NOW HEALTH INTERNATIONAL

WorldCare application form: Individuals and families (FMU)

For company use – intermediary details and stamp

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

Please complete this form in BLOCK CAPITALS or apply online at www.now-health.com.

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**.

Please keep a record of all information **You** supply to **Us** in connection with this application.

Please enclose any medical reports or test results with **Your** application if they are available. **We** may ask **You** to complete a further medical questionnaire if **We** need more information. All the information **You** provide will be treated in strict confidence.

We rely on the information that **You** provide in this form (i.e. **Your** representations) to decide whether or not to accept **Your** application, and whether or not **We** need to apply special terms. Special terms are exclusions or conditions that **We** may apply to **Your** cover. If **You** submit a claim for the **Treatment** of any existing condition which **You** did not tell **Us** about here or did not tell **Us** everything about, **We** may refuse to pay that claim. **We** also have the right to void **Your Plan**, or **We** may impose special terms on **Your Plan** which **We** will apply retrospectively. Please take the greatest care to ensure that this application form is completed fully and accurately.

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**, **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 **Your** 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: 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.)*

Section 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)

Section 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:
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)	

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they 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+):				

Section 4: Start Date

Date on which **You** wish **Your** Now Health International **Plan** to start (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 5: 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 6: Plan options

For detailed information about the **Plan** choices available, please refer to 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.

(i) Choice of Plan

Benefit	Essential	Advance	Excel	Apex
Maximum annual limit	USD 3m	USD 3.5m	USD 4m	USD 4.5m
In-Patient and **Day-Patient** care	▶	▶	▶	▶
Organ Transplant	▶	▶	▶	▶
Cancer Treatment	▶	▶	▶	▶
Acute **Medical Conditions** during **Pregnancy** and childbirth	▶	▶	▶	▶
Evacuation and **Repatriation**	▶	▶	▶	▶
Day-Patient or **Out-Patient** surgery	▶	▶	▶	▶
Out-Patient Medical Practitioner fees	▶	▶	▶	▶
Rehabilitation	▶	▶	▶	▶
Congenital cover	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental **Treatment**	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
Please choose	☐	☐	☐	☐

▶ Full refund ▶ Not covered ▶ Limited cover

(ii) Plan Deductible

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** USD 150, USD 250, USD 500, USD 1,000, USD 2,500 or USD 5,000 and an **Out-Patient** Charges Option or **Out-Patient** Charges – Option 2, **You** must also select an **Out-Patient Co-Insurance** Option.

	Essential	Advance	Excel	Apex
Standard **Deductible**	Nil	Nil	Nil	Nil
Optional **Deductible**				
USD 150	☐	☐	☐	☐
USD 250	☐	☐	☐	☐
USD 500	☐	☐	☐	☐
USD 1,000	☐	☐	☐	☐
USD 2,500	☐	☐	☐	☐
USD 5,000	☐	☐	☐	☐
USD 10,000	☐	☐	☐	☐
USD 15,000	☐	☐	☐	☐
Out-Patient Per Visit Excess Option				
USD 25	N/A	☐	☐	☐
USD 15	N/A	☐	☐	☐

Additional options

	Essential	Advance	Excel	Apex
USA elective **Treatment** ^	☐	☐	☐	☐
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**	☐*	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment**	☐*	☐	☐	☐
Hong Kong Preferred Provider Network (Hong Kong residents only)	☐	☐	☐	☐
Hospital room restriction in Hong Kong (Hong Kong residents only)	☐	☐	☐	☐
Hospital room restriction in Hong Kong and China (PRC residents only)	☐	☐	☐	☐
High Cost Provider Restriction Option (Hong Kong residents only)	☐	☐	☐	☐
Extended **Evacuation** and **Repatriation** Option	☐	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations** ø	☐	☐	☐	☐
Wellness, optical **Benefits** and **Vaccinations** – Option 2	N/A	☐	☐	☐
Wellness and **Vaccinations** – Option 3 ø	☐	☐	☐	☐
Dental Care	☐#	☐	Already covered	Already covered
Removal of Maternity	N/A	N/A	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 or **Out-Patient** Charges Option 2.
∞ No **Out-Patient Co-Insurance** Option and **Out-Patient Per Visit Excess** Option is allowed for WorldCare Essential with **Out-Patient** Charges – Option 3 as **Out-Patient** Charges – Option 3 on WorldCare Essential is subject to default USD 25/EUR 20/GBP 15 **Out-Patient Per Visit Excess**.
Dental Care can only be taken on WorldCare Essential if **You** select an **Out-Patient** Charges or **Out-Patient** Charges – Option 2.
^ US elective **Treatment** is not available if **You** selected an optional Regional Cover.
ø WorldCare Essential when **Out-Patient** Charges -Option 1 or 2 has been selected.

Section 7: 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
Credit card	☐	☐	☐	☐
Bank transfer	☐	N/A	N/A	N/A

Credit card: **We** accept Visa, MasterCard and American Express. 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 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 8: 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 9: Insurance details

9.1 Do **You** currently have health insurance with another company? Yes ☐ No ☐

If yes, please give details:

9.2 Do **You** intend to continue with the existing insurance? Yes ☐ No ☐

9.3 Have **You** been insured previously with Now Health International? Yes ☐ No ☐

If yes, please give dates of when insured and previous policy number:

9.4 Have **You** ever had an application for Medical Insurance declined or had special terms imposed? Yes ☐ No ☐

If yes, please give details:

Section 10: 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
10.1 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 ☐
10.2 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 ☐

Have **You** ever received **Treatment**, tests or investigations for, been diagnosed with, or been hospitalised or had signs or symptoms of for:

10.3 Asthma, bronchitis, tuberculosis, pneumonia or any other respiratory conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.5 Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Have **You** ever been tested positive for HIV, Hepatitis B or C?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.6 **Cancer**, cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.9 Diabetes, thyroid disorders or weight management problems?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.13 Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or **Medical Condition** not already noted above?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
10.14 Females only Have **You** ever suffered from any breast or gynaecological disorders?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.14, 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)

Section 11: 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 12: 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,** Insurers, **Your** Intermediary, Reinsurers, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside theHKSAR. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outsidethe 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.

By electing to participate in the Plan via online or other acceptance procedure, You are declaring that You agree with the data processing practices described herein. You also consent to the collection, processing and use of Personal Data (as defined under the applicable data protection law) by the Now Health group companies as well as the transfer of Personal Data to the third parties mentioned herein for the purpose of providing the services set out under the terms of this Plan. These third parties may be located in countries which may not be designated jurisdictions for data transfer as per applicable Data Protection Laws.

A parent or guardian should complete the consent for any member that is under the age of eighteen (18). If you accept the above, please sign, date and check the "I consent" box below which confirms that you have the prior and express consent of all persons to be covered pursuant to this application form, to submit this application on their behalf.

☐ I consent ☐ I do not consent

Now Health International 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.

☐ I consent ☐ I do not consent

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 **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/Entry 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/main applicant): **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.