

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 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/Entry Date**, anything occurs 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 to 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 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.

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 No

Are all directors included in **Your** intended membership? (If not please list all additional directors) Yes No

Are all Ultimate Beneficial Owners of the Company included in the intended membership? (If not please list all Ultimate Beneficial Owners) (natural persons owning more than 5%): Yes No

Section 3: Company Plan Administrator details

First name(s):

Family name:

What do **You** like to be called?

*(If **You** 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.)*

Job title:

Address (if different from above):

Telephone:

Fax:

Email address:

Section 4: Our environmental policy – Your document delivery settings

- **You** can use **Your** secure online portfolio to view and download **Plan** documents, including **Your Certificate of Insurance**
- **You** can use **Your** secure online portfolio to download **Your** virtual membership card
- Add **Your** membership card to **Your** smartphone wallet

Section 5: Group Plan options

For detailed information about the **Group Plan** choices available, please refer to the WorldCare **Benefit Schedule**. Please indicate **Your Group Plan** choice, **Deductible**, and any additional options.

Choice of Group Plan

Benefit	Essential	Advance	Excel	Apex
Maximum annual limit	USD 3m/ EUR 2.4m/GBP 1.9m	USD 3.5m/ EUR 2.8m/GBP 2.2m	USD 4m/ EUR 3.2m/GBP 2.5m	USD 4.5m/ EUR 3.6m/GBP 2.8m
In-Patient and Day-Patient care	▶	▶	▶	▶
Organ Transplant	▶	▶	▶	▶
Cancer Treatment	▶	▶	▶	▶
Acute Medical Conditions during Pregnancy and childbirth	▶	▶	▶	▶
Evacuation and Repatriation	▶	▶	▶	▶
Day-Patient or Out-Patient surgery	▶	▶	▶	▶
Out-Patient Medical Practitioner fees	▶	▶	▶	▶
Rehabilitation	▶	▶	▶	▶
Congenital cover	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental Treatment	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
Please choose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency

USD

EUR

GBP

Group Plan Deductible

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**.

If **You** choose an Optional **Deductible**, on WorldCare Advance, WorldCare Excel or WorldCare Apex, **You** must also select an **Out-Patient Co-Insurance** Option or an **Out-Patient Per Visit Excess** Option. On WorldCare Essential if **You** choose an optional **Deductible** and an **Out-Patient Charges** Option, **You** must also select an **Out-Patient Co-Insurance** Option.

	Essential	Advance	Excel	Apex
Standard Deductible	Nil	Nil	Nil	Nil
Optional Deductible				
USD 1,000/EUR 800/GBP 625	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 2,500/EUR 2,000/GBP 1,550	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 5,000/EUR 4,000/GBP 3,125	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 10,000/EUR 8,000/GBP 6,250	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 15,000/EUR 12,000/GBP 9,375	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Out-Patient Per Visit Excess Option

USD 25/EUR 20/GBP 15	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 15/EUR 12/GBP 10	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional options

	Essential	Advance	Excel	Apex
USA elective Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical history disregarded (compulsory Group Plans 10+ employees only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation and Repatriation Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out-Patient Charges	<input type="checkbox"/>	N/A	N/A	N/A
Out-Patient Charges – Option 2	<input type="checkbox"/>	N/A	N/A	N/A
Out-Patient Charges – Option 3	<input type="checkbox"/>	N/A	N/A	N/A
10% Co-Insurance on Out-Patient Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% Co-Insurance on Out-Patient Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations (compulsory Group Plans 3+ employees only)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical Benefits and Vaccinations – option 2 (compulsory Group Plans 3+ employees only)	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Routine maternity cover for Advance Group Plan option (compulsory Group Plans 10+ employees only)	N/A	<input type="checkbox"/>	N/A	Already covered
Routine maternity cover with 20% Co-Insurance for Advance Group Plan option (compulsory Group Plans 10+ employees only)	N/A	<input type="checkbox"/>	N/A	Already covered
Dental cover for Group Plan option (compulsory Group Plans 10+ employees only)	<input type="checkbox"/>	<input type="checkbox"/>	Already covered	Already covered
Routine maternity cover for Excel Group Plan option (compulsory Group Plans 10+ employees only)	N/A	N/A	<input type="checkbox"/>	Already covered
Removal of Dental Co-Insurance	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* Please note that on WorldCare Essential a **Co-Insurance Out-Patient Treatment** Option can only be taken if **You** select an **Out-Patient Charges** Option.

