SimpleCare application form: Groups

For company use – intermediary details and stamp

Intermediary company:	Fax number:
	Email address:
Contact name:	Official stamp:
Telephone number:	

To be completed by the employer (the **Planholder**). Please complete this form using BLOCK CAPITALS.

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 the state of health of any of **Your** 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 and submit it along with **Your** incorporation certificate (trade license) to **Us** via **Your** intermediary, or direct to Now Health International Limited, PO Box 482055, Dubai, UAE. **You** can also scan it and email it to MEAQuotes@now-health.com.

Section 1: Start Date

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.

The date the **Group Plan** will start from (dd/mm/yyyy): / /

Section 2: Company details

Company name:	
Trading name(s) if applicable:	
Registered office address:	
Office location address (if different from above):	
Company registration number:	
Other countries where **You** do business/have operations:	
Company website address:	Business activity:
Incorporating body:	
Incorporation number:	
Incorporation date (dd/mm/yyyy): / /	
Legal form of **Your** firm (e.g. Limited Liability Company):	

Is the Company, any party connected to the Company or any employees, their family members or close associates, a politically exposed person?
Is any party connected to the Company, any employees, their family members or close associates, a politically exposed person? Yes ◯ No ◯

Are all directors included in **Your** intended membership? (If not please list all additional directors) Yes ◯ No ◯

Are all Ultimate Beneficial Owners of the Company included in the intended membership? (If not please list all Ultimate Beneficial Owners) (natural persons owning more than 25%): Yes ◯ No ◯

Is **Your** firm owned, in whole or in part, by another? Yes ◯ No ◯

If yes, please state the name(s) and registration and incorporation jurisdiction(s) of the organization(s) together with the percentage of ownership and the type of business carried on by it (or each of them) and whether it is DFSA regulated. Please provide a copy of the company structure chart (if applicable) and registration certificate of each one of these organisations.

Details of Shareholders

Please state the full name(s) of the firm's shareholders/partners holding more than 25% of issued capital together with their nationality, date of birth and the percentage of their corresponding ownership. If a shareholder owns the controlling stake, in the case of a company please provide details of the ultimate owner.

Name	Nationality	Date of birth (dd/mm/yyyy)	Shareholding Percentage
		/ /	
		/ /	
		/ /	

If a shareholder owns the controlling stake, in the case of a company please provide details of the **ultimate owner**.

Please provide the full name, nationality, date of birth and current domicile.

Name	Nationality	Date of birth (dd/mm/yyyy)	Address	Shareholding Percentage
		/ /		
		/ /		

Details of Board Members

Please provide the full name(s), nationality, date of birth and current domicile of all Board Members.

Name	Nationality	Date of birth (dd/mm/yyyy)	Address	Shareholding Percentage
		/ /		
		/ /		
		/ /		

Is **Your** firm a regulated entity? (If yes, please complete the below information) Yes ◯ No ◯

Please provide the name and country of **Your** firm's national regulator:

Date and number of **Your** firm's licensing/registration by the regulator:

Date of Registration:	Number:

If **Your** firm is FATCA Registered, GIIN Number:

Section 3: Company Plan Administrator details

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.)*

Job title:	
Address (if different from above):	
Telephone:	Fax:
Email address:	

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: Group Plan options

For detailed information about the **Group Plan** choices available, please refer to the SimpleCare **Benefit Schedule**. Please indicate **Your Group Plan** choice, **Deductible,** and any additional options.

5.1 Choice of Group 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: Africa, Indian sub-continent, Jordan, Lebanon and the Philippines (residents of Africa)	○	○	○
Area of Cover: South East Asia (excluding Singapore) (residents of South East Asia (excluding Indonesia and Singapore))	○	○	○
Area of Cover: Europe (residents of Europe)	○	○	○
Area of Cover: Worldwide excluding USA (residents in the rest of the world)	○	○	○
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 ○

5.2 Geographical Area of Cover Options	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Area of Cover: Africa, Europe, Indian sub-continent, Jordan, Lebanon and the Philippines (residents of Africa)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of Africa)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of Europe)	○	○	○
Area of Cover: Worldwide Excluding USA (residents of South East Asia (excluding Indonesia and Singapore))	○	○	○

5.3 Group 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	○	○	○

5.4 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 **Group 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 **Plan**. **You** can only select such **Deductible** options if **You** buy this **Group 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.

