

## For company use – intermediary details and stamp

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

If **You** are applying for one of **Our Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer, which means that **We** will not ask for full details about **Your** medical history and cover can continue. For any new **Benefits** the waiting period will apply. Any **Benefits** covered under **Your** previous policy but not covered under **Our Plan** will not be **Eligible** for cover following the transfer. Any endorsements that applied to **Your** existing policy will continue to apply to **Your** new **Plan**.

Please complete this form in BLOCK CAPITALS. **You** should attach a copy of **Your** existing certificate of insurance, detailing any endorsements and the **Start Date** of the existing policy.

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**.

**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**, 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** or 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 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 it and email it to MEAQuotes@now-health.com or fax it to +971 (0) 4450 1520.

## Section 1: Previous Medical Insurance

Policy no.:	Date cover expires/expired (dd/mm/yyyy):	/	/
Name of Insurer:			
Do <b>You</b> intend to continue with the existing insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	

## Section 2: Individuals and families

### 2.1 Name of Planholder

First name(s):	Family name:
What do <b>You</b> 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.)*

### 2.2 Planholder details

Address:	
Email address:	
Preferred telephone number (including country code):	
Is this <b>Your</b> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/>	If <b>You</b> would like SMS notifications, please tell us <b>Your</b> mobile number:



Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy): / /
<b>Country of Residence:</b>	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are <b>You</b> 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)	

### 2.3 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): / /
<b>Country of Residence:</b>	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What does he/she 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"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth (dd/mm/yyyy): / /	/ /	/ /	/ /	/ /
<b>Country of Residence:</b>				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to <b>Planholder</b> :				
Occupation (ages 16+):				

### 2.4 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
2.4.1 Have <b>You</b> in the last five years ever undergone any <b>Surgical Procedure</b> , been a patient or been treated in a <b>Hospital</b> , clinic, sanatorium, nursing home or other medical institution where <b>You</b> were off work for more than one week, and/or received more than 10 days <b>Treatment</b> ?	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"/>
2.4.2 Have <b>You</b> ever been diagnosed with, hospitalised for, received <b>Treatment</b> , tests or investigations for any type of disease, physical impairment, congenital or had signs or symptoms of or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or <b>Medical Condition</b> ?	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"/>
2.4.3 Are <b>You</b> currently taking any kind of medication (other than oral contraceptives), or is any <b>Treatment</b> or tests currently being performed or planned, or any day or <b>In-Patient</b> 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"/>



## Additional information

If **You** answered 'Yes' to any of questions 2.4.1 to 2.4.3, 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)



## 2.5 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:	

## 2.6 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 3: Start Date

The date the **Plan** will start from (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 4: 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 5: 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:** Visa, MasterCard and American Express can be accepted. **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 or 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.	AE500211000000100708264	AE280211000000100708272	AE940211000000100708248
For USD bank account	Correspondent Bank: "Citibank N.A., New York, USA. SWIFT: CITIUS33"		Code: INS
For GBP & EUR bank account	Correspondent Bank: "Citibank London N.A. SWIFT: CITIGB2L"		Description: Insurance Services
		For transfer to banks in the UAE:	

## Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to the 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 disorders	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental Treatment	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
<b>Please choose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ Full refund   
 ▶ Not covered   
 ▶ Limited cover

Choice of currency	USD <input type="checkbox"/>	EUR <input type="checkbox"/>	GBP <input type="checkbox"/>
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## 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 <b>Deductible</b>	Nil	Nil	Nil	Nil
Optional <b>Deductible</b>				
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"/>
<b>Out-Patient Per Visit Excess</b> 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 <b>Treatment</b> – Area 1 rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10% <b>Co-Insurance</b> on <b>Out-Patient Treatment</b>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% <b>Co-Insurance</b> on <b>Out-Patient Treatment</b>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Out-Patient Charges</b>	<input type="checkbox"/>	N/A	N/A	N/A
<b>Out-Patient Charges</b> – 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 <b>Evacuation</b> and <b>Repatriation</b> Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical <b>Benefits</b> and <b>Vaccinations</b>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical <b>Benefits</b> and <b>Vaccinations</b> – 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: 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 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 **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**.
- 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):

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.

