NOW HEALTH INTERNATIONAL

WorldCare claim form

Important information:

Please complete the claim form in BLOCK CAPITALS and submit it to **Us** within six months of the initial **Treatment** date (unless this is not reasonably possible).

For all **Out-Patient Treatment** and if the total amount **You** are claiming (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) for **In-Patient** or **Day-Patient Treatment** is less than USD 500/EUR 400/GBP 300 **You** only need to complete Sections 1 and 2 and include a copy of **Your** receipt when **You** send **Us Your** claim form. **You** can scan **Your** claim form and receipt and email it to ClaimsService@now-health.com or fax it to +44 (0)1276 602130. Please keep a copy of the original documents in case they should be required by **Us**.

If the total amount **You** are claiming now or have claimed for **Day-Patient** and **In-Patient** (per **Insured Person**, per **Medical Condition**, per **Period of Cover**) is over USD 500/EUR 400/GBP 300, please ensure Section 3 is completed by the treating **Medical Practitioner**. **We** must also see receipts, diagnostic reports and discharge reports (if **You** have been a **Day-Patient** or **In-Patient**) for claims over this amount. **You** can scan **Your** claim form and receipts/diagnostic reports/discharge reports and email them to ClaimsService@now-health.com or fax them to +44 (0)1276 602130. Please keep a copy of the original documents in case they should be required by **Us**.

You can track the progress of **Your** claim online at any time in **Your** online secure portfolio area. Log in at www.now-health.com using **Your** username and password**.** If **You** have any questions about this form or any other aspect of your cover, please call us on +44 (0)1276 602110 or email us at ClaimsService@now-health.com.

Section 1: Member and Patient Information:

Planholder's name:	**Plan** number:
Patient's name:	Membership number:
Date of birth (dd/mm/yyyy): / /	
Email address:	Telephone number:
Reason for doctor visit/diagnosis: – specify symptoms or medical problem e.g. abdominal pain/rash on foot/eye infection	
Country where **Treatment** took place:	**Treatment** date (dd/mm/yyyy): / /
Currency claim incurred in:	Currency you would like your claim reimbursed in:
Total claimed amount:	
Type of service: **Out-Patient** ☐ **Day-Patient** ☐ **In-Patient** ☐ Dental ☐ Maternity ☐ Optical ☐ Routine check-up ☐	
Attending physician: Dentist ☐ **Medical Practitioner** ☐ **Specialist** ☐ Other ☐ Please specify:	
Is this claim due to **Accident**/injury? Yes ☐ No ☐ If yes, include complete medical information. Date of **Accident**/injury (dd/mm/yyyy): / /	

Third party insurers

If some of the costs are recoverable from a third party (for example, if the **Benefits You** are claiming relate to a **Medical Condition** or injury caused by a person or organisation, or if **You** have cover on another insurance policy for this claim), please provide details:

Section 2: Payment details

Please pay: **Planholder** ☐ Provider ☐		
Bank transfer – please complete all details to enable bank transfer payments.*		
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#:	
Intermediary/Correspondent Bank Details#:	Any other relevant information:	

Use NA if not applicable.

* **We** endeavour to ensure that all bank charges are paid by **Us**; however on occasions **You** may incur a charge levied by **Your** own bank, over which **We** have no control.

I have read the declaration in Section 4 on the next page
I agree to the declaration, give my authorisation and understand that any claim for **Benefit** is in accordance with the terms and conditions of **Our Plan**.
I will enclose Section 4 if authorisation has been limited by me where available.

Patient's signature (Insured/main applicant):	**Date** (dd/mm/yyyy):
	/ /

Section 3: Medical information, Day-Patient and In-Patient claims over USD 500/EUR 400/GBP 300

(to be completed by the doctor responsible for the patient's **Treatment**)

Medical Condition:	Diagnosis ICD10 code (if applicable):
Details of any underlying cause:	
When did the patient first see a doctor? (dd/mm/yyyy) / /	
Details of **Treatment**/medication:	
Details of operation (if any):	
	Procedure code (if applicable):
Hospital details (if applicable):	**Treatment** date (dd/mm/yyyy): / /
Name:	
Address:	
Admission date (dd/mm/yyyy): / /	Discharge date (dd/mm/yyyy): / /

Medical Practitioner Declaration:
I declare that I am the patient's **Medical Practitioner**, and that the particulars given are, to the best of my knowledge, true and correct.

Print name:	Official stamp:
Signature:	
Date (dd/mm/yyyy): / /	

If **Your Plan** includes a cash **Benefit**: If the patient stayed in **Hospital** overnight without charge please include confirmation from the **Hospital** including the **Hospital** stamp.

Direct Billing: It may be possible for **Us** to arrange direct settlement with the **Hospital** involved. Please call **Our** Customer Service team before **Treatment** to arrange this on+44 (0) 1276 602110.

Section 4: Declaration and authorisation

Data Protection

We and the **Underwriters** will collect certain information about **You** in the course of considering **Your** claim. This information will be processed for the purposes of meeting **Our** legal and regulatory obligations and administering **Your** claim.

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 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** claim.

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** for this claim. 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** claim.
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 claim.

3. Having seen the report, **You** can refuse **Your** consent – again this may affect **Our** ability to deal with **Your** claim.
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 supplied to **Us** within the last six months.

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/ membership of 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.

Declaration

I hereby declare that I am the patient/patient's guardian* (if the patient is under 16 years of age) (*please cross out if not applicable).

I wish to claim **Benefit** and declare the information I have given is, to the best of my knowledge, true, correct and complete even if it is not in my own handwriting.

I understand it is unlawful for me to knowingly provide false, incomplete or misleading facts or information (misrepresentations) to Now Health International for the purpose of defrauding or attempting to defraud Now Health International or the **Underwriters**. Penalties may include imprisonment, fines, denial of coverage, loss of or increase in premium, loss of **Benefits** and legal damages.

I agree to the data protection declaration above and understand that cover is provided in accordance with the terms and conditions of the Now Health International **Plan**.

I have read the statement notifying me of my rights under the Access to Medical Reports Act 1988 and consent to Now Health International seeking medical reports if needed from my **Medical Practitioner**, so Now Health International can deal with my claim for **Benefit**.

I do (NOT)* wish to see the medical report before it is sent to Now Health International. *Delete the word NOT if **You** wish to see the report.

I hereby consent to authorise any Doctor and/or **Hospital** who has treated or advised me to provide Now Health International with any information they may require in connection with this claim.

When completed and signed by the patient and **Medical Practitioner** (when appropriate), please return this form and the accompanying invoices and payment receipts to: Now Health International (UK) Limited, Suite 2.3, Building Three, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom.