NOW HEALTH INTERNATIONAL

WorldCare 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.

If **You** have used an authorised insurance broker **You** understand, acknowledge and agree that by buying this **Plan**, **We** will pay the authorised insurance broker commission during the life of the **Plan** including renewals. **You** also understand that this agreement is necessary for **Us** to proceed with **You**r application.

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 (Asia Pacific) Limited, Units 1501-3, 15/F, AIA Tower, 183 Electric Road, North Point, Hong Kong. **You** can also scan and email it to AsiaPacSales@now-health.com or fax it to +852 2279 7320.

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? Yes ☐ No ☐ (If yes please provide further details)	

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, 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/ 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:	

2.6 Claim reimbursement method

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

For bank transfer

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

The date the **Plan** will start from (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 **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
Cheque	☐	N/A	N/A	N/A
Credit card	☐	☐	☐	☐
Bank transfer	☐	N/A	N/A	N/A

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

Credit card: Visa, MasterCard and American Express can be accepted. **We** will contact **You** to take the required payment. **Your** card issuer may charge an additional conversion or transaction fee to process this payment.

Bank transfer: Please make sure **You** tell **Us Your** family or company name in the transfer details and send it to the bank account below.

	USD account
Bank	Citibank N.A.
Bank account name	Now Health International (Asia Pacific) Ltd
Address	9/F, Citi Tower, One Bay East, 83 Hoi Bun Road, Kwun Tong, Kowloon, Hong Kong
Account no.	00639162577093
Swift code	CITIHKHX

Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to the WorldCare **Benefit Schedule**. The currency **You** pay **Your** premium in is chosen for **You** by **Your Country of Residence** and the **Plan Deductible** will also be denominated in this currency. Please indicate **Your Plan** choice, **Deductible,** and any additional options.

Choice of **Plan**

Benefit	Essential	Advance	Excel	Apex
Maximum annual limit	USD 3m	USD 3.5m	USD 4m	N/A
In-Patient and **Day-Patient** care	▶	▶	▶	N/A
Organ Transplant	▶	▶	▶	N/A
Cancer Treatment	▶	▶	▶	N/A
Acute **Medical Conditions** during **Pregnancy** and Childbirth	▶	▶	▶	N/A
Evacuation and **Repatriation**	▶	▶	▶	N/A
Day-Patient or **Out-Patient** surgery	▶	▶	▶	N/A
Out-Patient Medical Practitioner fees	▶	▶	▶	N/A
Rehabilitation	▶	▶	▶	N/A
Congenital disorders	▶	▶	▶	N/A
Chronic Condition cover	▶	▶	▶	N/A
Routine and complex dental **Treatment**	▶	▶	▶	N/A
Routine maternity cover	▶	▶	▶	N/A
Please choose	☐	☐	☐	N/A

▶ Full refund ▶ Not covered ▶ Limited cover

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	N/A
Optional **Deductible**				
USD 1,000	☐	☐	☐	N/A
USD 2,500	☐	☐	☐	N/A
USD 5,000	☐	☐	☐	N/A
USD 10,000	☐	☐	☐	N/A
USD 15,000	☐	☐	☐	N/A
Out-Patient Per Visit Excess Option				
USD 25	N/A	☐	☐	N/A
USD 15	N/A	☐	☐	N/A

Additional options

	Essential	Advance	Excel	Apex
USA elective **Treatment**	☐	☐	☐	N/A
Out-Patient Charges	☐	N/A	N/A	N/A
Out-Patient Charges – Option 2	☐	N/A	N/A	N/A
Out-Patient Charges – Option 3	☐	N/A	N/A	N/A
10% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	N/A
20% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	N/A
Hong Kong Preferred Provider Network (Hong Kong residents only)	☐	☐	☐	N/A
Hospital room restriction in Hong Kong (Hong Kong residents only)	☐	☐	☐	N/A
Hospital room restriction in Hong Kong and China (PRC residents only)	☐	☐	☐	N/A
Extended **Evacuation** and **Repatriation** Option	☐	☐	☐	N/A
Wellness, optical **Benefits** and **Vaccinations**	N/A	☐	☐	N/A
Wellness, optical **Benefits** and **Vaccinations** – Option 2	N/A	☐	☐	N/A
Dental Care	☐#	☐	Already covered	N/A

* 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.

\# Dental Care can only be taken if **You** select an **Out-Patient** Charges or **Out-Patient** Charges – Option 2.

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 Privacy

We and **Your Underwriters** collect personal information about **You** and **Your Dependants** (including health, bank account and occupation) 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 Now Health group companies administering **Your Plan, Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the HKSAR. 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 HKSAR. **Your** personal details will not be disclosed to other organisations 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.

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.

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services, which may be of interest to **You**. If **You** do not wish this to happen please tick this box ☐. **You** may opt out of future marketing by contacting **Us** at any time. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

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 (Asia Pacific) 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.**
- 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
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - Now Health International (Asia Pacific) Limited is acting on behalf of AXA General Insurance Hong Kong 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 (Asia Pacific) 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) **Date** (dd/mm/yyyy):

/ /

Plans issued in Hong Kong are underwritten by AXA General Insurance Hong Kong Limited and arranged by Now Health International (Asia Pacific) Limited.

Registered address: Units 1501-3, 15/F, AIA Tower, 183 Electric Road, North Point, Hong Kong.
Insurance Agent Registration Number: 10974559.