Dental Care can only be taken if **You** select an **Out-Patient Charges**, **Out-Patient Charges -Option 2**.

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	CITIE2X	CITIE2X	CITIE2X
IBAN no.	IE46CITI99005133494416	IE77CITI99005133494343	IE80CITI99005133494386

Section 7: Previous Medical Insurance

Please complete this section if **You** have previously had private medical insurance for **Your** group members. Otherwise please go to section 8.

Policy no.:	Date cover expires/expired (dd/mm/yyyy):	/	/
Name of Insurer:			

Section 8: Underwriting Options

Full Medical Underwriting (FMU) <input type="checkbox"/>	Medical History Disregarded (MHD) <input type="checkbox"/>
Continued Personal Medical Exclusions (CPME) <input type="checkbox"/>	Continuous Transfer Terms (CTT) <input type="checkbox"/>

Full Medical Underwriting (FMU) is the process where the **Underwriters** assess the declared details in deciding if any special terms apply. For FMU, all members (employees and **Eligible Dependants**) are required to complete a WorldCare application form for group (FMU) employees and send it to Now Health International Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta.

Medical History Disregarded (MHD) is when **We** may be able to cover **Your** employees without asking detailed questions about their medical history up front. MHD is available for compulsory groups of 10 or more employees.

Continued Personal Medical Exclusions (CPME) is when **We** may be able to consider transferring **Your** employees, without a break in cover, from their previous insurer, without the need for **Your** employees to be asked further questions about their medical history up front. This means that any special acceptance terms applied by the previous insurer will be transferred to and governed by the terms and conditions of Now Health International **Plans**. In order for such a transfer to be considered, **We** will require **You** to complete a CPME Declaration Form, which will be assessed by **Our Underwriters**. **We** will also require a copy of each employee's expiring certificate from the previous insurer, showing their underwriting terms. CPME is available for compulsory groups of 5 or more members. CPME is not available for employees who were previously covered on either a MHD basis or a Moratorium basis with their previous insurer.

Continuous Transfer Terms (CTT) is when **You** are applying for one of **Our Group Plans** with **Benefits** similar to those of **Your** current policy and where the **Underwriters** assess the declared medical details and decide if **We** can offer **Your** members a Continuous Transfer. All members (employees and **Eligible Dependants**) are required to complete a WorldCare application form for group (CTT) employees and send it to Now Health International Services (Europe) Limited, Dragonara Business Centre 5th Floor, Dragonara Road, St Julian's, STJ 3141, Malta.

We need a full membership list as follows and it must include these details for each person to be covered (A template is available from www.now-health.com or by calling +356 2260 5100).

1. First name(s)
2. Family name
3. What do they like to be called?
*(If **Your** employee's full name is John Andrew Smith, he might like to be called John or Mr Smith or Andy. **We** will address all correspondence to him in this way.)*
4. Gender
5. Date of birth (dd/mm/yyyy)
6. Occupation
7. Employee category
8. **Entry Date** – first day of cover (dd/mm/yyyy)
9. **Country of Residence**
10. Nationality
11. Email address
12. Telephone no.
13. Relationship to primary insured
14. **Dependants** to be included
15. Start date of employment (employees only)

Section 9: Eligibility

Please define the member category:

Name of category e.g. directors, managers, general employees	All members	Number of members
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

- Compulsory or Voluntary
- Employees only or Employees and **Dependants**
- Expatriates** and/or Local Nationals
- Start Date for New Employees:
 First date of employment
 After _____ month(s) probation period

If cover choices vary according to the job position and there are more than five employees for each level, please provide details. For **Dependants** aged between 18 to 28 **We** may require written confirmation from their place of study that they are in full-time education.

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; **We** reserve the right to adjust the premium.

Section 10: 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, 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 Dependents** or employees and their **Dependents**, **You** represent and warrant that **You** have obtained consent from **Your** employees and their **Dependents** 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**.

Do **You** consent to use of **Your** contact details for the purpose of **Us** contacting **You** by email, phone or post about other products and services **We** think may be of interest to **You**? If **You** consent, please tick this box .

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 11: 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 even 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):

/ /