NOW HEALTH INTERNATIONAL | Tenet Sompo Insurance

WorldCare continuous transfer form

For company use – intermediary details and stamp

Intermediary company:	Fax number:
	Email address:
Contact/Adviser name:	Official stamp:
Telephone number:	

If **You** are applying for one of **Our Plans/Group Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer, which means that **We** will not ask for details about **Your/Your** employees' medical history and cover can continue. For any new **Benefits** the waiting period will apply. Any **Benefits** covered under **Your** previous policy but not covered under **Our Plan/Group Plan** will not be **Eligible** for cover following the transfer. Any endorsements that applied to **Your** existing policy will continue to apply to **Your** new **Plan/Group Plan**.

Please complete this form in BLOCK CAPITALS. **You** should attach a copy of **Your** existing policy schedule and certificate of insurance, detailing any endorsements and the **Start Date** of the existing policy.

You must disclose all material facts. Failure to do so may invalidate the **Plan/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 **Your** state of health or the state of health of any of **Your Dependants** or employees, **You** must tell **Us** in writing about the change.

If **You** have used an authorised insurance broker **You** understand, acknowledge and agree that by buying this **Plan**, **We** will pay the authorised insurance broker commission during the life of the **Plan** including renewals. **You** also understand that this agreement is necessary for **Us** to proceed with **Your** application.

Please send **Your** completed application form to **Us** via **You**r intermediary, or direct to Now Health International (Singapore) Pte. Ltd. c/o Tenet Sompo Insurance Pte. Ltd., 50 Raffles Place, #05-01/06 Singapore Land Tower, Singapore 048623. **You** can also scan and email it to SingaporeSales@now-health.com or fax it to +65 6220 6950.

Request to transfer from:

An existing Now Health International **Group Plan** to a Now Health International individual **Plan** – please complete sections 1, 2, 4 – 9a	☐
Another insurer to a Now Health International individual **Plan** – please complete sections 1, 2, 4 – 9a	☐
An existing Now Health International individual **Plan** to a new Now Health International individual **Plan** – please complete sections 1, 2, 4 – 9a	☐
An existing Now Health International individual **Plan** to a Now Health International **Group Plan** – please complete sections 1 – 9b	☐
Another insurer to a Now Health International **Group Plan** – please complete sections 1 – 9b	☐

Section 1: Previous Medical Insurance

Policy no.:	Date cover expires/expired (dd/mm/yyyy): / /
Name of Insurer:	
Do **You** intend to continue with the existing insurance?	Yes ☐ No ☐

Section 2: Individuals and families/Group members

2.1 Name of Planholder

First name(s):	Family name:
What do **You** like to be called?	

*(If **Your** full name is John Andrew Smith, **You** might like to be called John or Mr Smith or Andy. **We** will address all correspondence to **You** in this way.)*

2.2 Planholder details

Address:	
Email address:	
Preferred telephone number *(including country code)*:	
Is this **Your** Mobile ☐ Home ☐ Work ☐	*If **You** would like SMS notifications, please tell us **Your** mobile number:*
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:

2.3 Spouse and Dependant details

Spouse details	
First name(s):	Family name:
What does he/she like to be called?	
Gender: Male ☐ Female ☐	Date of birth (dd/mm/yyyy): / /
Country of Residence:	Nationality:
Height (cm/ft):	Weight (kg/lbs):
Occupation:	Occupation industry:

Dependant details	**Dependant 1**	**Dependant 2**	**Dependant 3**	**Dependant 4**
First name(s):				
Family name:				
What does he/she like to be called?				
Gender:	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐	Male ☐ Female ☐
Date of birth (dd/mm/yyyy):	/ /	/ /	/ /	/ /
Country of Residence:				
Nationality:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to **Planholder**:				
Occupation (ages 16+):				

2.4 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**, hayfever, uncomplicated fractures, or appendicectomy.

	Planholder	**Dependant (Spouse)**	**Dependant 1**	**Dependant 2**	**Dependant 3**	**Dependant 4**
2.4.1 Have **You** in the last five years ever undergone any **Surgical Procedure**, been a patient or been treated in a **Hospital**, clinic, sanatorium, nursing home or other medical institution where **You** were off work for more than one week, and/or received more than 10 days' **Treatment**?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2.4.2 Are **You** currently taking any kind of medication (other than oral contraceptives), or is any **Treatment** or tests currently being performed or planned, or any day or **In-Patient** hospitalisation scheduled?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
2.4.3 Have **You** ever suffered from, or been diagnosed with, hospitalised for, received **Treatment**, tests or investigations for any type of disease, physical impairment, congenital or hereditary disorder, disability, recurrent illness, currently pregnant, major injury or **Medical Condition** not already noted above?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Additional information

If **You** answered 'Yes' to any of questions 2.4.1 to 2.4.3, please provide details in the box below.

Name	Question number	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**.

2.5 Doctors 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:	

2.6 Claim reimbursement method

Please indicate how **You** would like to receive claim reimbursement payments. Bank transfer is the most secure and quickest method.