5.5 Additional Options	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Removal of Drugs and Dressings Limit (for compulsory **Group Plans** 3+ employees)	N/A	N/A	○
Wellness & Vaccinations - Option 1 # (combined limit up to USD 150/EUR 120/GBP 95) (for compulsory **Group Plans** 3+ employees)	N/A	○	○
Wellness & Vaccinations - Option 2 # (combined limit up to USD 250/EUR 200/GBP 155) (for compulsory **Group Plans** 3+ employees)	N/A	○	○
Maternity - Option 1 (Normal Pregnancy and Childbirth up to USD 5,000/EUR 4,000/GBP 3,125) (for compulsory **Group Plans** 10+ employees)	N/A	○	○
Maternity - Option 2 (Normal Pregnancy and Childbirth up to USD 7,000/EUR 5,600/GBP 4,375) (for compulsory **Group Plans** 10+ employees)	N/A	○	○

Please note Wellness & Vaccinations options can only be taken if **You** select a **Deductible** option of USD500/EUR400/GBP310 or lower.

Section 6: 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.

	Annually	Semi-annually	Quarterly	Monthly
Bank transfer	◯	◯	◯	N/A

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

	USD account	EUR account	GBP account
Bank	Citibank N.A.	Citibank N.A.	Citibank N.A.
Bank account name	Now Health International Limited	Now Health International Limited	Now Health International Limited
Address	Oud Metha Road, Al Wasl Branch, Dubai, UAE	Oud Metha Road, Al Wasl Branch, Dubai, UAE	Oud Metha Road, Al Wasl Branch, Dubai, UAE
Sort code	N/A	N/A	N/A
Swift code	CITIAEAD	CITIAEAD	CITIAEAD
IBAN no.	AE500211000000100708264	AE280211000000100708272	AE940211000000100708248

For USD bank account	**Correspondent Bank: "Citibank N.A., New York, USA. SWIFT: CITIUS33"**
For GBP & EUR bank account	**Correspondent Bank: "Citibank London N.A. SWIFT: CITIGB2L"**

For transfer to banks in the UAE:	**Code**	INS
	Description	Insurance Services

Section 7: Medical Insurance Details

7.1 Do **You** currently provide private medical insurance for **Your** group members? Yes ◯ No ◯
If yes, please give details below:

Policy no.:	Date cover expires/expired (dd/mm/yyyy): / /
Name of Insurer:	

7.2 Do **You** intend to continue with the existing insurance? Yes ◯ No ◯

7.3 Do **You** intend to buy this **Group Plan** as a **Secondary Health Insurance Plan** for **Your** group members? Yes ◯ No ◯

If **You** buy this **Group Plan** as a **Secondary Health Insurance Plan**, **You** must provide a copy of the **Certificate of Insurance** of **Your Group** members' **Primary Health Insurance** policy. If **You** have more than one health insurance policy, this **Group Plan** will be the health insurance policy that pays last.

Section 8: Underwriting Options

Full Medical Underwriting (FMU) ◯	Capped Cover (for compulsory **Group Plans** 5 to 19 employees) ◯	Medical History Disregarded (MHD) (for compulsory **Group Plans** 10+ employees) ◯

Full Medical Underwriting (FMU) is the process where the **Underwriters** assess the declared details in deciding if any special terms apply.
For FMU, all members (employees and **Eligible Dependants**) are required to complete a SimpleCare application form for group employees and send it to Now Health International Limited, PO Box 482055, Dubai, UAE.

Capped Cover is the process where the **Underwriters** assess the declared medical details and decide if **We** can offer **Your** members limited cover for a declared pre-existing **Medical Condition** after the **Waiting Period** has been fulfilled. All members (employees and **Eligible Dependants**) are required to complete a SimpleCare application form for group employees and send it to Now Health International Limited, PO Box 482055, Dubai, UAE.

Medical History Disregarded (MHD) is when we may be able to cover **Your** employees without asking detailed questions about their medical history up-front. MHD is available for compulsory groups of 10 or more employees.

We need a full membership list as follows and it must include these details for each person to be covered (A template is available from www.now-health.com or by calling +971 (0) 4450 1500).

1. First name(s)
2. Family name
3. What do they like to be called?
   *(If **Your** employee's full name is John Andrew Smith, he might like to be called John or Mr Smith or Andy. **We** will address all correspondence to him in this way.)*
4. Gender
5. Date of birth (dd/mm/yyyy)
6. Occupation
7. Employee category
8. **Entry Date** – first day of cover (dd/mm/yyyy)
9. **Country of Residence**
10. Nationality
11. Email address
12. Telephone no.
13. Relationship to primary insured
14. **Dependants** to be included
15. Start date of employment (employees only)

Section 9: Group Medical Declaration

9.1 Please complete this section if you currently provide or have provided medical insurance previously to your **Group** members. Otherwise, please go to Section 9.2.

