

For company use – intermediary details and stamp

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

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 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**.

Please keep a record of all information **You** supply to **Us** in connection with this application.

Please enclose any 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. All the information **You** provide will be treated 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 **Your** state of health or the state of health of any of **Your Dependants**, **You** must tell **Us** in writing about the change.

Please send **Your** completed application form 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 MEQuotes@now-health.com or fax it to +971 (0) 4450 1520.

Section 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.)*

Section 2: Planholder details

Address:	
Email address:	
Preferred telephone number <i>(including country code)</i> :	
Is this Your	Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/>
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>
	<i>If You would like SMS notifications, please tell us Your mobile number:</i>
	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:



Section 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): / /
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 do they 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"/>
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Country of Residence:				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to Planholder:				
Occupation (ages 16+):				

Section 4: Start Date

Date on which **You** wish **Your** Now Health International **Plan** 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 5: 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 6: Plan options

For detailed information about the **Plan** choices available, please refer to 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 cover	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental Treatment	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
Please choose	<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 Deductible	Nil	Nil	Nil	Nil
Optional Deductible				
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"/>
Out-Patient Per Visit Excess Option				
USD 25/EUR 20/GBP 15 – 12.5% discount	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 15/EUR 12/GBP 10 – 4.5% discount	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional options

	Essential	Advance	Excel	Apex
USA elective Treatment – Area 1 rates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10% Co-Insurance on Out-Patient Treatment – 6% Discount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% Co-Insurance on Out-Patient Treatment – 12% discount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-Patient Charges – 24% loading	<input type="checkbox"/>	N/A	N/A	N/A
Out-Patient Charges – Option 2 – 50% loading	<input type="checkbox"/>	N/A	N/A	N/A
Africa Area of Coverage restriction – 20% discount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation and Repatriation Option – Additional charge of USD100/EUR 80/GBP60 per Insured Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations – 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: 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. Please note that quarterly premiums have a 3% surcharge and monthly premiums have a 5% surcharge.

	Annually	Semi-annually	Quarterly	Monthly
Cheque	<input type="checkbox"/>	N/A	N/A	N/A
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

Cheque: Please make **Your** cheque payable to Now Health International Limited and attach it to this application form.

Credit card: **We** accept Visa, MasterCard and American Express. We will contact you to take the required 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	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.	AE810211000000100708191	AE690211000000100708213	AE500211000000100708167

Section 8: Claim reimbursement method

Please indicate how **You** would like to receive claim reimbursement payments. Bank transfer is the most secure and quickest method.

Cheque 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 9: Insurance details

9.1 Do **You** currently have health insurance with another company? Yes No

If yes, please give details:

9.2 Do **You** intend to continue with the existing insurance? Yes No

9.3 Have **You** been insured previously with Now Health International? Yes No

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

9.4 Have **You** ever had an application for Medical Insurance declined or had special terms imposed? Yes No

If yes, please give details:

Section 10: 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
10.1 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 <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"/>
10.2 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 <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"/>

Have **You** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised or had signs or symptoms of for:

10.3 Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	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"/>
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	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"/>
10.5 Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Have You ever been tested positive for HIV, Hepatitis B or C?	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"/>
10.6 Cancer , cyst, polyp, or any abnormal growth whether cancerous or benign?	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"/>
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	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"/>
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	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"/>
10.9 Diabetes, thyroid disorders or weight management problems?	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"/>
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	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"/>
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	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"/>
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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"/>
10.13 Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, major injury or Medical Condition not already noted above?	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"/>
10.14 Females only Have You ever suffered from any breast or gynaecological disorders?	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 10.1 to 10.14, please provide details in the box below.

Name	Question number	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 .

Section 11: 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 12: 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, 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 **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 .

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 13: 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 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 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 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):

/ /





UAE

Royal & Sun Alliance Insurance Middle East B.S.C. (c)
c/o Now Health International Gulf Third Party Administrators LLC
PO Box 502163, Al Shaiba Building, Dubai Outsource City, Dubai, UAE
T +971 (0) 4450 1415 | F +971 (0) 4450 1416
MEAQuotes@worldcare.ae

Now Health International

Rest of the World

Now Health International Limited
PO Box 482055, Dubai, UAE
T +971 (0) 4450 1500 | F +971 (0) 4450 1520
MEAQuotes@now-health.com

Europe

Now Health International (Europe) Limited
Suite G3/4, Building Three
Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom
T +44 (0) 1276 602100 | F +44 (0) 1276 602120
EuropeQuotes@now-health.com

Asia Pacific

Now Health International (Asia Pacific) Limited
Units 1501-3 & 9, 15/F, AIA Tower, 183 Electric Road
North Point, Hong Kong
T +852 2279 7300 | F +852 2279 7320
AsiaPacSales@now-health.com

China

Asia-Pacific Property & Casualty Insurance Co., Ltd.
c/o Now Health International (Shanghai) Limited
Room 1103-1105, 11/F, BM Tower
No. 218 Wusong Road
Hongkou District, Shanghai 200080, China
T +(86) 400 077 7500 / +86 21 6156 0910 | F +(86) 400 077 7900
ChinaSales@now-health.com

Singapore

Now Health International (Singapore) Pte. Ltd.
4 Robinson Road
#07-01A/02 The House of Eden
Singapore 048543
T +65 6880 230 | F +65 6220 6950
SingaporeSales@now-health.com

Indonesia

PT Now Health International Indonesia
17/F, Indonesia Stock Exchange, Tower II
Jl. Jend. Sudirman Kav. 52 – 53
Jakarta 12190, Indonesia
Toll-free 0800 1 889900/ Toll +62 21 2783 6910 | F +62 21 515 7639
IndonesiaSales@now-health.com



Plans issued by Now Health International Limited, which is regulated by the DFSA, are underwritten by AXA PPP healthcare Limited which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority.

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

Toll-free 0800 1 889900/ Toll +62 21 2783 6910 | F +62 21 515 7639
IndonesiaSales@now-health.com

