NOW HEALTH INTERNATIONAL

WorldCare continuous transfer form: Group Employees

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 **Group Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer. For any new **Benefits** the waiting period will apply. Any **Benefits** covered under **Your** previous policy but not covered under **Group 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 **Group 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** membership. Where **You** make a careless misrepresentation **We** may void **Your Group 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 Group 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/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** 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: Group members

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

Company name:
Group Plan number:
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:	

Section 3: 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 **Group 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 **Group 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 **Group 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 Group 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 Group Plan** may be subcontracted, including those based outside the HKSAR. **Your** personal details will not be disclosed to other organisations without **our** 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 4: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a Now Health International **Group Plan** as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Group Plan**. I understand that the Application Form, Group Agreement, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Group Plan** terms and conditions make up the contract between **Us** and all form part of the **Group 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 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/Entry Date**.
- I declare that I have read and understood the following from the members' handbook and Group Agreement:
  - cancellation and termination rights
  - complaints procedures
  - law and jurisdiction of the **Group Plan**
  - language of the **Group 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 **Group Plans**, receiving premiums and paying claims.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Group 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 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 **Group Plan.**

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