

## 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](http://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. **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 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 **Us** **Your** completed application form, either via **Your** intermediary or direct to Now Health International (Europe) Limited, Suite G3/4, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom. **You** can also scan and email it to [EuropeService@now-health.com](mailto:EuropeService@now-health.com) or fax it to +44 (0) 1276 602130.

## Section 1: Planholder information

Planholder name:	Plan number:
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## Section 2: Add Dependant details

First name(s):	Family name:
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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 <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Relationship to Planholder:	



## Section 6: Health declaration

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

		Dependant
6.1	Has <b>Your Dependant</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 they 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"/>
6.2	Is <b>Your Dependant</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"/>

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

## Additional information

If **Your Dependant** answered 'Yes' to any of questions 6.1 to 6.14, please provide details in the box below.

**Question number**

Please provide as much detail a 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**.

## Section 7: 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 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.

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 (Europe) 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 and understood 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 (Europe) Limited is acting on behalf of AXA PPP healthcare Limited for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- If I have indicated that I wish to pay by credit card, I authorise Now Health International to debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by Now Health International until I give written notice that I wish to terminate this Agreement.
- 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 (Europe) 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):

/ /

Now Health International (Europe) Limited is authorised and regulated by the Financial Conduct Authority.

Now Health International (Europe) Limited, Registered Office: Suite G3/4, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom, Registered in England No. 7121668.