NOW HEALTH INTERNATIONAL

WorldCare 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.

You must disclose all material facts. Failure to do so may invalidate the **Group Plan**. A material fact is one which is likely to influence the assessment and acceptance of this application. If **You** are in any doubt whether a fact is material, **You** should disclose it. **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.

Please send **Your** completed application form to **Us** via **Your** intermediary, or direct to Now Health International (Europe) Limited, Suite G3/4, Coliseum Building, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom. **You** can also scan it and email it to EuropeSales@now-health.com or fax it to +44 (0) 1276 602120.

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:

Company website address:	Type of business:

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.)*

Job title:

Address (if different from above):

Telephone:	Fax:

Email address:

Section 4: Document delivery settings

How would **You** like **Your** and **Your** employees' **Group Plan** documents delivered? In **Your** online secure portfolio area ☐ Printed and delivered to **You** by post ☐

As an international organisation, **We** are aware of the impact that printing and shipping has on the environment. **We** are committed to reducing **Our** carbon footprint by printing on sustainably sourced materials and ask **You** to access **Your** documents online only. **We** will print them however if **You** tick the appropriate box above. Regardless of which option **You** choose, **Your** employees will always receive a physical membership card.

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, **Excess,** 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	☐	☐	☐	☐

▶ Full refund ▶ Not covered ▶ Limited cover

Choice of currency	USD ☐	EUR ☐	GBP ☐

Group Plan Excess

If **You** would like to change from the Standard **Excess** to one of the other options, please tick the appropriate box. Please note that the **Group Plan Excess** is per **Insured Person**, per **Medical Condition**, per **Period of Cover**.

	Essential	**Advance**	**Excel**	**Apex**
Standard **Excess**	Nil	USD 100/ EUR 80/GBP 60	USD 100/ EUR 80/GBP 60	USD 100/ EUR 80/GBP 60
Optional **Excess**				
Nil	N/A	☐	☐	☐
USD 50/EUR 40/GBP 30	N/A	☐	☐	☐
USD 250/EUR 200/GBP 155	N/A	☐	☐	☐
USD 500/EUR 400/GBP 310	N/A	☐	N/A	N/A
USD 1,000/EUR 800/GBP 625	☐	☐	N/A	N/A
USD 2,500/EUR 2,000/GBP 1,550	☐	☐	N/A	N/A
USD 5,000/EUR 4,000/GBP 3,125	☐	N/A	N/A	N/A
USD 10,000/EUR 8,000/GBP 6,250	☐	N/A	N/A	N/A
USD 15,000/EUR 12,000/GBP 9,375	☐	N/A	N/A	N/A

Additional options

	Essential	**Advance**	**Excel**	**Apex**
USA elective **Treatment**	☐	☐	☐	☐
Medical history disregarded (compulsory **Group Plans** 10+ employees only)	☐	☐	☐	☐
Out-Patient Charges	☐	N/A	N/A	N/A
Out-Patient Per Visit **Excess***	N/A	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment**	N/A	☐	☐	☐
Wellness, optical **Benefits** and vaccinations (compulsory **Group Plans** 3+ employees only)	N/A	☐	☐	☐
Wellness, optical **Benefits** and vaccinations - option 2 (compulsory **Group Plans** 3+ employees only)	N/A	☐	☐	☐
Routine maternity cover for Advance **Group Plan** option (compulsory **Group Plans** 10+ employees only)	N/A	☐	N/A	Already covered
Routine maternity cover with 20% **Co-Insurance** for Advance **Group Plan** option (compulsory **Group Plans** 10+ employees only)	N/A	☐	N/A	Already covered
Dental cover for Advance **Group Plan** option (compulsory **Group Plans** 10+ employees only)	N/A	☐	Already covered	Already covered
Routine maternity cover for Excel **Group Plan** option (compulsory **Group Plans** 10+ employees only)	N/A	N/A	☐	Already covered

* **We** have a network of medical providers who will settle **Out-Patient** claims directly with **Us**. If **You** choose this option, **Your** employees can access the **Out-Patient Direct Billing** network but they must pay the first USD 25/EUR 20/GBP 15 of any **Eligible Out-Patient** claim. Not available with the WorldCare Essential **Out-Patient** Charges additional option.

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
Cheque	☐	☐	☐	N/A
Bank transfer	☐	☐	☐	N/A

Cheque: Please make **Your** cheque payable to Now Health International (Europe) Limited and attach it to this application form.
Bank transfer: Please make sure **You** tell **Us Your** company name in the transfer details and send it to the appropriate bank account below:

	USD account	EUR account	GBP account
Bank	Citibank	Citibank	Citibank
Bank account name	Now Health Intl (Europe) Ltd	Now Health Intl (Europe) Ltd	Now Health Intl (Europe) Ltd
Address	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom	25 Canada Square, Canary Wharf, London, E14 5LB, United Kingdom
Account no.	12682281	12682214	12682249
Sort code	18-50-08	18-50-08	18-50-08
Swift code	CITIGB2L	CITIGB2L	CITIGB2L
IBAN no.	GB11CITI18500812682281	GB74CITI18500812682214	GB02CITI18500812682249

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:	
Details of claims over USD 30,000 for any one condition:	
The past three years' claims information (if available) must be provided for groups of 50+ members.	

Section 8: Underwriting Options

Full Medical Underwriting (FMU) ☐	Medical History Disregarded (MHD) ☐

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 (Europe) Limited, Suite G3/4, Coliseum Building, Watchmoor Park, Camberley, Surrey, GU15 3YL, United Kingdom.

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 members.

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 +44 (0) 1276 602100).

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
	☐	
	☐	
	☐	
	☐	
	☐	

Compulsory	☐	or	Voluntary	☐
Employees only	☐	or	Employees and **Dependants**	☐
Expatriates	☐	and/or	Local Nationals	☐

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 18 and over **We** may require written confirmation from their place of study that they are in full-time education.

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 **Group 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 **Group 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 Body Mass Indexes being within normal limits.

Data protection
We and the **Underwriters** will collect certain information about **You** in the course of considering **Your** application and, if a **Group Plan** is issued to **You**, conducting **Our** relationship with **You**. This information will be processed for the purposes of underwriting **Your** insurance coverage, managing any **Group Plan** issued and administering claims. **Your** information may be passed to **Underwriters, Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside the European Economic Area. The same duty of confidentiality is required of any third parties to whom the administration of **Your Group Plan** may be subcontracted, including those based outside the European Economic Area. **Your** name and contact details will not be disclosed to other organisations (except as stated above).

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. If **You** do not wish this to happen please tick this box ☐.

Access to Medical Reports Act 1988
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.

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 (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**.
- If I have indicated that I wish to pay by credit card, I authorise Now Health International to debit my account with the appropriate premiums on or before their due dates, and all subsequent renewal premiums due as invoiced by Now Health International until I give written notice that I wish to terminate this Agreement.
- 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 to the financial ombudsman service
  - law and jurisdiction of the **Group Plan**
  - language of the **Group Plan** and **Our** service
  - compensation arrangements
  - Now Health International (Europe) Limited is acting on behalf of AXA PPP healthcare 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 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**.

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