

# SimpleCare application form: Groups



Administered by:

**NOW**  
HEALTH INTERNATIONAL

Insured by:



## For company use – intermediary details and stamp

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

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.

**We** reserve the right to decline or accept **Your** application or to accept **Your** application form with special terms.

Please send **Your** completed application form and submit it along with **Your** incorporation certificate (trade license) to **Us** via **Your** intermediary, or direct to Royal & Sun Alliance Insurance Middle East B.S.C. (c), c/o Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, Dubai, UAE. **You** can also scan and email it to MEAQuotes@worldcare.ae

## 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 establishment number:

Tax registration number (TRN):

Other countries where **You** do business/have operations:

Company website address:

Type of business:

Is the Company, any party connected to the Company or any employees, their family members or close associates, a politically exposed person?

Is any party connected to the Company, any employees, their family members or close associates, a politically exposed person?

Yes  No

Are all directors included in **Your** intended membership? (If not please list all additional directors)

Yes  No

Are all Ultimate Beneficial Owners of the Company included in the intended membership (If not please list all Ultimate Beneficial Owners) (natural persons owning more than 5%):

Yes  No

### Section 3: Company Plan Administrator details

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.)*

Job title:

Address (if different from above):

Telephone:

Fax:

Email address:

### Section 4: Our environmental policy – Your document delivery settings



**You** can use **Your** secure online portfolio to view and download **Your Plan** documents, including **Your Certificate of Insurance**



**You** can use **Your** secure online portfolio to download **Your** virtual membership card.



Add **Your** membership card to **Your** smartphone wallet

## Section 5: Group Plan options

For detailed information about the **Group Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Group Plan** choice, any **Out-Patient** option and/or Additional option.

### 5.1 Choice of Group Plan

Benefit	SimpleCare CORE #	SimpleCare 100 ‡	SimpleCare 250 ‡
<b>Annual Maximum Plan Limit</b>	USD 1,000,000	USD 1,500,000	USD 1,500,000
<b>Area of Cover: Worldwide Excluding USA</b> Residents of the UAE			
<b>Default Out-Patient Co-Insurance</b>	<i>(i) For Treatment inside SimpleCare UAE Network</i>	N/A	<i>(i) Tier 1 medical providers: 20% Tier 2 medical providers: 15% Tier 3 medical providers: 0%</i>
	<i>(ii) For Treatment outside SimpleCare UAE Network</i>	N/A	<i>(ii) 20%</i>
<b>In-Patient and Day-Patient care</b>	▶	▶	▶
<b>Day-Patient or Out-Patient surgery</b>	▶	▶	▶
<b>Cancer Treatment</b>	▶	▶	▶
<b>Organ Transplant</b>	▶	▶	▶
<b>Congenital cover</b>	▶	▶	▶
<b>Rehabilitation</b>	▶	▶	▶
<b>Evacuation and Repatriation</b>	▶	▶	▶
<b>Out-Patient fees (for Treatment outside the UAE)</b>	▶	▶	▶
<b>Dental Treatment</b>	▶	▶	▶
<b>Please Choose</b>	○	○	○

▶ Full refund    ▶ Not covered    ▶ Limited cover

### 5.2 Out-Patient option

	SimpleCare CORE #	SimpleCare 100 ‡	SimpleCare 250 ‡
<b>Co-Insurance Out-Patient Treatment - option 1</b>	<i>(i) For Treatment inside SimpleCare UAE Network</i>	N/A	<i>(i) Tier 1 medical providers: 10% Tier 2 medical providers: 10% Tier 3 medical providers: 0%</i>
	<i>(ii) For Treatment outside SimpleCare UAE Network</i>	N/A	<i>(ii) 10%</i>
		○	○

# SimpleCare CORE is not available to **Insured Persons** with residence visas in the Emirates of Dubai and Abu Dhabi. SimpleCare CORE is a non-DHA compliant plan.

‡ SimpleCare 100 and SimpleCare 250 is not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

5.3 Additional Options	SimpleCare CORE #	SimpleCare 100 <sup>‡</sup>	SimpleCare 250 <sup>‡</sup>
<b>Removal of Drugs and Dressings Limit</b> (for compulsory <b>Group Plans</b> 3+ employees)	N/A	N/A	<input type="radio"/>
<b>Wellness &amp; Vaccinations - Option 1</b> (combined limit up to USD 150) (for compulsory <b>Group Plans</b> 3+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
<b>Wellness &amp; Vaccinations - Option 2</b> (combined limit up to USD 250) (for compulsory <b>Group Plans</b> 3+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
<b>Maternity - Option 1</b> (Normal Pregnancy and Childbirth up to USD 5,000) (for compulsory <b>Group Plans</b> 10+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
<b>Maternity - Option 2</b> (Normal Pregnancy and Childbirth up to USD 7,000) (for compulsory <b>Group Plans</b> 10+ employees)	N/A	<input type="radio"/>	<input type="radio"/>

## 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 semi-annual premiums have a 3% surcharge and quarterly premiums have a 5% surcharge.

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

**Cheque:** Please make **Your** cheque payable to Royal & Sun Alliance Insurance Middle East B.S.C. (c) and attach it to this application form.

