

For company use – intermediary details and stamp

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

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

A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your Plan** with loss of premium. Where **You** make a careless misrepresentation **We** may void **Your 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 Plan**). **You** should ensure that **You** complete **Your** application carefully, accurately and fairly. If **You** are unsure on any matter **You** should contact **Us**.

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.

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 along with a copy of **Your** government issued identity document to **Us** via **Your** intermediary, or direct to Now Health International Limited, PO Box 482055, Dubai, UAE. **You** can also scan and email it to MEASQuotes@now-health.com or fax it to +971 (0) 4450 1520.

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 <i>(including country code)</i> :	
Is this Your	Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/>
<i>If You would like SMS notifications, please tell us Your mobile number:</i>	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are You or any intended member of this policy, or any family member or close associate a politically exposed person? Yes <input type="checkbox"/> No <input type="checkbox"/>	
(If yes please provide further details)	

Section 3: Spouse and Dependant details

Spouse details

First name(s):	Family name:
What does he/she like to be called?	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are You or any intended member of this policy, or any family member or close associate a politically exposed person? (If yes please provide further details) Yes <input type="checkbox"/> No <input type="checkbox"/>	

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they like to be called?				
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
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: 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 Plan** no matter which option **You** choose and **You** can access all of **Your** remaining **Plan** documents in **Your** secure online portfolio.



Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to WorldCare **Benefit Schedule**. Please indicate **Your Plan** choice, **Deductible**, 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency

USD

EUR

GBP

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 **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 – Area 1 rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
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
Africa Area of Coverage restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation and Repatriation Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations – Option 2	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 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.

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

Credit card: **We** accept Visa, MasterCard and American Express. **We** will contact **You** to take the required payment. **Your** card issuer may charge an additional conversion or transaction fee to process this payment.

Bank transfer: Please make sure **You** tell **Us** **Your** family 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		
For USD bank account	Correspondent Bank: "Citibank N.A., New York, USA. SWIFT: CITIUS33"		For transfer to banks in the UAE:	Code	INS
For GBP & EUR bank account	Correspondent Bank: "Citibank London N.A. SWIFT: CITIGB2L"			Description	Insurance Services

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.

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

9.3 Have **You** been insured previously with Now Health International? Yes No

If yes, please give dates of when insured and previous policy number:

Please also note to complete Section 6 even if **You** were previously insured with **Us**.

9.4 Have **You** ever had an application for Medical Insurance declined or had special terms imposed? Yes No

If yes, please give details:

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** or hayfever.

	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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Have **You** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised or had signs or symptoms of for:

10.3 Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.6 Cancer , cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.9 Diabetes, thyroid disorders or weight management problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.14 Females only Have You ever suffered from any breast or gynaecological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>



Additional information

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

Member name	Diagnosis (If none made please describe the exact nature of symptoms suffered)	Date of consultation	Treatment/ Medication received	Date of last treatment/ symptoms	Any underlying cause	Specific location on body including left or right	Outcome (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)

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. The same duty of confidentiality is required of any third parties to whom the administration of **Your 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 **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 .

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 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 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 the following from the members' handbook:
 - cancellation and termination rights
 - complaints procedures
 - law and jurisdiction of the **Plan**
 - language of the **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 **Plans**, receiving premiums and paying claims.
- 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 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 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.

