NOW HEALTH INTERNATIONAL

WorldCare continuous transfer form: Group Employees

For company use – intermediary details and stamp

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

If **You** are applying for one of **Our Group 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** employees' 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 Group 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 **Group 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** membership. Where **You** make a careless misrepresentation **We** may void **Your Group 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 Group 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/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** or employees, **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 **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 (UK) Limited, Suite 2.3, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom. **You** can also scan it and email it to UKSales@now-health.com or fax it to +44 (0) 1276 602120.

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: Group members

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

Company name:	
Group Plan number:	
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, 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 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 3: Important notes

Data protection

We and the **Underwriters** will collect certain information about **You** in the course of considering **You**r application to become a member under **Your** employer's **Group Plan** and, if approved, conducting **Our** ongoing relationship with **You**. This information will be processed for the purposes of meeting **Our** legal and regulatory obligations, approving **Your** application and, where approved, administering **Your** membership cover and any claims **You** make under **Your** employer's **Group Plan**.

The information **We** collect about **You** includes details such as **Your** name and address as well as more sensitive details such as information about **Your** health.

The way **Your** cover under the **Group Plan** works means **Your** information may be shared with and used by a number of third parties, including **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators – but only in connection with **Your** membership cover under the **Group Plan**.

Other people's information You provide to Us

Your membership of **Your** employer's **Group Plan** may cover **You** and **Your** family members. Where **You** provide **Us** with information about **Your** family members, such as **Your** spouse, **You** must inform each of them that **You** are giving their personal information to **Us** in connection with **Your** membership cover and that their information will be processed in the manner and for the purposes described in this data protection notice. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so.

Marketing

We would also like to use **Your** contact details in order to keep **You** informed of other products and services We think may be of interest to **You**.

We need **Your** consent to use **Your** contact details for this purpose. **You** do not have to give **Your** consent and **You** may withdraw **Your** consent at any time.

Do **You** consent to use of **Your** contact details for the purpose of **Us** contacting **You** by email, phone or post about other products and services **We** think may be of interest to **You**? If **You** consent, please tick this box ☐.

Want more details?

For more information about how **We** use **Your** personal information please see **Our** full privacy notice, a copy of which is available online at www.now-health.com or on request.

Contacting Us and Your rights

You have rights in relation to the information **We** hold about You, including the right to access **Your** information. Please contact Us at hello@now-health.com if **You** wish to exercise **Your** rights, discuss how **We** use **Your** information or request a copy of **Our** full privacy notice.

Access to Medical Reports Act 1988

It may be necessary to obtain a medical report from Your usual Doctor/**Medical Practitioner** in connection with **Your** application to become a member under **Your** employer's G**roup Plan**. If **We** need to do this, this Act gives **You** specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do We may be unable to deal with **Your** application.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **Your** consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   (i) **You** have seen the report and approved it; or
   (ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.

Important note: The sooner We receive the report, the sooner We can deal with Your application for membership.

3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with **Your** application.
4. **You** may ask the Doctor to change the report if **You** disagree with it. If (s)he refuses, **You** can require him/her to attach a statement of **Your** views to the report.
5. **You** may also ask the Doctor to let **You** see all reports about **You** supplied to **Us** within the last six months (if any).

Important note: Your Doctor is entitled to charge You for supplying You with a copy of the report (to cover cost). This is not covered by Your employer's Group Plan.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care. In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

Sanctions Limitation and Exclusion

We will not provide cover nor pay claims under this **Plan** if **Our** obligations (or the obligations of **Our** group companies & administrators) under the laws of any relevant jurisdiction including UAE, UK, European Union, the United States of America, United Nations resolutions, trade or economic sanctions or international laws sanctions, prevents or restricts **Us** from doing so.

We will not provide You with any services or benefits including but not limited to acceptance of premium payments, claim payments and other reimbursements if in doing so, **We** violate applicable law, regulation, code or court order or are or will be otherwise sanctioned, prevented or restricted.

We may terminate Your Plan if **We** consider **You** or **Your** directors or officers as sanctioned persons, or **You** conduct an activity which is sanctioned, according to trade or economic laws & regulations.

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 4: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a Now Health International **Group Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Group Plan**. I understand that the Application Form, Group Agreement, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Group Plan** terms and conditions make up the contract between **Us** and all form part of the **Group 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 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 (UK) 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**.
- I declare that I have read and understood the following from the members' handbook and Group Agreement:
  - cancellation and termination rights
  - complaints procedures and referral rights to the financial ombudsman service
  - law and jurisdiction of the **Group Plan**
  - language of the **Group Plan** and **Our** service
  - compensation arrangements
  - Now Health International (UK) Limited is acting on behalf of Starr International (Europe) Limited for the purposes of issuing and administering **Group Plans**, receiving premiums and paying claims.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Group 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 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 (UK) 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 **Group Plan**.

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

/ /