Administered by:

NOW HEALTH INTERNATIONAL

Insured by:

Arabia INSURANCE

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.

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 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.

We reserve the right to decline or accept **Your** application or to accept **Your** application form with special terms.

For applicants with residence visas in the **Emirate of Abu Dhabi ONLY. Please include a passport-sized photograph using a white background of each applicant.*

Please send **Your** completed application form and photograph(s) along with a copy of **Your** government issued identity document to **Us** via **Your** intermediary, or direct to Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, Regus Deira, Office 123 – 127, 1st Floor, Port Saeed Road, P.O. Box 334337, Dubai, United Arab Emirates.**You** can also scan and email it to MEAQuotes@worldcare.ae.

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): / /
Marital status:	Married ☐	Unmarried ☐			**Country of Residence**:
Residential region: (e.g. Umm Suqeim First)					Nationality:
Passport number:		UID (Visa) number:			File number (Visa):
Emirates ID number: (000-0000-0000000-0)					Emirate of Visa issuance:
Height (cm/ft):					Weight (kg/lbs):
Occupation:					Occupation industry:

Work region:
(e.g. Oud Metha)

Monthly salary: < 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐

Commission based salary: Yes ☐ No ☐

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?	
Email address:	Phone number:
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Marital status: Married ☐ Unmarried ☐	**Country of Residence**:
Residential region: (e.g. Umm Suqeim First)	Nationality:
Passport number:	UID (Visa) number: / File number (Visa):
Emirates ID number: (000-0000-0000000-0)	Emirate of Visa issuance:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Work region: (e.g. Oud Metha)	
Monthly salary: < 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	
Commission based salary: Yes ☐ No ☐	
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?				
Email address:				
Phone number:				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Marital status:	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐	Married ☐ Unmarried ☐
Country of Residence:				
Residential region: (e.g. Umm Suqeim First)				
Nationality:				
Passport number:				

UID (Visa) number:				
File number (Visa):				
Emirates ID number: (000-0000-0000000-0)				
Emirate of Visa issuance:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to **Planholder**:				
Occupation (ages 16+):				
Occupation industry:				
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐	< 4,000 AED ☐ 4000 < 12,000 AED ☐ > 12,000 AED ☐ Unsalaried ☐
Commission based:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Section 4: Start Date

Date on which **You** wish **Your 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	☐	☐	☐	☐

WorldCare Essential is not available to **Insured Persons** with residence visas in the Emirates of Dubai or Abu Dhabi.

▶ 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.

§ Annual **Deductibles** are not available to **Insured Persons** with residence visas in the Emirates of Dubai or Abu Dhabi.

	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	☐	☐	☐

† If **You** choose an optional **Deductible**, **You** must also select either a **Co-insurance Out-Patient Treatment** option or an **Out-patient Per Visit Excess** option.

◊ Please note that only **Out-Patient Per Visit Excess** USD 15 is available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

(iii) Additional options

	Essential	Advance	Excel	Apex
USA elective **Treatment** ^	☐	☐	☐	☐
10% **Co-Insurance** on **Out-Patient Treatment** ▲	☐*	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment** ▲	☐*	☐	☐	☐
Restricted Network**	N/A	☐	☐	☐
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
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	☐

▲ **Co-Insurance Out-Patient Treatment** is not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

* 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.

** For residents of the UAE, the premium can be reduced by a further 10% by choosing the **Restricted Network** Option which excludes cover for **Treatment** received in the American Hospital and associated clinics, the City Hospital, the Welcare Hospital and associated clinics of the Mediclinic Group.
Please note that if **You** selected the USD25/USD 15 per visit **Out-Patient Excess** or one of the **Co-insurance Plan** options, these will still apply in the **Restricted Network.** The **Restricted Network** is not available for resident visa holders in the Emirate of Abu Dhabi.

∞ 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 **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.

	Annual	Semi-annual	Quarterly	Monthly
Credit card **We** accept Visa, MasterCard and American Express. ++ 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 appropriate bank account below.)	☐	N/A	N/A	N/A

	Bank transfer – USD account			
Bank	Citibank			
Bank account name	Arabia Insurance Company SAL (Dubai Branch)			
Account number	0110555237			
Address	PO Box 749, Oud Metha Road, Dubai, United Arab Emirates			
Swift code	CITIAEAD			
IBAN number	AE490211000000110555237			
For USD bank account	**Correspondent Bank:** **"Citibank N.A., New York, USA. SWIFT: CITIUS33"**	**For transfer to banks in the UAE:**	**Code**	INS
			Description	Insurance Services

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:

Please also note to complete Section 6 even if **You** were previously insured with **Us**.

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, 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 ☐
10.15 Are **You** currently pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
If yes, have there been any complications to date? Please give details:						
Last menstrual period date :						
10.16 Are **You** currently trying to get pregnant?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
10.17 Are **You** undergoing any form of fertility **Treatment**?	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
If yes, please give details:						

☐ I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of Arabia Insurance Company S.A.L. Arabia Insurance Company S.A.L. has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of Arabia Insurance Company S.A.L.

Additional information

If **You** answered 'Yes' to any of questions 10.1 to 10.17, 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 WorldCare **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** WorldCare **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.

*As per the Dubai Health Authority circular, **We** cannot back date cover for Dubai resident visa holders (only in exceptions for new born and this is limited to up to 7 days).

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, **Your** Intermediary, 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**.

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

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.

Section 13: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a WorldCare **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 for the purpose of defrauding or attempting to defraud Arabia Insurance Company S.A.L. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify 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 any information which may be required 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 Gulf Third Party Administrators LLC is acting on behalf of Arabia Insurance Company S.A.L. for the purpose of administering **Plans**.
- I and those to be covered under this **Plan** acknowledge and agree to our personal data being processed by Arabia Insurance Company S.A.L., its administrator or its group companies and those other parties, wherever located, for the purpose of administering my **Plan**.
- I understand that Arabia Insurance Company S.A.L. cannot be liable and therefore will not pay claims if my **Plan** is lapsed should Arabia Insurance Company S.A.L. be unable to collect my premium for whatever reason and I do not provide an alternate method of payment within seven days of receiving 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 Arabia Insurance Company S.A.L., 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 Arabia Insurance Company S.A.L. 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 Arabia Insurance Company S.A.L. in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Arabia Insurance Company S.A.L. and/or my **Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Arabia Insurance Company S.A.L. 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, Arabia Insurance Company S.A.L. 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 WorldCare **Plan**.

Signature (Insured/main applicant):

Date (dd/mm/yyyy):

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