

## 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](http://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.

**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](mailto:EuropeSales@now-health.com).

## Section 1: Name of Planholder

First name(s):	Family name:
What do <b>You</b> 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 <i>(including country code)</i> :	
Is this <b>Your</b>	Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> <i>If <b>You</b> would like SMS notifications, please tell us <b>Your</b> mobile number:</i>
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy):      /      /
<b>Country of Residence:</b>	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are <b>You</b> 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 <input type="checkbox"/> No <input type="checkbox"/>	

### Section 3: Spouse and Dependant details

#### Spouse details

First name(s):	Family name:
What does he/she like to be called?	
Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:
Are <b>You</b> 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 <input type="checkbox"/> No <input type="checkbox"/>	

Dependant details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
First name(s):				
Family name:				
What do they like to be called?				
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Country of Residence:				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to <b>Planholder</b> :				
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 **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 WorldCare **Benefit Schedule**. Please indicate **Your Plan** choice, **Deductible**, and any additional options.

### (i) Choice of 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
<b>In-Patient</b> and <b>Day-Patient</b> care	▶	▶	▶	▶
<b>Organ Transplant</b>	▶	▶	▶	▶
<b>Cancer Treatment</b>	▶	▶	▶	▶
Acute <b>Medical Conditions</b> during <b>Pregnancy</b> and childbirth	▶	▶	▶	▶
<b>Evacuation</b> and <b>Repatriation</b>	▶	▶	▶	▶
<b>Day-Patient</b> or <b>Out-Patient</b> surgery	▶	▶	▶	▶
<b>Out-Patient Medical Practitioner</b> fees	▶	▶	▶	▶
<b>Rehabilitation</b>	▶	▶	▶	▶
Congenital cover	▶	▶	▶	▶
<b>Chronic Condition</b> cover	▶	▶	▶	▶
Routine and complex dental <b>Treatment</b>	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
<b>Please choose</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

▶ Full refund    ▶ Not covered    ▶ Limited cover

Choice of currency	USD <input type="checkbox"/>	EUR <input type="checkbox"/>	GBP <input type="checkbox"/>
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### (ii) Plan Deductible

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** USD 150/EUR 120/GBP 95, USD 250/EUR 200/GBP 155, USD 500/EUR 400/GBP 310, USD 1,000/EUR 800/GBP 625, USD 2,500/EUR 2,000/GBP 1,550 or USD 5,000/EUR 4,000/GBP 3,125 and an **Out-Patient Charges** Option or **Out-Patient Charges** – Option 2, **You** must also select an **Out-Patient Co-Insurance** Option.

	Essential	Advance	Excel	Apex
Standard <b>Deductible</b>	Nil	Nil	Nil	Nil
Optional <b>Deductible</b>				
USD 150/EUR 120/GBP 95	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 250/EUR 200/GBP 155	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
USD 500/EUR 400/GBP 310	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>
<b>Out-Patient Per Visit Excess</b> 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"/>

### (iii) Additional options

	Essential	Advance	Excel	Apex
USA elective <b>Treatment</b> ^	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10% <b>Co-Insurance</b> on <b>Out-Patient Treatment</b>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20% <b>Co-Insurance</b> on <b>Out-Patient Treatment</b>	<input type="checkbox"/> *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Out-Patient Charges</b>	<input type="checkbox"/>	N/A	N/A	N/A
<b>Out-Patient Charges</b> – Option 2	<input type="checkbox"/>	N/A	N/A	N/A
<b>Out-Patient Charges</b> – Option 3	<input type="checkbox"/> ∞	N/A	N/A	N/A
Extended <b>Evacuation</b> and <b>Repatriation</b> Option	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical <b>Benefits</b> and <b>Vaccinations</b> ∅	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness, optical <b>Benefits</b> and <b>Vaccinations</b> – Option 2	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness and <b>Vaccinations</b> – Option 3 ∅	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Care	<input type="checkbox"/> #	<input type="checkbox"/>	Already covered	Already covered
Removal of Maternity	N/A	N/A	N/A	<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 or **Out-Patient Charges** Option 2.

∞ No **Out-Patient Co-Insurance** Option and **Out-Patient Per Visit Excess** Option is allowed for WorldCare Essential with **Out-Patient Charges** – Option 3 as **Out-Patient Charges** – Option 3 on WorldCare Essential is subject to default USD 25/EUR 20/GBP 15 **Out-Patient Per Visit Excess**.

# Dental Care can only be taken on WorldCare Essential if **You** select an **Out-Patient Charges** or **Out-Patient Charges** – Option 2.

^ US elective **Treatment** is not available if **You** selected an optional Regional Cover.

∅ WorldCare Essential when **Out-Patient Charges** -Option 1 or 2 has been selected.

(iii) Additional options We provide regional cover according to Your Country of Residence.

Essential

Advance

Excel

Apex

Regional Cover Options

Europe (excluding United Kingdom, Germany and Switzerland)  
(residents of Europe)

^ US elective Treatment is not available if You selected an optional Regional Cover.

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

Section 8: Claim reimbursement method

Bank transfer is the most secure and quickest method to receive claim reimbursement payments.

For bank transfer

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

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

9.4 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 <b>You</b> in the last five years ever undergone any <b>Surgical Procedure</b> , been a patient or been treated in a <b>Hospital</b> , clinic, sanatorium, nursing home or other medical institution where <b>You</b> were off work for more than one week, and/or received more than 10 days <b>Treatment</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.2 Are <b>You</b> currently taking any kind of medication (other than oral contraceptives), or is any <b>Treatment</b> or tests currently being performed or planned, or any day or <b>In-Patient</b> hospitalisation scheduled?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.4 Anxiety, depression, psychological, psychiatric, mental condition, drug or alcohol addiction or abuse?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.5 Blood disorders, anaemia, haemophilia, thalassemia or other abnormal blood tests? Have <b>You</b> ever been tested positive for HIV, Hepatitis B or C?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.6 <b>Cancer</b> , cyst, polyp, or any abnormal growth whether cancerous or benign?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.7 Digestive disorder including stomach, colon, rectum, hernia or any other bowel problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.8 Disorders of the kidneys, spleen, liver, pancreas, bladder, prostate, renal or recurrent urinary conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.9 Diabetes, thyroid disorders or weight management problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.10 Epilepsy, multiple sclerosis or other neurological conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.11 High blood pressure, heart or circulatory conditions, stroke or higher than normal cholesterol level?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.12 Knee, back or skin disorders, rheumatism, gout, arthritis or disease of the bone, spine, joint, muscle?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.13 Any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, major injury or <b>Medical Condition</b> not already noted above?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10.14 Have <b>You</b> ever suffered from any breast or gynaecological disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

## 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/ Medication 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

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 Dependents** 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](http://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](mailto: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 **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 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, 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):**

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