NOW HEALTH INTERNATIONAL

# SimpleCare application form: Individuals and families (FMU)

## 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 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.

**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 Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta. **You** can also scan and email it to EuropeSales@now-health.com.

## 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 *(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? Yes ◯ No ◯
(If yes please provide further details)

## Section 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: |

Are **You** or any intended member of this policy, or any family member or close associate a politically exposed person? Yes ◯ No ◯
(If yes please provide further details)

| **Dependant details** | **Dependant 1** | **Dependant 2** | **Dependant 3** | **Dependant 4** |
|---|---|---|---|---|
| First name(s): | | | | |
| Family name: | | | | |
| What do they 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+): | | | | |

## 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

**You** can use **Your** secure online portfolio to view and download **Your Plan** documents, including **Your Certificate of Insurance**

**You** can use **Your** secure online portfolio to download **Your** virtual membership card.

Add **Your** membership card to **Your** smartphone wallet

## Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Plan** choice, Geographical **Area of Cover** options, **Deductible,** and any **Out-Patient** options.

### 6.1 Choice of Plan

| Benefit | SimpleCare CORE | SimpleCare 100 | SimpleCare 250 |
|---|---|---|---|
| **Annual Maximum Plan Limit** | USD 1,000,000/ EUR 800,000/ GBP 625,000 | USD 1,500,000/ EUR 1,200,000/ GBP 937,500 | USD 1,500,000/ EUR 1,200,000/ GBP 937,500 |
| **Geographical Area of Cover Default** | | | |
| **Area of Cover: Europe** | | | |
| **In-Patient** and **Day-Patient** care | ▶ | ▶ | ▶ |
| **Day-Patient** or **Out-Patient** surgery | ▶ | ▶ | ▶ |
| **Cancer Treatment** | ▶ | ▶ | ▶ |
| **Organ Transplant** | ▶ | ▶ | ▶ |
| **Congenital cover** | ▶ | ▶ | ▶ |
| **Rehabilitation** | ▶ | ▶ | ▶ |
| **Evacuation** and **Repatriation** | ▶ | ▶ | ▶ |
| **Out-Patient** fees | ▶ | ▶ | ▶ |
| **Dental Treatment** | ▶ | ▶ | ▶ |
| **Please Choose** | ○ | ○ | ○ |
| | ▶ Full refund | ▶ Not covered | ▶ Limited cover |
| Choice of currency | USD ○ | EUR ○ | GBP ○ |

| 6.2 Geographical Area of Cover Option | SimpleCare CORE | SimpleCare 100 | SimpleCare 250 |
|---|---|---|---|
| **Area of Cover: Worldwide Excluding USA** | ○ | ○ | ○ |

| 6.3 Plan Deductible* | SimpleCare CORE | SimpleCare 100 | SimpleCare 250 |
|---|---|---|---|
| **Standard Deductible** | USD 500/ EUR 400/GBP 310 | USD 500/ EUR 400/GBP 310 | USD 500/ EUR 400/GBP 310 |
| **Optional Deductible** | | | |
| Nil | ○ | ○ | ○ |
| USD 150/EUR 120/GBP 95 | ○ | ○ | ○ |
| USD 250/EUR 200/GBP 155 | ○ | ○ | ○ |
| USD 1,000/EUR 800/GBP 625 | ○ | ○ | ○ |
| USD 2,500/EUR 2,000/GBP 1,550 | ○ | ○ | ○ |
| USD 5,000/EUR 4,000/GBP 3,125 | ○ | ○ | ○ |
| USD 10,000/EUR 8,000/GBP 6,250 | ○ | ○ | ○ |
| USD 15,000/EUR 12,000/GBP 9,375 | ○ | ○ | ○ |

| 6.4 Out-Patient options** | SimpleCare CORE | SimpleCare 100 | SimpleCare 250 |
|---|---|---|---|
| USD 25/EUR 20/GBP 15 **Out-Patient Per Visit Excess** | N/A | ○ | ○ |
| 20% **Co-Insurance Out-Patient Treatment** | N/A | ○ | ○ |

* 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**, **Day-Patient** and **Out-Patient Treatment** is per **Insured Person**, per **Period of Cover**.
USD 10,000/EUR 8,000/GBP 6,250 or USD 15,000/EUR 12,000/GBP 9,375 **Deductible** is only available if **You** are covered by more than one health insurance policy. **You** can only select such **Deductible** options if **You** buy this **Plan** as a **Secondary Health Insurance Plan**.

** Please note that **Out-Patient** Options can only be taken if **You** select a **Deductible** option of USD 500/EUR 400/GBP 310 or lower.

## 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 |
|---|---|---|---|---|
| Credit card | ◯ | ◯ | ◯ | ◯ |
| Bank transfer | ◯ | N/A | N/A | N/A |
| Apple Pay/Google Pay | ◯ | N/A | N/A | N/A |

**Credit card**: **We** accept Visa, MasterCard, and American Express, please pay via the payment link which **Our** Customer Service Team will send to **Your** email address. If **You** have not received this payment link, please call **Our** team on +356 2260 5110. **Your** card issuer may charge an additional conversion or transaction fee to process this payment.

**Bank transfer**: Please use the relevant bank details for the currency of **Your Plan**. Please quote **Your Plan** number in the transfer details as a reference.

**Apple Pay/Google Pay**: **We** accept Apple Pay or Google Pay for annual premium payment.

| Bank transfer | USD account | EUR account | GBP account |
|---|---|---|---|
| Bank | Citibank | Citibank | Citibank |
| Bank account name | Now Health International Services (Europe) Limited | Now Health International Services (Europe) Limited | Now Health International Services (Europe) Limited |
| Address | Citibank, 1 North Wall Quay, Dublin 1, Ireland | Citibank, 1 North Wall Quay, Dublin 1, Ireland | Citibank, 1 North Wall Quay, Dublin 1, Ireland |
| Account no. | 33494416 | 33494343 | 33494386 |
| Sort code | 990051 | 990051 | 990051 |
| Swift code | CITIIE2X | CITIIE2X | CITIIE2X |
| IBAN no. | IE46CITI99005133494416 | IE77CITI99005133494343 | IE80CITI99005133494386 |

## Section 8: Claim reimbursement

**Bank transfer** - Please complete all details

| | | |
|---|---|---|
| Account/payee name: | Payment currency: | |
| Name of bank: | Bank code: | Branch code: |
| Branch address & country: | | |
| Bank account currency: | IBAN no: | |
| Account no: | Routing code: | |
| Local banking code: | Swift code: | |
| Any other relevant information: | | |

## 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 Do **You** intend to buy this **Plan** as a **Secondary Health Insurance Plan**? Yes ◯ No ◯

If **You** buy this **Plan** as a **Secondary Health Insurance Plan**, **You** must provide a copy of the **Certificate of Insurance** of **Your Primary Health Insurance** policy. If **You** have more than one health insurance policy, this **Plan** will be the health insurance policy that pays last.

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

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

9.5 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 ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 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 ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |

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 ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 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 ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.6 **Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.9 Diabetes, thyroid disorders or weight management problems? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.10 Epilepsy, multiple sclerosis or other neurological conditions? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle? | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 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 ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ | Yes ◯ No ◯ |
| 10.14 Have **You** ever suffered from any breast or gynaecological disorders? | Yes ◯ No ◯ N/A ◯ | Yes ◯ No ◯ N/A ◯ | Yes ◯ No ◯ N/A ◯ | Yes ◯ No ◯ N/A ◯ | Yes ◯ No ◯ N/A ◯ | Yes ◯ No ◯ N/A ◯ |

## Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.14, 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 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) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## 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 Dependant's Body Mass Index being within normal limits.**

### Data protection

Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

**We** and the **Underwriters** will deal with all personal information supplied in the strictest confidence as required by the Data Protection Act. **We** and **Your Underwriters** collect personal information about **You** and **Your Dependents** (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administrating **Your Plan**, **Underwriters**, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside **Your** country of residence. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the country of **Your** residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organizations without **Your** consent.

**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. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the **Plan**, including claims correspondence, will be sent to the **Planholder**. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

When **You** provide information about **Your Dependants** or employees and their **Dependants**, **You** represent and warrant that **You** have obtained consent from **Your** employees and their **Dependants** to provide and receive information about their personal information and the cost of their medical insurance **Plan**, but not of medical condition.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a Medical Practitioner's fitness to practice may be impaired.

Please contact **Our** Customer Services team or write to **Us** at the address on the back of this form if **You** wish Now Health International group companies to contact **You** via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com/privacy.

**We** need **Your** consent to use **Your** contact details for this purpose, which **We** will ask for before **We** start sending **You** any marketing communications. **You** do not have to give **Your** consent and **You** may withdraw **Your** consent at any time by contacting **Our** customer service at CustomerService@now-health.com or write to **Us** at the address on the back of this form.

**Your** health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

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 ◯.

### 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 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 **You**r 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.**

**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 Malta, 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 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 Services (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
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - Now Health International Services (Europe) Limited is acting on behalf of Starr Europe Insurance Limited for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- 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 Services (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):<br>/ / |
|---|---|