WorldCare application form: Individuals and families (FMU)

Administered by: NOW HEALTH INTERNATIONAL

Insured by: RSA

For company use – intermediary details and stamp

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

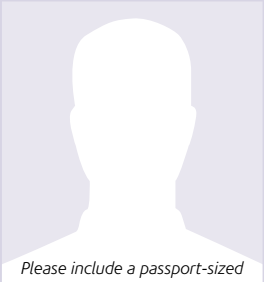
Please complete this form in BLOCK CAPITALS.

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 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 **U** 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.



Please include a passport-sized photograph using a white background of each applicant.

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 and photograph(s) along with a copy of **Your** government issued identity document 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 or fax it to +971 (0) 4450 1416.

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): / /
Marital status:	Married ☐	Unmarried ☐			**Country of Residence**:
Residential region: (e.g. Umm Suqeim First)					Nationality:
Passport number:		UID (Visa) number:			File number (Visa):
Emirates ID number: (000-0000-0000000-0)					Emirate of Visa issuance:
Height (cm/ft):					Weight (kg/lbs):
Occupation:					Occupation industry:

Work region:
(e.g. Oud Metha)

Monthly salary: < 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐

Commission based salary: Yes ☐ No ☐

Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? Yes ☐ No ☐
(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?	
Email address:	Phone number:
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Marital status: Married ☐ Unmarried ☐	**Country of Residence**:
Residential region: (e.g. Umm Suqeim First)	Nationality:
Passport number:	UID (Visa) number: / File number (Visa):
Emirates ID number: (000-0000-0000000-0)	Emirate of Visa issuance:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Work region: (e.g. Oud Metha)	
Monthly salary: < 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	
Commission based salary: Yes ☐ No ☐	
Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? Yes ☐ No ☐ (If yes please provide further details)	

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they like to be called?				
Email address:				
Phone number:				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Marital status:	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐
Country of Residence:				
Residential region: (e.g. Umm Suqeim First)				
Nationality:				
Passport number:				

UID (Visa) number:				
File number (Visa):				
Emirates ID number: (000-0000-0000000-0)				
Emirate of Visa issuance:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to **Planholder**:				
Occupation (ages 16+):				
Occupation industry:				
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐
Commission based:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Section 4: Start Date

Date on which **You** wish **Your 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**. The currency **You** pay **Your** premium in is chosen for **You** by **Your Country of Residence** and the **Plan Deductible** will also be denominated in this currency. Please indicate **Your Plan** choice, **Deductible,** and any additional options.

Choice of Plan

Benefit	**Essential** #	**Advance**	**Excel**	**Apex**
Maximum annual limit	USD 3m	USD 3.5m	USD 4m	USD 4.5m
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	☐	☐	☐	☐

WorldCare Essential is not available to **Insured Persons** with residence visas in the Emirates of Dubai or Abu Dhabi.

▶ Full refund ▶ Not covered ▶ Limited cover

Plan Deductible[ø]

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.

ø Annual **Deductibles** are not available to **Insured Persons** with residence visas in the Emirates of Dubai or Abu Dhabi.

	Essential	Advance	Excel	Apex
Standard **Deductible**	Nil	Nil	Nil	Nil
Optional **Deductible**				
USD 1,000	☐	☐	☐	☐
USD 2,500	☐	☐	☐	☐
USD 5,000	☐	☐	☐	☐
USD 10,000	☐	☐	☐	☐
USD 15,000	☐	☐	☐	☐
Out-Patient Per Visit Excess Option[†]				
USD 25 – 12.5% discount	N/A	☐	☐	☐
USD 15 – 4.5% discount ◊	N/A	☐	☐	☐

† If you choose an optional **Deductible**, You must also select either a **Co-insurance Out-Patient Treatment** option or an **Out-patient Per Visit Excess** option.

