



WorldCare application form: Group (FMU) employees

For company use – intermediary details and stamp							
Intermediary company:	Fax number:						
	Email address:						
Contact/Adviser name:	Official stamp:						
Telephone number:							
Please complete this form using BLOCK CAPITALS.							
Full medical underwriting (FMU) is the process whereby the Underwriters assess the declared details in deciding if any special terms apply. All employees and Eligible Dependants must complete an application form and send it to Now Health International (Singapore) Pte. Ltd. 4 Robinson Road, #07-01A/02 The House of Eden, Singapore 048543. You can also scan and email it to SingaporeSales@now-health.com or fax it to +65 6220 6950.							
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 connect	• •						
Please enclose any medical reports or test results with Your application. You r information. All information will be treated in strict confidence.	may be required to complete a further medical questionnaire if We need more						
We rely on the information that You provide in this form 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 declare Your membership to the Group Plan void, or We may impose special terms on Your Group 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 a							
Please send Your completed application form along with a copy of Your governow Health International (Singapore) Pte. Ltd. 4 Robinson Road, #07-01A/02 SingaporeSales@now-health.com or fax it to +65 6220 6950.							
Section 1: Name of Insured Person							
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 add	ress all correspondence to You in this way.)						
Section 2: Insured Person details							
Company name:	Group Plan number:						
Address:							
Email address:	Preferred telephone number: (including country code)						
Is this Your Mobile \square Home \square Work \square	If You would like SMS notifications, please tell us You r mobile number:						
Gender: Male □ Female □	Date of birth (dd/mm/yyyy): / /						
Country of Residence:	Nationality:						
Height (cm/ft): Weight (kg/lbs):							
Occupation: Occupation industry:							
Start Date of Employment (Employees only) (dd/mm/yyyy):	/ /						
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 De	pendant de	etails						
Spouse details								
First name(s):				Family name:				
What does he/she like to be called?								
Gender: Male] Female [Date of birth (dd/r	mm/yyyy):	/	/	
Country of Residence:				Nationality:				
Height (cm/ft):			Weight (kg/lbs):					
Occupation:	Occupation industry:							
Dependant details	Dependant 1 De			ependant 2	Depe	ndant 4		
First name(s):								
Family name:								
What do they like to be called?								
Gender:	Male □	Female □	Male	☐ Female ☐	Male □	Female □	Male □	Female □
Date of birth (dd/mm/yyyy):	/	/	/	/	/	/	/	/
Country of Residence:								
Nationality:								
Height (cm/ft):								
Weight (kg/lbs):								
Relationship to Insured Person :								
Occupation (ages 16+):								
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 5: Insurance detail			.a					Vos 🗆 No 🗆
5.1 Do You currently have health insurance with another company? Yes ☐ No ☐						res 🔲 No 📙		
If yes, please give details:								
5.2 Do You intend to continue with	the existing in	surance?						Yes □ No □
					Yes □ No □			
If yes, please give dates of when insured and previous policy number:								
yes, prease give dates of when	p	. 11.000 policy III						
5.4 Have You ever had an application for Medical Insurance declined or had special terms imposed? Yes □ No □								
If yes, please give details:								
ii yes, piease give detaits.								

Section 6: 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.

		Insured Person	Dependant (Spouse)	Dependant 1	Dependant 2	Dependant 3	Dependant 4
6.1	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 □
6.2	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 diag	gnosed with, or	been hospitali	sed or had sign	ns or symptom	s of for:	
6.3	Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □
6.4	Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □
6.5	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□
6.6	Cancer, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes□ No□
6.7	Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □
6.8	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 □
6.9	Diabetes, thyroid disorders or weight management problems?	Yes□ No□	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes□ No□
6.10	Epilepsy, multiple sclerosis or other neurological conditions?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □
6.11	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 □
6.12	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 □
6.13	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 □
6.14	Females only Have You ever suffered from any breast or gynaecological disorders?	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □	Yes □ No □

Additional information

If **You** answered 'Yes' to any of questions 6.1 to 6.14, 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 7: Important notes

Data Privacy

We and Your Underwriters collect personal information about You and Your Dependants (including health, bank account and occupation) 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 Now Health group companies administering Your Plan, Underwriters, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside Singapore. The same duty of confidentiality is required of any third parties to whom the administration of Your Plan may be subcontracted, including those based outside Singapore. Your personal details will not be disclosed to other organisations without Your consent.

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

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

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services, which may be of interest to **You**. If **You** wish this to happen please tick this box . **You** may opt out of future marketing by contacting **Us** at any time. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

Section 8: 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, **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 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, rescission of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Singapore) Pte. Ltd. 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 **Group 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 "Your Guide to Health Insurance" Booklet and the Members' Handbook which contains Product Information and Key Product Provisions, details of my rights and **Your** obligations to me:
 - cancellation and termination rights
 - complaints procedures
 - law and jurisdiction of the **Group Plan**
 - language of the Group Plan and Our service
 - compensation arrangements
 - Plans are underwritten by Sompo Insurance Singapore Pte. Ltd. and Now Health International (Singapore) Pte. Ltd. is acting on behalf of Sompo Insurance Singapore Pte. Ltd. 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 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 Group 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 have consent from all my Dependants covered under the Group Plan to administer additions and deletions and review claim payment reports on their behalf.
- 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 **Group 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 Membership of the Group Plan may be terminated with immediate effect.
- I understand that if any persons named in this application are able to claim any costs from another insurance policy for the cost of any treatment or benefits,
 Now Health International 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.

Signature (Insured Person):	Date (dd/mm/yyyy):		
		/	/











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Plan Owners' Protection Scheme

This plan is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your plan is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association of Singapore (GIA)/Life Insurance Association of Singapore (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

Now Health International (Singapore) Pte. Ltd.(No.201317502C) is a general insurance agent of Sompo Insurance Singapore Pte. Ltd. and is registered with the Agents' Registration Board of the General Insurance Association of Singapore (GIA).

Registered at 16 Raffles Quay #33-03 Hong Leong Building Singapore 048581.

Visit www.sompo.com.sg to find out more about Sompo Singapore.