NOW HEALTH INTERNATIONAL

SimpleCare continuous transfer form: Individuals and families

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 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** 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 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 **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 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**.

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**, 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: Individuals and families

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

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:
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 ◯

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+):				

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, currently pregnant, termination of pregnancy, 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 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:	

2.6 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 3: 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 4: 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 5: 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 +44 (0)1276 602110. **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 (UK) Limited	Now Health International (UK) Limited	Now Health International (UK) Limited
Address	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom
Account no.	12448351	12448319	12448335
Sort code	185008	185008	185008
Swift code	CITIGB2L	CITIGB2L	CITIGB2L
IBAN no.	GB63CITI18500812448351	GB54CITI18500812448319	GB10CITI18500812448335

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: 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 to become a member under **Your 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 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 **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 **Plan**.

*Other people's information **You** provide to **Us***

Your membership of **Your 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 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 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 8: 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 (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**.
- 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 (UK) Limited is acting on behalf of Starr International (Europe) 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 (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 **Plan**.

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