◊ Please note that only **Out-Patient Per Visit Excess** USD 15 is available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

Additional options

	Essential	Advance	Excel	Apex
USA elective **Treatment** – Area 1 rates	☐	☐	☐	☐
10% **Co-Insurance** on **Out-Patient Treatment** – 6% discount▲	☐*	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment** – 12% discount▲	☐*	☐	☐	☐
Restricted Network**	N/A	☐	☐	☐
Out-Patient Charges – 52% loading	☐	N/A	N/A	N/A
Out-Patient Charges – Option 2 – 64% loading	☐	N/A	N/A	N/A
Extended **Evacuation** and **Repatriation** Option – Additional charge of USD100 per **Insured Person**	☐	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations**	N/A	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations** – Option 2	N/A	☐	☐	☐

▲ **Co-Insurance Out-Patient Treatment** is not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

* 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.

** For residents of the UAE, the premium can be reduced by a further 10% by choosing the **Restricted Network** Option which excludes cover for **Treatment** received in the American Hospital and associated clinics, the City Hospital, the Welcare Hospital and associated clinics of the Mediclinic Group.
Please note that if **You** selected the USD25/USD 15 per visit **Out-Patient Excess** or one of the **Co-insurance Plan** options, these will still apply in the **Restricted Network.**
The **Restricted Network** is not available for resident visa holders in the Emirate of Abu Dhabi.

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.

	Annual	Semi-annual	Quarterly	Monthly
Cheque (Please make **Your** cheque payable to Royal & Sun Alliance Insurance Middle East B.S.C. (c) and attach it to this application form.)	☐	☐	☐	N/A
Credit card (**We** accept Visa, MasterCard and American Express. **We** will contact **You** to take the required payment. Please note that **You** need to visit **Our** office in person if **You** choose to make payment by American Express.) *++Your card issuer may charge an additional conversion or transaction fee to process this payment.*	☐	N/A	N/A	N/A
Bank transfer [1] (Please make sure **You** tell **Us Your** family name in the transfer details and send it to the appropriate bank account below.)	☐	N/A	N/A	N/A
Direct debit authorisation [2] (Please complete the Direct debit authorisation form and attach it to this application form. According to UAE Central Bank Regulations, **We** require the original signature on the direct debit authorisation form. **Our** customer services team will complete the form on **Your** behalf and send **You** the original to be verified and signed.)	N/A	☐	☐	☐

	Bank transfer – USD account [1]
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.	AE210211000000500027231
	Direct debit information [2]
Account holder's name	
Bank name	
IBAN no.	

For USD bank account
Correspondent Bank: "Citibank N.A., New York, USA. SWIFT: CITIUS33"

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 ☐

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:

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 ☐ 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 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 ☐ 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, currently pregnant, 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 ☐
10.15 Are **You** currently pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

If yes, have there been any complications to date? Please give details:

Last menstrual period date :

10.16 Are **You** currently trying to get pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
10.17 Are **You** undergoing any form of fertility **Treatment**?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

If yes, please give details:

☐ I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of Royal & Sun Alliance Insurance Middle East B.S.C. (c). Royal & Sun Alliance Insurance Middle East B.S.C. (c) has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of Royal & Sun Alliance Insurance Middle East B.S.C. (c).

Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.17, 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 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 WorldCare **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** WorldCare **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.

*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).

Royal & Sun Alliance Insurance Middle East B.S.C. (c) and 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 ☐.

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 WorldCare **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 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**.
- 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 any information which may be required 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 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 **Plans**.
- I and those to be covered under this **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 **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 **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 agree that where medical **Treatment** is received within the provider network by me or any of my **Dependants** and, except where previously agreed by Royal & Sun Alliance Insurance Middle East B.S.C. (c), 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 Royal & Sun Alliance Insurance Middle East B.S.C. (c) 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 Royal & Sun Alliance Insurance Middle East B.S.C. (c) in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Royal & Sun Alliance Insurance Middle East B.S.C. (c) and/or my **Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Royal & Sun Alliance Insurance Middle East B.S.C. (c) 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, 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 WorldCare **Plan**.

Signature (Insured/main applicant):

Date (dd/mm/yyyy):

/ /

Now Health International

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