

For company use – intermediary details and stamp

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

To be completed by the employer (the **Planholder**). Please complete this form using BLOCK CAPITALS.

A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your** membership. Where **You** make a careless misrepresentation **We** may void **Your Group Plan** or decline or reduce related claim payments. A misrepresentation is an untrue statement of fact relied on by one party, in this case **Us**, in establishing the terms of a contract (**Your Group Plan**). **You** should ensure that **You** complete **Your** application carefully, accurately and fairly. If **You** are unsure on any matter **You** should contact **Us**.

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

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 the state of health of any of **Your** employees, **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 Limited, PO Box 482055, Dubai, UAE. **You** can also scan it and email it to MEAQuotes@now-health.com or fax it to +971 (0) 4450 1520.

Section 1: Start Date

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.

The date the **Group Plan** will start from (dd/mm/yyyy): / /

Section 2: Company details

Company name:	
Company address:	
Company registration number:	
Company website address:	Type of business:

Section 3: Company Plan Administrator details

First name(s):	Family name:
What do You like to be called? <small>(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.)</small>	
Job title:	
Address (if different from above):	
Telephone:	Fax:
Email address:	

Section 4: Our environmental policy – Your document delivery settings

As an international organisation, **We** are committed to reducing **Our** carbon footprint by working to minimise the impact of printing and shipping on the environment. To opt out of **Our** environmental policy and receive printed documents, please check this box . **You** will automatically receive a physical membership card for every **Insured Person** on **Your Group Plan** no matter which option **You** choose and **You** can access all of **Your** remaining **Group Plan** documents in **Your** secure online portfolio.

Section 5: Group Plan options

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

Choice of **Group 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency	USD <input type="checkbox"/>	EUR <input type="checkbox"/>	GBP <input type="checkbox"/>
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Group Plan Deductible

If **You** would like to change from the Standard **Deductible** to one of the other options, please tick the appropriate box. Please note that the **Group Plan Deductible** applies to **In-Patient** and **Day-Patient Treatment** is per **Insured Person**, per **Period of Cover**.

If **You** choose an Optional **Deductible**, on WorldCare Advance, WorldCare Excel or WorldCare Apex, **You** must also select an **Out-Patient Co-Insurance** Option or an **Out-Patient Per Visit Excess** Option. On WorldCare Essential if **You** choose an optional **Deductible** and an **Out-Patient Charges** Option, **You** must also select an **Out-Patient Co-Insurance** Option.

	Essential	Advance	Excel	Apex
Standard Deductible	Nil	Nil	Nil	Nil
Optional Deductible				
USD 1,000/EUR 800/GBP 625	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 2,500/EUR 2,000/GBP 1,550	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 5,000/EUR 4,000/GBP 3,125	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 10,000/EUR 8,000/GBP 6,250	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 15,000/EUR 12,000/GBP 9,375	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-Patient Per Visit Excess Option				
USD 25/EUR 20/GBP 15	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 15/EUR 12/GBP 10	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional options

	Essential	Advance	Excel	Apex
USA elective Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical history disregarded (compulsory Group Plans 10+ employees only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Africa Area of Coverage restriction – 20% discount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation and Repatriation Option – Additional charge of USD100/EUR 80/GBP60 per Insured Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-Patient Charges	<input type="checkbox"/>	N/A	N/A	N/A
Out-Patient Charges – Option 2	<input type="checkbox"/>	N/A	N/A	N/A
10% Co-Insurance on Out-Patient Treatment	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% Co-Insurance on Out-Patient Treatment	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and vaccinations (Combined limit up to USD 500) (compulsory Group Plans 3+ employees only)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and vaccinations – Option 2 (Combined limit up to USD 1000) (compulsory Group Plans 3+ employees only)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Routine maternity cover for Advance Group Plan option (compulsory Group Plans 10+ employees only)	N/A	<input type="checkbox"/>	N/A	Already covered
Routine maternity cover with 20% Co-Insurance for Advance Group Plan option (compulsory Group Plans 10+ employees only)	N/A	<input type="checkbox"/>	N/A	Already covered
Dental cover for Advance Group Plan option (compulsory Group Plans 10+ employees only)	N/A	<input type="checkbox"/>	Already covered	Already covered
Routine maternity cover for Excel Group Plan option (compulsory Group Plans 10+ employees only)	N/A	N/A	<input type="checkbox"/>	Already covered
Removal of Dental Co-Insurance	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Please note that on WorldCare Essential a **Co-Insurance Out-Patient Treatment** Option can only be taken if **You** select an **Out-Patient Charges** Option.

Section 6: 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.

	Annually	Semi-annually	Quarterly	Monthly
Cheque	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A
Bank transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A

Cheque: Please make **Your** cheque payable to Now Health International Limited and attach it to this application form.

