WorldCare continuous transfer form: Individuals and families

For company use – intermediary details and stamp

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

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.

If **You** have used an authorised insurance broker **You** understand, acknowledge and agree that by buying this **Plan**, **We** will pay the authorised insurance broker commission during the life of the **Plan** including renewals. **You** also understand that this agreement is necessary for **Us** to proceed with **Your** application.

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 (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.

Section 1: Previous Medical Insurance

Policy no.:	Date cover expires/expired (dd/mm/yyyy): / /
Name of Insurer:	
Do **You** intend to continue with the existing insurance?	Yes ☐ No ☐

Section 2: Individuals and families

2.1 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.)*

2.2 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? (If yes please provide further details)			Yes ☐	No ☐

2.3 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:	

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 ☐ 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+):				

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 **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 ☐
2.4.2 Have **You** ever been diagnosed with, hospitalised for, received **Treatment**, 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, major injury or **Medical Condition**?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2.4.3 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 ☐

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 Doctors 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
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 (Singapore) Pte. Ltd. and attach it to this application form.

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 name in the transfer details and send it to the bank account below. For a USD/SGD policy, premium needs to be paid to the respective bank accounts only.

	USD account	SGD account
Bank	Citibank N.A. Singapore Branch	Citibank N.A. Singapore Branch
Bank code	N/A	7214
Branch code	N/A	001
Bank account name	Now Health International (Singapore) Pte. Ltd	Now Health International (Singapore) Pte. Ltd
Address	8 Marina View 21-01 Asia Square Tower 1 Singapore 018960	8 Marina View 21-01 Asia Square Tower 1 Singapore 018960
Account no.	0857607104	0857607074
Swift code	CITISGSG	CITISGSG

Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to the 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/SGD 3.9m	USD 3.5m/SGD 4.55m	USD 4m/SGD 5.2m	USD 4.5m/SGD 5.85m
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	▶	▶	▶	▶
Please choose	☐	☐	☐	☐

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency	USD ☐	SGD ☐

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 **Deductible**	Nil	Nil	Nil	Nil
Optional **Deductible**				
USD 1,000/SGD 1,300	☐	☐	☐	☐
USD 2,500/SGD 3,250	☐	☐	☐	☐
USD 5,000/SGD 6,500	☐	☐	☐	☐
USD 10,000/SGD 13,000	☐	☐	☐	☐
USD 15,000/SGD 19,500	☐	☐	☐	☐
Out-Patient Per Visit Excess Option				
USD 25/SGD 30	N/A	☐	☐	☐
USD 15/SGD 20	N/A	☐	☐	☐

Additional options	Essential	Advance	Excel	Apex
USA elective **Treatment** – Area 1 rates	☐	☐	☐	☐
10% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	☐
Hospital room restriction in Singapore and Hong Kong	☐	☐	☐	☐
Out-Patient Charges	☐	N/A	N/A	N/A
Out-Patient Charges – Option 2	☐	N/A	N/A	N/A
Extended **Evacuation** and **Repatriation** Option	☐	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations**	N/A	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations** – Option 2	N/A	☐	☐	☐

* 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

Buying health insurance products that are not suitable for **You** may impact **Your** ability to finance **Your** future healthcare needs. **You** should seek advice from **Us** or a qualified adviser if in doubt before **You** sign this application form. Should **You** choose not to, **You** are taking sole responsibility to ensure that this product is appropriate to **Your** financial needs and insurance objectives.

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.

This **Plan** is not a Medisave-approved **Plan** and **You** may not use Medisave **Plan** to pay the premium for this **Plan**.

If **You** are a citizen or permanent resident of Singapore, **You** are covered by MediShield Life for life, for **Treatments** in Singapore, regardless of pre-existing medical conditions or other circumstances that **You** face. For more details on **Your** coverage, please visit www.medishieldlife.sg.

This is a short-term accident and health **Plan** and **We** are not required to renew this **Plan**. **We** may terminate this **Plan** at renewal by giving You 30 days notice in writing.

The premiums quoted have been based on Your Body Mass Index being within normal limits.

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 **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, 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**.
- 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 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 **Plan**
  - language of the **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 **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 have consent from all my dependants covered under the **Plan** to administer additions and deletions and review claim payment reports on their behalf.
- I acknowledge that if it is determined by Now Health International that a claim was fraudulent my **Plan** may be terminated 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 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):
	/ /

Signature & Name of Adviser:	**Date** (dd/mm/yyyy):
/	/ /

Now Health International (Europe) Limited can arrange annual international private medical insurance products through Now Health International (Singapore) Pte. Ltd and will collect payment by credit card for onward settlement to them. Now Health International (Europe) Limited is authorised and regulated by the Financial Conduct Authority (FCA). **Our** FCA registered number is 7121668. This information can be checked at the FCA website at: http://www.fsa.gov.uk/register/home.do

Now Health International (Europe) Limited can offer the products of a single but distinct insurer in each region in which **We** have group companies. **You** will not receive advice or a recommendation from **Us** on the policies **We** offer. **We** may ask questions to narrow down the selection of products that **We** will provide details on. **You** will then need to make your own choice about how to proceed.

We will not charge **You** a fee without first disclosing and agreeing this with **You** in advance. **You** will receive a quotation in advance of purchasing a product. If **You** wish to register a complaint, please contact:

The Managing Director
Now Health International (Europe) Limited
Suite G3/4, Building Three
Watchmoor Park
Camberley
Surrey, GU15 3YL, United Kingdom
Tel: +44(0) 1276 602110
Fax: +44(0) 1276 602130
Email: EuropeService@now-health.com

If **You** cannot settle your complaint with **Us**, **You** may be entitled to refer it to the Financial Ombudsman Service who can be contacted at:

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
Telephone: 0845 080 1800
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

We are covered by the FSCS. **You** may be entitled to compensation from the scheme if **We** cannot meet **Our** obligations. This depends on the type of business and the circumstances of the claim. Insurance advising and arranging is covered for 90% of the claim, without any upper limit.

Where **We** act on your behalf **We** shall hold premiums due to insurers, any claims payments and/or premium refunds due to **You** as client money ("Client Money"). During the provision of the Services to **You**, **We** will deposit all payments received in respect of Client Money in a statutory trust bank account that complies with FCA Rules ("Trust Account"). These regulations seek to protect clients against any inability of an insurance broker to transfer premiums to an insurer or to transfer claims payments and/or premium refunds to the client.

Where **We** act on insurers' behalf **We** shall hold money as insurer money ("Insurer Money"). Premiums received by **Us** will be treated as having been received by insurers whereas claims payments and/or premium refunds will only be treated as having been received by **You** when they are actually paid to **You**. In the normal course of business and within the standard terms of **Our** Trust Account(s) arrangements, **We** may place part of the Trust Monies into money market funds. **We** shall retain sole rights to all interest and earnings received on Trust Monies rather than pay them to **You**. Under the terms of the Trust Account(s) **We** are responsible for meeting any trust fund shortfalls arising from this.

We will pay premiums directly to insurers and receive premium refunds and/or claim payments directly from insurers or their representatives except where **We** have engaged the services of another intermediary or settlement agent in which case settlements may then be transferred between **Us** and the other intermediary or settlement agent. Should such an intermediary or settlement agent be located outside of the United Kingdom, payments will be made to and from their jurisdiction and will be subject to a legal and regulatory regime different from that of the United Kingdom**.** In the event of a failure of the intermediary or settlement agent, the Client Money may be treated differently from the Treatment which would have applied if it were held by an intermediary in the United Kingdom. **You** may notify **Us** if **You** do not wish your money to be passed to a person in a particular jurisdiction and **We** will consider making a payment to an alternative jurisdiction.

We may deposit Client Money in a client bank account outside the United Kingdom, unless **You** notify Us that **You** do not wish your money to be held in a particular jurisdiction. In such circumstances, the legal and regulatory regime applying to the approved bank will be different from that of the United Kingdom and, in the event of a failure of the bank, your money may be treated in a different manner from that which would apply if the money were held by a bank in the United Kingdom.

We believe the above arrangements provide **You** with significant and effective protection for Client Money. **Your** agreement to all aspects of these arrangements will be assumed unless an objection is registered with **Us** prior to your first remittance being received by **Us**.

This plan is not a Medisave-approved plan and you may not use Medisave plan to pay the premium for this plan. If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.

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.