NOW HEALTH INTERNATIONAL

SimpleCare application form: Add a dependant

For company use – intermediary details and stamp

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

A **Dependant** is one spouse or adult partner and/or unmarried children who are no more than 18 years old and residing with **You**, or up to 28 years old if in full-time education (written proof may be required from the educational institute where they are enrolled), at the **Start Date** or any subsequent **Renewal Date**. The term partner shall mean husband, wife, civil partner or the person permanently living with **You** in a similar relationship. All **Dependants** must be named as **Insured Persons** in the **Certificate of Insurance**.

To add a **Dependant** to **Your Plan**, 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 claims 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.

Please enclose any relevant 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. **We** will treat all the information **You** provide in strict confidence.

We rely on the information that **You** provide in this form (i.e. misrepresentation) 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 the state of health of any of **Your Dependants**, **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 **Us 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. **You** can scan and email it to apintermediarysales@now-health.com.

Section 1: Planholder information

Planholder name:	**Plan** number:

Section 2: Add Dependant details

First name(s):	Family name:
What does he/she like to be called?	

*(If their full name is John Andrew Smith, they might like to be called John or Mr Smith or Andy. **We** will address all correspondence to them in this way.)*

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)	
Relationship to **Planholder**:	

Section 3: Entry date

Date **You** wish **Your Dependant's** cover 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 4: 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. The additional premium for this **Dependant** should be paid in the same method as **Your Plan**. Details of how to pay are listed below.

Credit card: **We** accept Visa, MasterCard and American Express. **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:

	USD account
Bank	Citibank N.A.
Bank account name	Now Health International Limited
Address	Oud Metha Road, Al Wasl Branch, Dubai, UAE
Account no.	100708264
Sort code	N/A
Swift code	CITIAEAD
IBAN no.	AE500211000000100708264

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

Section 5: Insurance details

5.1 Does **Your Dependant** currently have health insurance with another company? Yes ◯ No ◯

If yes, please give details:

5.2 Does **Your Dependant** intend to continue with the existing insurance? Yes ◯ No ◯

5.3 Do **You** buy this **Plan** as a **Secondary Health Insurance Plan** for **Your Dependant**? 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 Dependant's Primary Health Insurance** policy. If **Your Dependant** has more than one health insurance policy, this **Plan** will be the health insurance policy that pays last.

5.4 Has **Your Dependant** been insured previously with Now Health International? Yes ◯ No ◯

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

5.5 Has **Your Dependant** ever had an application for Medical Insurance declined or had special terms imposed? Yes ◯ No ◯

If yes, please give details:

Section 6: Health declaration

Your Dependant does not need to disclose matters related to common colds, **Vaccinations** or hayfever.

		Dependant
6.1	Has **Your Dependant** 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 they were off work for more than one week, and/or received more than 10 days' **Treatment**?	Yes ◯ No ◯
6.2	Is **Your Dependant** 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 ◯

Has **Your Dependant** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised or had signs or symptoms of for:

6.3	Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes ◯ No ◯
6.4	Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes ◯ No ◯
6.5	Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Has **Your Dependant** ever been tested positive for HIV, Hepatitis B or C?	Yes ◯ No ◯
6.6	**Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes ◯ No ◯
6.7	Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes ◯ No ◯
6.8	Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes ◯ No ◯
6.9	Diabetes, thyroid disorders or weight management problems?	Yes ◯ No ◯
6.10	Epilepsy, multiple sclerosis or other neurological conditions?	Yes ◯ No ◯
6.11	High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes ◯ No ◯
6.12	Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes ◯ No ◯
6.13	Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, major injury or **Medical Condition** not already noted above?	Yes ◯ No ◯
6.14	Females only Has **Your Dependant** ever suffered from any breast or gynaecological disorders?	Yes ◯ No ◯

Additional information

If **Your Dependant** answered 'Yes' to any of questions 6.1 to 6.14, please provide details in the box below.
Please provide as much detail as possible, including the date and nature of diagnosis, frequency and severity of symptoms, date of last episode as well as details of any past, current or known future **Treatment**.

Member name	**Diagnosis** (If none made please describe the exact nature of symptoms suffered)	**Date of consultation**	**Treatment received**	**Date of last treatment/ symptoms**	**Any underlying cause**	**Specific location on body including left or right**	**Outcome** (e.g. on-going complete recovery, likely to recur) or for smears, frequency (annually, 6-monthly)

Section 7: Doctor's contact details

Please give details of **Your Dependant's** current usual doctor or the one who is most familiar with **Your Dependant's** medical history.

Medical Practitioner's details	
Name:	Telephone number:
Address:	
Date of last attendance and reason:	

Section 8: 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 Dependant's 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, including those located outside the European Economic Area. 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 the European Economic Area. **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 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 this to happen please tick this box ◯.

Access to Medical Reports Act 1988

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 9: 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
  - 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/main applicant):	**Date** (dd/mm/yyyy): / /

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