NOW HEALTH INTERNATIONAL

Change of contact information form

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 and send it 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 GlobalService@now-health.com or fax it to +971 (0) 4450 1530.

Section 1: Planholder's details

First name(s):	Family name:
Membership number:	

Section 2: What would You like to change?

Family name ☐ Address ☐ Email address ☐

Family name

Old name:	New name:
Date the change to take effect from (dd/mm/yyyy): / /	

*Please note that **We** need a copy of the official document e.g. marriage certificate to update **Our** records*

Address

Old address:

New address:

Date the change to take effect from (dd/mm/yyyy): / /

Email address

Old email address:	New email address:
Date the change to take effect from (dd/mm/yyyy): / /	

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.

By signing this 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.

Signature (Insured/main applicant): **Date** (dd/mm/yyyy): / /

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