SimpleCare 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 (Singapore) Pte. Ltd., 4 Robinson Road, #07-01A/02 The House of Eden, Singapore 048543. **You** can also scan and email it to SingaporeSales@now-health.com.

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 **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 6: Plan options

For detailed information about the **Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Plan** choice, **Deductible,** any **Out-Patient** option and/or Additional option.

6.1 Choice of Group Plan

Benefit		SimpleCare CORE	SimpleCare 100	SimpleCare 250
Annual Maximum Plan Limit		USD 1,000,000/ SGD 1,300,000	USD 1,500,000/ SGD 1,950,000	USD 1,500,000/ SGD 1,950,000
Area of Cover: Worldwide excluding USA				
In-Patient and Day-Patient Co-Insurance	**Treatment in Singapore**			
	(i) Singapore Public Hospital *(ii) Singapore Private Hospital*	*(i) Nil* *(ii) 20%*	*(i) Nil* *(ii) 20%*	*(i) Nil* *(ii) 20%*
	Treatment outside Singapore	Nil	Nil	Nil
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 ○	SGD ○

6.2 Plan Deductible*

	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Standard Deductible	USD 500/SGD 650	USD 500/SGD 650	USD 500/SGD 650
Optional Deductible			
Nil	○	○	○
USD 150/SGD 195	○	○	○
USD 250/SGD 325	○	○	○
USD 1,000/SGD 1,300	○	○	○
USD 2,500/SGD 3,250	○	○	○
USD 5,000/SGD 6,500	○	○	○
USD 10,000/SGD 13,000*	○	○	○
USD 15,000/SGD 19,500*	○	○	○

6.3 Out-Patient options**

	SimpleCare CORE	SimpleCare 100	SimpleCare 250
USD 25/SGD 30 **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 **Plan Deductible** applies to **In-Patient** and **Day-Patient Treatment** is per **Insured Person**, per **Period of Cover**.
USD 10,000/SGD 13,000 or USD 15,000/SGD 19,500 **Deductible** is only available if **You** are covered by more than one health insurance policy. **You** can only select such **Deductible** options if **You** buy this **Plan** as a **Secondary Health Insurance Plan**.
Please note an Integrated Shield Plan is not considered as **Primary Health Insurance** for the purpose of purchasing this **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/SGD 650 or lower.

6.4 Additional Option

	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Removal of Co-Insurance for In/Day-Patient Treatment in Singapore Private Hospitals	○	○	○

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. For a USD/SGD policy, premium needs to be paid to the respective bank accounts only.

	USD account	SGD account
Bank	Citibank N.A. Singapore Branch	Citibank N.A. Singapore Branch
Bank code	N/A	7214
Branch code	N/A	001
Bank account name	Now Health International (Singapore) Pte. Ltd	Now Health International (Singapore) Pte. Ltd
Address	8 Marina View 21-01 Asia Square Tower 1 Singapore 018960	8 Marina View 21-01 Asia Square Tower 1 Singapore 018960
Account no.	0857607104	0857607074
Swift code	CITISGSG	CITISGSG

Section 8: Claim reimbursement

Bank transfer - Please complete all details

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 Do **You** intend to buy this **Plan** as a **Secondary Health Insurance Plan**? Yes ○ No ○

If **You** buy this **Plan** as a **Secondary Health Insurance Plan**, **You** must provide a copy of the **Certificate of Insurance** of **Your Primary Health Insurance** policy. If **You** have more than one health insurance policy, this **Plan** will be the health insurance policy that pays last.
Please note an Integrated Shield Plan is not considered as **Primary Health Insurance** for the purpose of purchasing this **Plan** as a **Secondary Health Insurance Plan**.

9.4 Have **You** been insured previously with Now Health International? Yes ○ No ○

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

9.5 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, 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 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

Buying health insurance products that are not suitable for **You** may impact **Your** ability to finance **Your** future healthcare needs. **You** should seek advice from **Us** or a qualified adviser if in doubt before **You** sign this application form. Should **You** choose not to, **You** are taking sole responsibility to ensure that this product is appropriate to **Your** financial needs and insurance objectives.

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.

Pre-Existing Medical Conditions

Your Plan does not cover **You** for **Treatment** of **Pre-Existing Medical Conditions** and **Related Conditions** unless accepted by **Us** in writing.

A Pre-Existing Medical Condition means any disease, injury or illness for which:

1. **You** have received **Treatment**, test or investigations for, been diagnosed with or been hospitalised for; or
2. **You** have suffered from or experienced symptoms; whether the **Medical Condition** has been diagnosed or not, at any time before your **Start Date/ Entry Date** into the **Plan.**

This **Plan** is not a Medisave-approved **Plan** and **You** may not use Medisave **Plan** to pay the premium for this **Plan**.

If **You** are a citizen or permanent resident of Singapore, **You** are covered by MediShield Life for life, for **Treatments** in Singapore, regardless of pre-existing medical conditions or other circumstances that **You** face. For more details on **Your** coverage, please visit www.medishieldlife.sg.

This is a short-term accident and health **Plan** and **We** are not required to renew this **Plan. We** may terminate this **Plan** at renewal by giving **You** 30 days notice in writing.

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 Singapore. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside Singapore. **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.

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.

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** 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, rescission of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Singapore) Pte. Ltd. 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 "Your Guide to Health Insurance" Booklet, and the Members' Handbook which contains Product Information and Key Product Provisions, details of my rights and **Your** obligations to me:
  - cancellation and termination rights
  - complaints procedures
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - **Plans** are underwritten by Sompo Insurance Singapore Pte. Ltd. and Now Health International (Singapore) Pte. Ltd. is acting on behalf of Sompo Insurance Singapore Pte. Ltd. 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 have consent from all my dependants covered under the **Plan** to administer additions and deletions and review claim payment reports on their behalf.
- I acknowledge that if it is determined by Now Health International that a claim was fraudulent my **Plan** may be terminated 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 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): / /
Signature & Name of Adviser: /	**Date** (dd/mm/yyyy): / /

This plan is not a Medisave-approved plan and you may not use Medisave plan to pay the premium for this plan.
If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.

Plan Owners' Protection Scheme

This plan is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your plan is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association of Singapore (GIA)/Life Insurance Association of Singapore (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

Now Health International (Singapore) Pte. Ltd.(No.201317502C) is a general insurance agent of Sompo Insurance Singapore Pte. Ltd. and is registered with the Agents' Registration Board of the General Insurance Association of Singapore (GIA).

Registered at 16 Raffles Quay #33-03 Hong Leong Building Singapore 048581.

Visit www.sompo.com.sg to find out more about Sompo Singapore.