NOW HEALTH INTERNATIONAL

Intermediary application form

Please complete this form in BLOCK CAPITALS.

Please send **Your** completed application form 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: Intermediary details

1.1 Full legal name of intermediary:

1.2 Place of registration:

1.3 Business registration number (a copy of registration certificate is required):

1.4 Date of registration (dd/mm/yyyy): / /

1.5 Registered address:

1.6 Trading address (if different from 1.5):

1.7 Website address:

Section 2: Intermediary relationship holder details

2.1 Responsible person for application:

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 Telephone: | 2.3 Fax:

2.4 Email:

Section 3: Intermediary contact details

3.1 Contact person for future business operation (if different from Section 2)

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.)*

3.2 Telephone: | 3.3 Fax:

3.4 Email:

Section 4: Authorisations

4.1 Name of body that regulates your insurance intermediary activity (a copy of current authorisation required):

4.2 Date of authorisation (dd/mm/yyyy): / /

4.3 Has your firm or any of its staff been subject to disciplinary action or investigation by regulators? If yes, please provide details:

4.4 Has the firm, directors or senior managers been convicted of any criminal offence? If yes, please provide details:

4.5 Has the firm, directors or senior managers been subject to insolvency or bankruptcy proceedings or come to any agreement with creditors over unpaid debts? If yes, please provide details:

4.6 Does your firm have arrangements in place to prevent bribery and corruption, money laundering and breaches of sanctions policies and violations of the modern slavery legislation? If yes, please provide details:

4.7 Has your firm had any previous record of, or does it anticipate any infringement of bribery and corruption, money laundering, sanctions or modern slavery requirements? If yes, please provide details:

4.8 What is the scope of your authorisation and/or your authorised business line(s)? Please provide details:

4.9 What is the geographic limitation of your authorisation? Please provide details:

4.10 Do you have a valid professional indemnity policy to cover your activity? (A copy of your current policy schedule is required.)

4.11 Please provide the names, qualifications and experience of your senior executives:

4.12 Has your firm ever had any agencies with an insurance company refused or cancelled? If yes, please give details:

4.13 Is your firm registered with a data protection agency? Please provide your registration number and details of how this can be checked:

Section 5: Industry experience

5.1 What is your experience in health insurance? Please provide details:

5.2 What is your average gross premium written in health insurance during the last 24 months?

5.3 Please provide the contact details of two major suppliers for us to take references:

5.4 Bank details (include IBAN number and Swift code) for commission/brokerage payments:

Bank Name:	
Account Name:	
Bank account number:	Sort code:
IBAN number:	
Swift code:	
Bank Address:	

Section 6: Important notes

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 7: Declaration

We declare that answers and statements given in this application are accurate to the best of **Our** knowledge and undertake to inform Now Health International Services (Europe) Limited of any material change of circumstances promptly.

We further declare that **We** have the necessary licence and authorisation to carry and advise plans managed by Now Health International Services (Europe) Limited in the market **We** operate.

Signature:	**Date** (dd/mm/yyyy):
	/ /

Official stamp: