

SimpleCare application form: Groups

For company use – intermediary details and stamp								
Intermediary company:	Fax number:							
	Email address:							
Contact name:	Official stamp:							
Telephone number:								
To be completed by the employer (the Planholder). Please complete this form using BLOCK CAPITALS. A deliberate or reckless misrepresentation by You may lead to Us voiding Your membership. Where You make a careless misrepresentation We may void Your Group 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 Group Plan). You should ensure that You complete Your application carefully, accurately and fairly. If You are unsured 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/Entry Date , anythoccurs which affects the information You provided in this form, such as a change in the state of health of any of Your 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 and submit it along with Your incorporation certificate (trade license) to Us via Your intermediary, or direct Now Health International Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta. You can also scan it and email it to EuropeSales@now-health.com.								
Section 1: Start Date								
Cover cannot start until You have accepted all of Our terms and conditions fo premium. You can apply for cover to start at a future date within 60 days of co	llowing Our receipt of this application form and We have received the correct ompletion of this application form.							
The date the Group Plan will start from (dd/mm/yyyy):	/							
Section 2: Company details								
Company name:								
Company address:								
Company registration number:								
Other countries where You do business/have operations:								
Company website address:	Type of business:							
Is the Company, any party connected to the Company or any employees, their family members or close associates, a politically exposed person? Is any party connected to the Company, any employees, their family members or close associates, a politically exposed person? Yes O No								
Are all directors included in Your intended membership? (If not please list all a	additional directors) Yes No							
Are all Ultimate Beneficial Owners of the Company included in the intended m (natural persons owning more than 5%):	nembership (If not please list all Ultimate Beneficial Owners) Yes O No O							

Section 3: Company Plan Administrator details						
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.)						
ob title:						
Address (if different from above):						
Telephone:	Fax:					
Email address:						
Section 4: Our environmental policy – Your doci	ument delivery settings					
	omene deavery seemigs					
You can use Your secure online portfolio to view and d	download Your Plan documents, includ	ding Your Certificate of In	surance			
You can use Your secure online portfolio to download	Your virtual membership card.					
Add Your membership card to Your smartphone wallet						
Add Your membership card to Your smartphone wallet						
Add Your membership card to Your smartphone wallet						
Add Your membership card to Your smartphone wallet Section 5: Group Plan options						
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Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit	SimpleCare CORE USD 1,000,000/ EUR 800,000/	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit Annual Maximum Plan Limit	SimpleCare CORE USD 1,000,000/ EUR 800,000/	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit Annual Maximum Plan Limit Geographical Area of Cover Default Area of Cover: Europe	SimpleCare CORE USD 1,000,000/ EUR 800,000/	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit Annual Maximum Plan Limit Geographical Area of Cover Default	SimpleCare Benefit S SimpleCare CORE USD 1,000,000/ EUR 800,000/ GBP 625,000	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/ GBP 937,500	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit Annual Maximum Plan Limit Geographical Area of Cover Default Area of Cover: Europe In-Patient and Day-Patient care	SimpleCare CORE USD 1,000,000/ EUR 800,000/ GBP 625,000	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/ GBP 937,500	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
Section 5: Group Plan options For detailed information about the Group Plan choices available, pl Deductible, and any additional options. 5.1 Choice of Group Plan Benefit Annual Maximum Plan Limit Geographical Area of Cover Default Area of Cover: Europe In-Patient and Day-Patient care Day-Patient or Out-Patient surgery	SimpleCare CORE USD 1,000,000/ EUR 800,000/ GBP 625,000	SimpleCare 100 USD 1,500,000/ EUR 1,200,000/ GBP 937,500	SimpleCare 250 USD 1,500,000/ EUR 1,200,000/			
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 $\mathsf{USD} \ \bigcirc$

EUR \bigcirc

Choice of currency

 $\mathsf{GBP} \ \bigcirc$

5.2 Geographical Area of Cover Options	CORE	100	250		CORE	100	250
Area of Cover: Worldwide Excluding USA	0	0	0	Regional Cover#: Europe (excluding United Kingdom, Germany and Switzerland) (residents of Europe)	0	0	0

 [#] 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.

5.3 Group 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	0	0	0
USD 150/EUR 120/GBP 95	0	0	0
USD 250/EUR 200/GBP 155	0	0	0
USD 1,000/EUR 800/GBP 625	0	0	0
USD 2,500/EUR 2,000/GBP 1,550	0	0	0
USD 5,000/EUR 4,000/GBP 3,125	0	0	0
USD 10,000/EUR 8,000/GBP 6,250	0	0	0
USD 15,000/EUR 12,000/GBP 9,375	0	0	0

5.4 Out-Patient options**	SimpleCare CORE	SimpleCare 100	SimpleCare 250
USD 25/EUR 20/GBP 15 Out-Patient Per Visit Excess	N/A	0	0
20% Co-Insurance Out-Patient Treatment	N/A	0	0

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 **Group 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 Plan. You can only select such Deductible options if You buy this Group 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.

5.5 Additional Options	SimpleCare CORE	SimpleCare 100	SimpleCare 250
Removal of Drugs and Dressings Limit (for compulsory Group Plans 3+ employees)	N/A	N/A	0
Wellness & Vaccinations - Option 1 # (combined limit up to USD 150/EUR 120/GBP 95) (for compulsory Group Plans 3+ employees)	N/A	0	0
Wellness & Vaccinations - Option 2 # (combined limit up to USD 250/EUR 200/GBP 155) (for compulsory Group Plans 3+ employees)	N/A	0	0
Maternity - Option 1 (Normal Pregnancy and Childbirth up to USD 5,000/EUR 4,000/GBP 3,125) (for compulsory Group Plans 10+ employees)	N/A	0	0
Maternity - Option 2 (Normal Pregnancy and Childbirth up to USD 7,000/EUR 5,600/GBP 4,375) (for compulsory Group Plans 10+ employees)	N/A	0	0

[#] Please note Wellness & Vaccinations options can only be taken if You select a Deductible option of USD500/EUR400/GBP310 or lower.

Section 6: 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.

	Annually	Semi-annually	Quarterly	Monthly
Bank transfer	0	0	0	N/A

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

	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 7: Medical Insurance Details								
7.1 Do You currently provide private medical insurance for Your ground If yes, please give details below:		Yes 🔾	No 🔾					
Policy no.:	Date cover expires/expired (dd/mm/yyyy):	/	/					
Name of Insurer:								
7.2 Do You intend to continue with the existing insurance?		Yes 🔾	No 🔾					
7.3 Do You intend to buy this Group Plan as a Secondary Health I	Yes 🔾	No 🔾						
· · · · · · · · · · · · · · · · · · ·	If You buy this Group Plan as a Secondary Health Insurance Plan, You must provide a copy of the Certificate of Insurance of Your Group members' Primary Health Insurance policy. If You have more than one health insurance policy, this Group Plan will be the health insurance policy that pays last.							

All Medical Underworking (IPMU is the process where the Underwriters as to 19 High parts of the chinachos Curbon Control Contr	2. Family name 3. What do they like to be called? 3. What do they like to be called? 3. What do they like to be called? 4. What do they like to be called? 5. Cender 5. Date of birth (dd/mm/yyyy) 6. Cender 6. Date of birth (dd/mm/yyyy) 7. Employee category 7. Employee category 7. Employee category 7. Start date of employment (employees only) 7. Employees complete this section if you currently provide or have provided medical insurance previously to your Group members. 7. Otherwise, please go to Section 9.2. 7. Details of any claims over USD 20,000/EUR 16,000/GBP 12,500 for any one Medical Condition in the last three years: 7. Details of any planned Treatment for cancer, heart surgery, In-Patient psychiatric conditions, congenital conditions, renal failure or back surgery. 7. Details of any planned Treatment for cancer, heart surgery, In-Patient psychiatric conditions, congenital conditions, renal failure or back surgery. 7. Details of any planned Treatment for cancer, heart surgery, In-Patient psychiatric conditions, congenital conditions, renal failure or back surgery. 7. Details of any planned Treatment for cancer, heart surgery, In-Patient psychiatric conditions, congenital conditions, renal failure or back surgery. 7. Details of any planned Treatment for cancer, heart surgery In-Patient psychiatric conditions, congenital conditions, renal failure or back surgery. 7. Section 10: Eligibility 8. Section 10: Eligibility 8. Section 10: Eligibility 9. Start Date for New Employees: 9. Outputsory	Please note: If a M Section 10: E Please define the r	ledical Condition	on is dec	ers, general employees Voluntary Employees and Dependants	t psychiatric o	conditions, co	e for New Employed	Number of members Page 25: The state of the surgery:	
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If **We** have accepted the **Group Plan** on the basis that it is compulsory group and subsequently find out that the **Group Plan** is on a voluntary basis;

 $\ensuremath{\mathbf{We}}$ reserve the right to adjust the premium.

Section 11: 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 consen

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.

\bigcirc I consent \bigcirc 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 Your 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 12: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a Now Health International Group Plan as specified above.

I have received and read the **Benefit Schedule**, Terms and Conditions, Definitions, **Benefits** and exclusions of this **Group Plan**. I understand that the Application Form, Group Agreement, **Certificate of Insurance**, **Benefit Schedule** and the Members' Handbook incorporating the **Group Plan** terms and conditions make up the contract between **Us** and all form part of the **Group 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 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**.
- · I declare that I have read and understood the following from the members' handbook and Group Agreement:
 - cancellation and termination rights
 - complaints procedures and referral rights
 - law and jurisdiction of the Group Plan
 - language of the Group 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
 Group Plans, receiving premiums and paying claims.
- I understand that Now Health International cannot be liable and therefore will not pay claims if my **Group 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 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 **Group Plan** and **Group** Agreement.

Signature (Authorised person/Plan Administrator):	Date (dd/mm/yyyy):	
	/ /	

Now Health International Services (Europe) Limited is an enrolled insurance agent under the Insurance Distribution Act (Cap 487) to act as an Insurance Agent for Starr Europe Insurance Limited (C 85380) who is authorised by the Malta Financial Services Authority (MFSA) under the Insurance Business Act. Both entities are regulated by the MFSA. This Product is co-manufactured by Starr Europe Insurance Limited (Starr) and Now Health International Services (Europe) Limited (NHISEL). Starr Europe Insurance Limited provides the cover under this policy and is distributed by Now Health International Services (Europe) Limited.

Now Health International Services (Europe) Limited, Registered Office: Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta. Company No. C94330.

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