NOW HEALTH INTERNATIONAL

SimpleCare application form: Groups

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 Now Health International Limited, PO Box 482055, Dubai, UAE. **You** can also scan it and email it to MEAQuotes@now-health.com.

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:	
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 the SimpleCare **Benefit Schedule**. Please indicate **Your Group Plan** choice, **Deductible,** and any additional options.

5.1 Choice of Group Plan

Benefit	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Annual Maximum Plan Limit	USD 1,000,000/ EUR 800,000/ GBP 625,000	USD 1,500,000/ EUR 1,200,000/ GBP 937,500	USD 1,500,000/ EUR 1,200,000/ GBP 937,500
Geographical Area Of Cover Default			
Area of Cover: Africa, Indian sub-continent, Jordan, Lebanon and the Philippines (residents of Africa)	○	○	○
Area of Cover: Europe (residents of Europe)	○	○	○
Area of Cover: South East Asia (excluding Singapore) (residents of South East Asia (excluding Indonesia and Singapore))	○	○	○
Area of Cover: Worldwide Excluding USA (residents in the rest of the world)	○	○	○
In-Patient and **Day-Patient** care	▶	▶	▶
Day-Patient or **Out-Patient** surgery	▶	▶	▶
Cancer Treatment	▶	▶	▶
Organ Transplant	▶	▶	▶
Congenital cover	▶	▶	▶
Rehabilitation	▶	▶	▶
Evacuation and **Repatriation**	▶	▶	▶
Out-Patient fees	▶	▶	▶
Dental Treatment	▶	▶	▶
Please Choose	○	○	○
	▶ Full refund	▶ Not covered	▶ Limited cover
Choice of currency	USD ○	EUR ○	GBP ○

5.2 Geographical Area Of Cover Options	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Area of Cover: Africa, Europe, Indian sub-continent, Jordan, Lebanon and the Philippines (residents of Africa)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of Africa)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of Europe)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of South East Asia (excluding Indonesia and Singapore))	○	○	○

5.3 Group Plan Deductible*	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Standard Deductible	USD 500/ EUR 400/GBP 310	USD 500/ EUR 400/GBP 310	USD 500/ EUR 400/GBP 310
Optional Deductible			
Nil	○	○	○
USD 150/EUR 120/GBP 95	○	○	○
USD 250/EUR 200/GBP 155	○	○	○
USD 1,000/EUR 800/GBP 625	○	○	○
USD 2,500/EUR 2,000/GBP 1,550	○	○	○
USD 5,000/EUR 4,000/GBP 3,125	○	○	○
USD 10,000/EUR 8,000/GBP 6,250	○	○	○
USD 15,000/EUR 12,000/GBP 9,375	○	○	○

5.4 Out-Patient options**	SimpleCare CORE	SimpleCare 100	SimpleCare 250
USD 25/EUR 20/GBP 15 **Out-Patient Per Visit Excess**	N/A	○	○
20% **Co-Insurance Out-Patient Treatment**	N/A	○	○

* 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**, **Day-Patient** and **Out-Patient Treatment** is per **Insured Person**, per **Period of Cover**.
USD 10,000/EUR 8,000/GBP 6,250 or USD 15,000/EUR 12,000/GBP 9,375 **Deductible** is only available if **You** are covered by more than one health insurance **Plan**. **You** can only select such **Deductible** options if **You** buy this **Group Plan** as a **Secondary Health Insurance Plan**.

** Please note that **Out-Patient** Options can only be taken if **You** select a **Deductible** option of USD 500/EUR 400/GBP 310 or lower.

5.5 Additional Options	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Removal of Drugs and Dressings Limit (for compulsory **Group Plans** 3+ employees)	N/A	N/A	○
Wellness & Vaccinations - Option 1 # (combined limit up to USD 150/EUR 120/GBP 95) (for compulsory **Group Plans** 3+ employees)	N/A	○	○
Wellness & Vaccinations - Option 2 # (combined limit up to USD 250/EUR 200/GBP 155) (for compulsory **Group Plans** 3+ employees)	N/A	○	○
Maternity - Option 1 (Normal Pregnancy and Childbirth up to USD 5,000/EUR 4,000/GBP 3,125) (for compulsory **Group Plans** 10+ employees)	N/A	○	○
Maternity - Option 2 (Normal Pregnancy and Childbirth up to USD 7,000/EUR 5,600/GBP 4,375) (for compulsory **Group Plans** 10+ employees)	N/A	○	○

Please note Wellness & Vaccinations options can only be taken if **You** select a **Deductible** option of USD500/EUR400/GBP310 or lower.

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	◯	◯	◯	N/A
Bank transfer	◯	◯	◯	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.	AE810211000000100708191	AE690211000000100708213	AE500211000000100708167

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

For GBP & EUR bank account
Correspondent Bank: "Citibank London N.A. SWIFT: CITIGB2L"

Section 7: Medical Insurance Details

7.1 Do **You** currently provide private medical insurance for **Your** group members? Yes ◯ No ◯
If yes, please give details below:

Policy no.: | Date cover expires/expired (dd/mm/yyyy): / /

Name of Insurer:

7.2 Do **You** intend to continue with the existing insurance? Yes ◯ No ◯

7.3 Do **You** intend to buy this **Group Plan** as a **Secondary Health Insurance Plan** for **Your** group members? Yes ◯ No ◯

If **You** buy this **Group Plan** as a **Secondary Health Insurance Plan**, **You** must provide a copy of the **Certificate of Insurance** of **Your Group** members' **Primary Health Insurance** policy. If **You** have more than one health insurance policy, this **Group Plan** will be the health insurance policy that pays last.

Section 8: Underwriting Options

Full Medical Underwriting (FMU) ◯ | Capped Cover (for compulsory **Group Plans** 5 to 19 employees) ◯ | 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 Dependants**) are required to complete a SimpleCare application form for group employees and send it to Now Health International Limited, PO Box 482055, Dubai, UAE.

Capped Cover is the process where the **Underwriters** assess the declared medical details and decide if **We** can offer **Your** members limited cover for a declared pre-existing **Medical Condition** after the **Waiting Period** has been fulfilled. All members (employees and **Eligible Dependants**) are required to complete a SimpleCare application form for group 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.

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: Group Medical Declaration

9.1 Please complete this section if you currently provide or have provided medical insurance previously to your **Group** members. Otherwise, please go to Section 9.2.

Details of any claims over USD 20,000/EUR 16,000/GBP 12,500 for any one **Medical Condition** in the last three years:

9.2 Details of any planned **Treatment** for cancer, heart surgery, **In-Patient** psychiatric conditions, congenital conditions, renal failure or back surgery:

Please note: If a **Medical Condition** is declared, **We** reserve the right to review **Our** terms.

Section 10: Eligibility

Please define the member category:

Name of category e.g. directors, managers, general employees	All members	Number of members
	◯	
	◯	
	◯	
	◯	
	◯	

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 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 to become a member under **Your** employer's **Group Plan** and, if approved, conducting **Our** ongoing relationship with **You**. This information will be processed for the purposes of meeting **Our** legal and regulatory obligations, approving **Your** application and, where approved, administering **Your** membership cover and any claims **You** make under **Your** employer's **Group Plan**.

The information **We** collect about **You** includes details such as **Your** name and address as well as more sensitive details such as information about **Your** health.

The way **Your** cover under the **Group Plan** works means **Your** information may be shared with and used by a number of third parties, including **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators – but only in connection with **Your** membership cover under the **Group Plan**.

Marketing

We would also like to use **Your** contact details in order to keep **You** informed of other products and services **We** think may be of interest to **You**.

We need **Your** consent to use **Your** contact details for this purpose. **You** do not have to give **Your** consent and **You** may withdraw **Your** consent at any time.

Do **You** consent to use of **Your** contact details for the purpose of **Us** contacting **You** by email, phone or post about other products and services **We** think may be of interest to **You**? If **You** consent, please tick this box ◯.

Want more details?

For more information about how **We** use **Your** personal information please see **Our** full privacy notice, a copy of which is available online at www.now-health.com or on request.

*Contacting **Us** and **Your** rights*

You have rights in relation to the information **We** hold about **You**, including the right to access **Your** information. Please contact **Us** at hello@now-health.com if **You** wish to exercise **Your** rights, discuss how **We** use **Your** information or request a copy of **Our** full privacy notice.

Section 12: 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 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**.
- I declare that I have read 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 Limited is acting on behalf of AXA PPP healthcare 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): / /