Bank transfer: Please make sure **You** tell **Us** **Your** company name in the transfer details and send it to the bank account below:

	USD account	EUR account	GBP account
Bank	Citibank N.A.	Citibank N.A.	Citibank N.A.
Bank account name	Now Health International Limited	Now Health International Limited	Now Health International Limited
Address	Oud Metha Road, Al Wasl Branch, Dubai, UAE	Oud Metha Road, Al Wasl Branch, Dubai, UAE	Oud Metha Road, Al Wasl Branch, Dubai, UAE
Sort code	N/A	N/A	N/A
Swift code	CITIAEAD	CITIAEAD	CITIAEAD
IBAN no.	AE500211000000100708264	AE280211000000100708272	AE940211000000100708248

Section 7: Previous Medical Insurance

Please complete this section if **You** have previously had private medical insurance for **Your** group members. Otherwise please go to section 8.

Policy no.:	Date cover expires/expired (dd/mm/yyyy):	/	/
Name of Insurer:			

Section 8: Underwriting Options

Full Medical Underwriting (FMU)	<input type="checkbox"/>	Medical History Disregarded (MHD)	<input type="checkbox"/>
Continuous Transfer Terms (CTT)	<input type="checkbox"/>		

Full Medical Underwriting (FMU) is the process where the **Underwriters** assess the declared details in deciding if any special terms apply. For FMU, all members (employees and **Eligible Dependants**) are required to complete a WorldCare application form for group (FMU) employees and send it to Now Health International Limited, PO Box 482055, Dubai, UAE.

Medical History Disregarded (MHD) is when we may be able to cover **Your** employees without asking detailed questions about their medical history up-front. MHD is available for compulsory groups of 10 or more employees.

Continuous Transfer Terms (CTT) is when **You** are applying for one of **Our Group Plans** with **Benefits** similar to those of **Your** current policy and where the **Underwriters** assess the declared medical details and decide if **We** can offer **Your** members a Continuous transfer. All members (employees and **Eligible Dependants**) are required to complete a WorldCare application form for group (CTT) employees and send it to Now Health International Limited, PO Box 482055, Dubai, UAE.

We need a full membership list as follows and it must include these details for each person to be covered (A template is available from www.now-health.com or by calling +971 (0) 4450 1500).

1. First name(s)
2. Family name
3. What do they like to be called?
*(If **Your** employee's full name is John Andrew Smith, he might like to be called John or Mr Smith or Andy. **We** will address all correspondence to him in this way.)*
4. Gender
5. Date of birth (dd/mm/yyyy)
6. Occupation
7. Employee category
8. **Entry Date** – first day of cover (dd/mm/yyyy)
9. **Country of Residence**
10. Nationality
11. Email address
12. Telephone no.
13. Relationship to primary insured
14. **Dependants** to be included
15. Start date of employment (employees only)

Section 9: Eligibility

Please define the member category:

Name of category e.g. directors, managers, general employees	All members	Number of members
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

Compulsory or Voluntary Start Date for New Employees:
 Employees only or Employees and **Dependants** First date of employment
Expatriates and/or Local Nationals After _____ month(s) probation period

If cover choices vary according to the job position and there are more than five employees for each level, please provide details.

For **Dependants** aged between 18 to 28 **We** may require written confirmation from their place of study that they are in full-time education.

If **We** have accepted the **Group Plan** on the basis that it is compulsory group and subsequently find out that the **Group Plan** is on a voluntary basis; **We** reserve the right to adjust the premium.

Section 10: 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 **Group 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 **Group Plan** or if the number of members eligible to participate in the **Group Plan** is different to the original census provided that Now Health International quoted on. 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 Body Mass Indexes 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 **Group 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 **Group Plan** issued and administering claims. **Your** information may be passed to **Underwriters, Medical Practitioners, Medical Assistance Companies and Claims Administrators** for these purposes. The same duty of confidentiality is required of any third parties to whom the administration of **Your Group Plan** may be subcontracted. **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 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 this to happen please tick this box .

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.

Important note: We regard the rights above as best practice but the legal requirements may differ in the country in which You reside. Please contact Us for additional information regarding regulations in Your jurisdiction.

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 11: Declaration and authorisation

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

I have received and read the **Benefit Schedule, Terms and Conditions, Definitions, Benefits** and exclusions of this **Group Plan**. I understand that the Application Form, Group Agreement, **Certificate of Insurance, Benefit Schedule** and the Members' Handbook incorporating the **Group Plan** terms and conditions make up the contract between **Us** and all form part of the **Group 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 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 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**.
- 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 declare that I have read the following from the members' handbook and Group Agreement:
 - cancellation and termination rights
 - complaints procedures
 - law and jurisdiction of the **Group Plan**
 - language of the **Group Plan** and **Our** service
 - compensation arrangements
 - Now Health International Limited is acting on behalf of Best Doctors Insurance Limited for the purposes of issuing and administering **Group Plans**, receiving premiums and paying claims.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Group 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 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 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 **Group Plan** and **Group** Agreement.

Signature (Authorised person/Plan Administrator):

Date (dd/mm/yyyy):

/ /

Now Health International Limited ("NHIL"), which is regulated by the Dubai Financial Service Authority, issues plans underwritten by Best Doctors Insurance Limited (which is regulated by the Bermuda Monetary Authority and is under the same common ownership as NHIL) Plans are only available to those outside the UAE.

Now Health International Limited - Registered Office: Office 814, Liberty House, Level 8, Gate Drive Street, P.O.Box 482055, Dubai.

