NOW HEALTH INTERNATIONAL

SimpleCare application form: Individuals and families (FMU)

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 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 MEAQuotes@now-health.com.

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): / /
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 ◯ 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?	
Gender: Male ◯ Female ◯	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 ◯ 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?				
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 **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

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 6: Plan options

For detailed information about the **Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Plan** choice, Geographical **Area of Cover** options, **Deductible,** and any **Out-Patient** options.

6.1 Choice of 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 ○

6.2 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))	○	○	○

6.3 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	○	○	○

6.4 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 **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 policy. **You** can only select such **Deductible** options if **You** buy this **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.

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 semi-annual premiums have a 3% surcharge, quarterly premiums have a 5% surcharge and monthly premiums have a 10% surcharge.

	Annually	Semi-annually	Quarterly	Monthly
Cheque	○	N/A	N/A	N/A
Credit card	○	○	○	○
Bank transfer	○	N/A	N/A	N/A

Cheque: Please make **Your** cheque payable to Now Health International Limited and attach it to this application form.
Credit card: **We** accept Visa, MasterCard and American Express. We will contact you to take the required 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.	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 8: Claim reimbursement

Bank transfer - Please complete all details

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 Do **You** intend to buy this **Plan** as a **Secondary Health Insurance Plan**? Yes ◯ No ◯

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

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

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

9.5 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:

	Planholder	Dependant (Spouse)	Dependant 1	Dependant 2	Dependant 3	Dependant 4
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, major injury or **Medical Condition** not already noted above?	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○	Yes ○ No ○
10.14 Have **You** ever suffered from any breast or gynaecological disorders?	Yes ○ No ○ N/A ○	Yes ○ No ○ N/A ○	Yes ○ No ○ N/A ○	Yes ○ No ○ N/A ○	Yes ○ No ○ N/A ○	Yes ○ No ○ N/A ○

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 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 to become a member under **Your 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 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 **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 **Plan**.

Other people's information You provide to Us

Your membership of **Your Plan** may cover **You** and **Your** family members. Where **You** provide **Us** with information about **Your** family members, such as **Your** spouse, **You** must inform each of them that **You** are giving their personal information to **Us** in connection with **Your** membership cover and that their information will be processed in the manner and for the purposes described in this data protection notice. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so.

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.

Access to Medical Reports Act 1988

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** in connection with **Your** application to become a member under **Your Plan**. If **We** need to do this, this Act gives **You** specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** application.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   (i) **You** have seen the report and approved it; or
   (ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.

Important note: The sooner We receive the report, the sooner We can deal with Your application for membership.

3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with Your application.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s)he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let **you** see all reports about **You** supplied to **Us** within the last six months (if any).

Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your Plan.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care. In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

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 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 Limited is acting on behalf of AXA PPP healthcare 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): / /