Details of any claims over USD 20,000/EUR 16,000/GBP 12,500 for any one **Medical Condition** in the last three years:

9.2 Details of any planned **Treatment** for cancer, heart surgery, **In-Patient** psychiatric conditions, congenital conditions, renal failure or back surgery:

Please note: If a **Medical Condition** is declared, **We** reserve the right to review **Our** terms.

Section 10: Eligibility

Please define the member category:

Name of category e.g. directors, managers, general employees	All members	Number of members
	◯	
	◯	
	◯	
	◯	
	◯	

Compulsory	◯ or	Voluntary	◯	Start Date for New Employees:	
Employees only	◯ or	Employees and **Dependants**	◯	◯	First date of employment
Expatriates	◯ and/or	Local Nationals	◯	◯	After _____ month(s) probation period

If cover choices vary according to the job position and there are more than five employees for each level, please provide details.
For **Dependants** aged between 18 to 28 **We** may require written confirmation from their place of study that they are in full-time education.

If **We** have accepted the **Group Plan** on the basis that it is compulsory group and subsequently find out that the **Group Plan** is on a voluntary basis; **We** reserve the right to adjust the premium.

Section 11: 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** or if the number of members eligible to participate in the **Group Plan** is different to the original census provided that Now Health International quoted on. 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 Body Mass Indexes being within normal limits.

Data Protection

Please ensure that **You** show the following information to others covered under **Your Plan** or make them aware of its contents.

We and the Underwriters will deal with all personal information supplied in the strictest confidence as required by the Personal Data Protection Act. **We** and **Your** underwriters collect personal information about **You** and **Your Dependents** (including health, bank account and occupation) for the purpose of establishing and administering **Your Plan**. This includes information supplied by **You**, those family members, medical providers or **Your** employer (if applicable). **Your** information may be passed to Now Health group companies administrating **Your Plan**, Underwriters, Insurers, Reinsurers, Medical Practitioners, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside **Your** country of residence. Confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside the country of **Your** residency. In certain circumstances, medical service providers (or others) may be asked to supply further information. **Your** personal details will not be disclosed to other organizations 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. When **You** provide information about family members, **We** will take this as confirmation that **You** have their consent to do so. As the legal holder of the **Plan** all correspondence about the **Plan**, including claims correspondence, will be sent to the Planholder. If any family member over 18 insured under the **Plan** does not want this to happen they should apply for their own **Plan**.

There is a legal requirement, in certain circumstances, to disclose information to law enforcement agencies relating to suspicions of fraudulent claims and other crimes. If required, information will be disclosed to third parties including other insurers for the purposes of prevention or investigation of crime including fraud or otherwise improper claims where there is reasonable suspicion. This may involve adding non-medical information to a database that will be accessible to other insurers and law enforcement agencies. Additionally, the General Medical Council or other relevant regulatory body will be notified about any issue where there is reason to believe a **Medical Practitioner's** fitness to practice may be impaired.

Please contact **Our** Customer Services team or write to us at the address on the back of this form if **You** wish Now Health International group companies to contact **You** via letter, SMS or email with details of other IPMI or related product and services. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com/privacy

Your health claims information may be shared by Now Health International Group companies to other Insurance Companies or Reinsurance Companies for the purposes of risk management, contract negotiations, research, development and analysis, as well as, to promote other products that may be of interest to **You**.

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 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 12: Required Documentation

Please provide copies of the valid documents as listed below along with this signed form. These documents must be in **English** or accompanied by a translation into English:

- **This completed application form (signed & stamped)**
- **Certificate of Incorporation / Registration**
- **Valid Commercial License / Trade License**
- **Regulatory License (if applicable)**
- **Articles of Association / Memorandum of Association**
- **ID Of the Ultimate owner**

Section 13: 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 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 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 Limited is acting on behalf of Best Doctors Insurance 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 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** and **Group** Agreement.
- **We** understand that **We** are purchasing an international policy to cover all my eligible employees to ensure they are provided with international flexibility and coverage in accordance with the terms of the policy. The policy is issued in the Dubai International Financial Centre by Now Health International Limited (regulated by the Dubai Financial Services Authority) and underwritten by Best Doctors Insurance Limited (regulated by the Bermuda Monetary Authority). **We** understand this policy may not be issued locally therefore may not fulfill all local regulatory requirements.

Signature (Authorised person/Plan Administrator):	**Date** (dd/mm/yyyy): / /

Name:	**Official stamp:**
Position:	