NOW HEALTH INTERNATIONAL

SimpleCare 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).

Please submit this fully completed claim form along with itemized bills with receipts, laboratory request sheet, diagnostic reports, medical or discharge reports. **You** can scan all claim documents along with completed claim form by the treating **Medical Practitioner** and email it to ClaimsService@now-health.com. 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 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 ◯ Routine check-up or Vaccinations ◯	
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

Are some of the costs 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) Yes ◯ No ◯
If yes, name of third party insurer :
please provide details:
If this **Plan** is purchased as a **Secondary Health Insurance Plan**, then **You** need to submit the claims to the **Primary Health Insurer** first and send **Us** their copy of claims settlement advices along with claim documents. If **You** have more than one health insurance policy, this **Plan** will be the health insurance policy that pays last. **We** will only pay the remaining balance of an **Eligible** claim amount that was not settled by the **Primary Health Insurance**.

Section 2: Payment details

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 (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.

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 administering claims**. Your** information may be passed to **Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

We may contact **You** with details of other products and services which may be of interest to **You. You** may be contacted by post, telephone or email if appropriate. If **You** do not wish this to happen please tick this box ◯ .

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** for this claim. If **We** need to do this, **You** have the following rights:

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.

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**.

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 regarding 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 Limited, PO Box 482055, Dubai, UAE.

Plans issued by Now Health International Limited, which is regulated by Dubai Financial Services Authority, register number F001448, are underwritten by Best Doctors Insurance Limited, which is regulated by the Bermuda Monetary Authority, register number 42307.

Plans are only available to those outside the UAE.

Now Health International Limited, Registered Office: Unit OT 19-37, Level 19, Central Park Offices, DIFC, United Arab Emirates PO Box 482055, Dubai, UAE