**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
Bank	Citibank
Bank account name	Royal & Sun Alliance Insurance Middle East B.S.C. (c)
Address	PO Box 749, Dubai, UAE
Swift code	CITIAEAD
IBAN no.	AE21021100000500027231

For USD bank account

**Correspondent Bank:** "Citibank N.A., New York, USA. SWIFT: CITIUS33"

## Section 7: Medical Insurance Details

7.1 Do <b>You</b> currently provide private medical insurance for <b>Your</b> group members? If yes, please give details below:		Yes <input type="radio"/> No <input type="radio"/>
Policy no.:	Date cover expires/expired (dd/mm/yyyy):	/ /
Name of Insurer:		
7.2 Do <b>You</b> intend to continue with the existing insurance?		Yes <input type="radio"/> No <input type="radio"/>

## Section 8: Group Medical Declaration

Details of any known or planned **In-Patient Treatment** in the last three years for any on-going **Treatment** for but not limited to; cancer, heart conditions, psychiatric disorders, congenital conditions, renal failure or back disorders:

\* Please note that if a **Medical Condition** is declared that the terms originally offered by the previous medical insurance are subject to underwriting review and approval which may require new underwriting conditions for the effectivity period of this application.

Please complete the following if **You** have previously had private medical insurance for **Your** group members. Otherwise please go to section 9.

Policy no.:

Date cover expires/expired (dd/mm/yyyy):        /        /

Name of Insurer:

## Section 9: Underwriting Options

Full Medical Underwriting (FMU)

Default

Medical History Disregarded (MHD) (for compulsory **Group Plans** 10+ employees)

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 Dependents**) are required to complete a SimpleCare application form for group employees and send it to Royal & Sun Alliance Insurance Middle East B.S.C. (c), c/o Now Health International Gulf Third Party Administrators LLC, Ground floor, Al Shaiba Building, Dubai Outsource City, PO Box 502163, 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.

Please note that the waiting period does not apply to either Maternity or Dental Care benefits if Medical History Disregarded is selected.

**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](http://www.now-health.com) or by calling +971 (0) 4450 1428).

- |   |  |
|---|--|
| 1. First name(s)  | 15. Occupation   |
| 2. Family name  | 16. Occupation industry  |
| 3. What do they like to be called?<br><i>(If <b>Your</b> employee's full name is John Andrew Smith, he might like to be called John or Mr Smith or Andy. <b>We</b> will address all correspondence to him in this way.)</i> | 17. Work region (e.g. Oud Metha)   |
| 4. Gender   | 18. Emirate of residence   |
| 5. Date of birth (dd/mm/yyyy)   | 19. Monthly salary range:<br><4,000 AED / 4,000<12,000AED / >12,000 AED / Unsalariated |
| 6. Marital Status   | 20. Commission based salary: Yes / No  |
| 7. Residential region   | 21. Employee category  |
| 8. Nationality  | 22. <b>Entry Date</b> – first day of cover (dd/mm/yyyy)                                |
| 9. Passport number  | 23. <b>Country of Residence</b>  |
| 10. UID (Visa) number   | 24. Email address  |
| 11. File number (Visa)  | 25. Telephone no.  |
| 12. Emirates ID number  | 26. Relationship to primary insured  |
| 13. Emirate of Visa issuance  | 27. <b>Dependants</b> to be included   |
| 14. Emirate of work   | 28. Start date of employment (employees only)  |

## Section 10: Eligibility

Please define the member category:

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

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 11: Important notes

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with SimpleCare **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** SimpleCare **Group Plan** or if the number of members eligible to participate in the **Group Plan** is different to the original census provided that Royal & Sun Alliance Insurance Middle East B.S.C. (c) 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 Your Body Mass Index being within normal limits.**

\* As per the Dubai Health Authority circular, **We** cannot back date cover for Dubai resident visa holders (only in exceptions for new born and this is limited to up to 7 days).

### 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).

Royal & Sun Alliance Insurance Middle East B.S.C. (c) and 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 12: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a SimpleCare **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 for the purpose of defrauding or attempting to defraud Royal & Sun Alliance Insurance Middle East B.S.C. (c). Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify 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**.

- I declare that I have read and understood the following from the members' handbook and Group Agreement:
  - cancellation and termination rights
  - complaints procedures and referral rights to the financial ombudsman service
  - law and jurisdiction of the **Group Plan**
  - language of the **Group Plan** and **Our** service
  - compensation arrangements
  - Now Health International Gulf Third Party Administrators LLC is acting on behalf of Royal & Sun Alliance Insurance Middle East B.S.C. (c) for the purpose of administering **Group Plans**.
- I and those to be covered under this **Group Plan** acknowledge and agree to our personal data being processed by Royal & Sun Alliance Insurance Middle East B.S.C. (c), its administrator or its group companies and those other parties, wherever located, for the purpose of administering my **Group Plan**.
- I understand that Royal & Sun Alliance Insurance Middle East B.S.C. (c) cannot be liable and therefore will not pay claims if my **Group Plan** is lapsed should Royal & Sun Alliance Insurance Middle East B.S.C. (c) be unable to collect my premium for whatever reason and I do not provide an alternate method of payment within seven days of receiving 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, Royal & Sun Alliance Insurance Middle East B.S.C. (c) 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 SimpleCare **Group Plan** and **Group** Agreement.

**Signature (Authorised person/Plan Administrator):**

**Date (dd/mm/yyyy):**

/ /



**UAE** ◀

**Now Health International**

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