NOW HEALTH INTERNATIONAL

SimpleCare continuous transfer form: Individuals and families

For company use – intermediary details and stamp

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

If **You** are applying for one of **Our Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer, which means that **We** will not ask for full details about **Your** medical history and cover can continue. For any new **Benefits** the waiting period will apply. Any **Benefits** covered under **Your** previous policy but not covered under **Our Plan** will not be **Eligible** for cover following the transfer. Any endorsements that applied to **Your** existing policy will continue to apply to **Your** new **Plan**.

Please complete this form in BLOCK CAPITALS. **You** should attach a copy of **Your** existing certificate of insurance, detailing any endorsements and the **Start Date** of the existing policy.

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**.

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**, 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** or 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 along with a copy of **Your** government issued identity document to **Us** via **Your** intermediary, or direct to Now Health International Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta. **You** can also scan and email it to EuropeSales@now-health.com.

Section 1: Previous Medical Insurance

Policy no.:	Date cover expires/expired (dd/mm/yyyy): / /
Name of Insurer:	
Do **You** intend to continue with the existing insurance?	Yes ◯ No ◯

Section 2: Individuals and families

2.1 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.)*

2.2 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? (If yes please provide further details)	Yes ◯ No ◯

2.3 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? (If yes please provide further details)	Yes ◯ No ◯

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+):				

2.4 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**
2.4.1 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 ◯
2.4.2 Have **You** ever been diagnosed with, hospitalised for, received **Treatment**, tests or investigations for any type of disease, physical impairment, congenital or had signs or symptoms of or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or **Medical Condition**?	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
2.4.3 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 ◯

Additional information

If **You** answered 'Yes' to any of questions 2.4.1 to 2.4.3, 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)

2.5 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:	

2.6 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 3: 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 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: 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, please pay via the payment link which **Our** Customer Service Team will send to **Your** email address. If **You** have not received this payment link, please call **Our** team on +356 2260 5110. **Your** card issuer may charge an additional conversion or transaction fee to process this payment.

Bank transfer: Please use the relevant bank details for the currency of **Your Plan**. Please quote **Your Plan** number in the transfer details as a reference.

Bank transfer	**USD account**	**EUR account**	**GBP account**
Bank	Citibank	Citibank	Citibank
Bank account name	Now Health International Services (Europe) Limited	Now Health International Services (Europe) Limited	Now Health International Services (Europe) Limited
Address	Citibank, 1 North Wall Quay, Dublin 1, Ireland	Citibank, 1 North Wall Quay, Dublin 1, Ireland	Citibank, 1 North Wall Quay, Dublin 1, Ireland
Account no.	33494416	33494343	33494386
Sort code	990051	990051	990051
Swift code	CITIIE2X	CITIIE2X	CITIIE2X
IBAN no.	IE46CITI99005133494416	IE77CITI99005133494343	IE80CITI99005133494386

Section 6: Plan options

For detailed information about the **Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Plan** choice, Geographical **Area of Cover** options, **Deductible,** and any **Out-Patient** options.

6.1 Choice of 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: Europe			
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 ○

6.2 Geographical Area of Cover Options

	CORE	100	250		CORE	100	250
Area of Cover: Worldwide Excluding USA	○	○	○	**Regional Cover#: Europe (excluding United Kingdom, Germany and Switzerland)** (residents of Europe)	○	○	○

\# We provide regional cover according to Your Country of Residence.
\## Worldwide excluding USA is applicable to residents of Africa, Europe and South East Asia where a default Regional Cover applies. By selecting this option, Your area of cover will change to Worldwide excluding USA.

6.3 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	○	○	○

6.4 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 **Plan Deductible** applies to **In-Patient** and **Day-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 policy. **You** can only select such **Deductible** options if **You** buy 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/EUR 400/GBP 310 or lower.

Section 7: 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 Dependant's Body Mass Index 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 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**.

When **You** provide information about **Your Dependants** or employees and their **Dependants**, **You** represent and warrant that **You** have obtained consent from **Your** employees and their **Dependants** to provide and receive information about their personal information and the cost of their medical insurance **Plan**, but not of medical condition.

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 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.

We need **Your** consent to use **Your** contact details for this purpose, which **We** will ask for before **We** start sending **You** any marketing communications. **You** do not have to give **Your** consent and **You** may withdraw **Your** consent at any time by contacting **Our** customer service at CustomerService@now-health.com or write to **Us** at the address on the back of this form.

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

Access to Medical Reports Act 1988

It may be necessary to obtain a medical report from **Your** usual Doctor/**Medical Practitioner** in connection with **Your** application to become a member under **Your Plan**. If **We** need to do this, this Act gives **You** specific rights and they are set out below. If **You** wish:

1. **You** can refuse to give **Your** consent – but if **You** do **We** may be unable to deal with **Your** application.
2. **You** can ask to see the report before it is sent to **Us**. If **You** give **You**r consent, **We** will be able to contact **Your** Doctor direct for a report. If **You** wish to see it, delete the word "NOT" in the declaration and **We** will inform the Doctor accordingly. Then the Doctor will not send it to **Us** until:
   (i) **You** have seen the report and approved it; or
   (ii) 21 days have passed since **We** requested the report and the Doctor has not heard from **You**.

Important note: The sooner We receive the report, the sooner We can deal with Your application for membership.

Your Doctor may refuse to let **You** see **Your** report if (s)he feels it will do serious harm to **Your** physical or mental health, or it will indicate the Doctor's intentions in respect of **You**, or it may reveal the identity of another person who has supplied information about **You** who is not a health professional but is involved in **Your** care. In such cases **You** will be entitled to see the remainder of the report. If this affects the entire report, **Your** Doctor must obtain **Your** consent before (s)he sends it to **Us**.

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 Malta, 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 8: 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 Services (Europe) 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 and referral rights
  - law and jurisdiction of the **Plan**
  - language of the **Plan** and **Our** service
  - compensation arrangements
  - Now Health International Services (Europe) Limited is acting on behalf of Starr Europe Insurance 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 Services (Europe) 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): / /