of this application I authorise any doctor who has ever treated or advised any of the persons named in this application to provide Now Health International with any information they may require in connection with **Treatment** related to any claim under this **Plan**. I have discussed the terms of this authorisation with my partner and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation.
- I declare that I have read and understood the following from the members' handbook:
  - cancellation and termination rights
  - complaints procedures and referral rights to the financial ombudsman service
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - Now Health International (Europe) Limited is acting on behalf of AXA PPP healthcare Limited for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- If I have indicated that I wish to pay by credit card, I authorise Now Health International to debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by Now Health International until I give written notice that I wish to terminate this Agreement.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Plan** is lapsed should Now Health International be unable to collect my premium for whatever reason and I do not provide Now Health International with an alternate method of payment within seven days of Now Health International requests for alternative methods of payment.
- I agree that where medical **Treatment** is received within the provider network by me or any of my **Dependants** and, except where previously agreed by Now Health International, it is determined that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Plan**, I agree that I am liable to Now Health International for all claims settled for such medical **Treatment** in connection with any non-covered claim.
- I understand and confirm that where I have not repaid funds disbursed in good faith by Now Health International in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Now Health International and/or my **Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Now Health International that a claim was fraudulent my **Plan** may be voided with immediate effect.
- I understand that if I am able to claim any costs from another insurance policy for the cost of any treatment or benefits received, Now Health International (Europe) Limited will only be liable for a proportional share of the total costs.
- I have read the important notes.
- I agree to the declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

Signature (Insured/main applicant):

Date (dd/mm/yyyy):

/ /

Now Health International

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