NOW HEALTH INTERNATIONAL

Authorisation for Release of Medical Information Form

Please complete and sign the following authority for the release of **Your** medical information. **We** ask **You** also to refer to section 3.6 of **Your** members' handbook which outlines the additional information **You** may be asked to provide in the event of a claim. Please note that if **You** do not allow **Us** reasonable access to this information, **We** may not be able to process **Your** claim.

Member Details

Member name:	
Membership number:	Date of birth (dd/mm/yyyy): / /

Medical facility details

Medical facility/treating **Medical Practitioner**:	
Email:	
Telephone number:	Fax:

Medical details

I/the member named above authorise the above medical facility/treating **Medical Practitioner** to release the following medical records and confidential information to Now Health International (UK) Limited or to its authorised representative:

- ☐ Complete record
- ☐ Records of care from (dd/mm/yyyy) / / to (dd/mm/yyyy) / / only
- ☐ Records of care concerning the following **Medical Condition(s)**:
- ☐ Other. Please specify:
- ☐ Authorisation to confer with above named treating **Medical Practitioner** orally about information in my medical record

Important notes

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.

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.

Authorisation

I understand that I may have access to the medical information requested and may equally decline its release (preventing the assessment of my claim) and hereby consent to Now Health International (UK) Limited or to its authorised representative obtaining medical information from the above medical facility/treating **Medical Practitioner**.

A photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

Signature of member/authorised representative: (parent/legal guardian/next of kin)	Date (dd/mm/yyyy): / /

Note: Now Health International (UK) Limited **will not pay for the release of any medical reports/records**.

Return this form by email to ClinicalService@now-health.com