Cheque ☐ Bank transfer ☐

For bank transfer

Account holder's name:	Country:
Bank name:	
Bank address:	
IBAN or account no.:	
Routing code (e.g. Swift or sort code):	

Section 3: Companies

3.1 Company details

Company name:	
Company address:	
Company registration number:	
Company website:	Type of business:

3.2 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:	

3.3 Membership

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 +65 6880 2300).

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) (dd/mm/yyyy)

3.4 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 ☐

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

Section 4: Start Date

The date the **Plan/Group Plan** will start from (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: Document delivery settings

How would **You** like **Your** (and **Your** employees' if applicable) **Plan/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, **You** and/or **Your** employees will always receive a physical membership card.

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 note that quarterly premiums carry a 3% surcharge and monthly premiums carry a 5% surcharge.

Individuals and families	Annually	Semi-annually	Quarterly	Monthly
Cheque	☐	N/A	N/A	N/A
Credit card	☐	☐	☐	☐
Bank transfer	☐	N/A	N/A	N/A

Companies	Annually	Semi-annually	Quarterly	Monthly
Cheque	☐	☐	☐	N/A
Bank transfer	☐	☐	☐	N/A

Cheque: Please make **Your** cheque payable to Now Health International (Singapore) Pte. Ltd. and attach it to this application form.
Credit card: Visa, MasterCard and American Express can be accepted. Please complete the Credit Card Authority.
Bank transfer: Please make sure **You** tell **Us Your** family or company name in the transfer details and send it to the bank account below.

	USD account
Bank	Citibank N.A. Singapore Branch
Bank code	N/A
Branch code	N/A
Bank account name	Now Health International (Singapore) Pte. Ltd
Address	8 Marina View 21-01 Asia Square Tower 1 Singapore 018960
Account no.	0857607031
Swift code	CITISGSG

Section 7: Plan options

For detailed information about the **Plan/Group Plan** choices available, please refer to the WorldCare **Benefit Schedule**. The currency **You** pay **Your** premium in is chosen for **You** by **Your Country of Residence** and the **Plan/Group Plan Excesses** will also be denominated in this currency. Please indicate **Your Plan/Group Plan** choice, **Excess,** and any additional options.

Choice of **Plan/Group Plan**

Benefit	Essential	Advance	Excel	Apex
Maximum annual limit	USD 3m	USD 3m	USD 3m	USD 3m
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 disorders	▶	▶	▶	▶
Chronic Condition cover	▶	▶	▶	▶
Routine and complex dental **Treatment**	▶	▶	▶	▶
Routine maternity cover	▶	▶	▶	▶
Please choose	☐	☐	☐	☐

▶ Full refund ▶ Not covered ▶ Limited cover

Plan/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 **Plan/Group Plan Excess** is per **Insured Person**, per **Medical Condition**, per **Period of Cover**.

	Essential	Advance	Excel	Apex
Standard **Excess**	Nil	USD 100	USD 100	USD 100
Optional **Excess**				
Nil	N/A	☐	☐	☐
USD 50	N/A	☐	☐	☐
USD 250	N/A	☐	☐	☐
USD 500	N/A	☐	N/A	N/A
USD 1,000	☐	☐	N/A	N/A
USD 2,500	☐	☐	N/A	N/A
USD 5,000	☐	N/A	N/A	N/A
USD 10,000	☐	N/A	N/A	N/A
USD 15,000	☐	N/A	N/A	N/A

Additional options

	Essential	Advance	Excel	Apex
USA elective **Treatment**	☐	☐	☐	☐
Hospital room restriction in Singapore and Hong Kong	☐	☐	☐	☐
Out-Patient Per Visit **Excess***	N/A	☐	☐	☐
10% **Co-Insurance** on **Out-Patient Treatment**	N/A	☐	☐	☐
20% **Co-Insurance** on **Out-Patient Treatment**	N/A	☐	☐	☐
Out-Patient Charges	☐	N/A	N/A	N/A
Out-Patient Charges - Option 2	☐	N/A	N/A	N/A

Additional options for companies

	Essential	Advance	Excel	Apex
Medical history disregarded (compulsory **Group Plans** 10+ employees only)	☐	☐	☐	☐
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 of any **Eligible Out-Patient** claim. Not available with the WorldCare Essential **Out-Patient** Charges additional option.

Section 8: Important notes

Buying health insurance products that are not suitable for **You** may impact **Your** ability to finance **Your** future healthcare needs. **You** should seek advice from **Us** or a qualified adviser if in doubt before **You** sign this application form. Should **You** choose not to, **You** are taking sole responsibility to ensure that this product is appropriate to **Your** financial needs and insurance objectives.

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with Now Health International **Plan/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 **Plan/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 Your Body Mass Index being within normal limits.

Data Privacy

We and **Your Underwriters** collect personal information about **You** and **Your Dependants** (including health, bank account and occupation) in the course of considering **Your** application and, if a **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 **Plan** issued and administering claims. **Your** information may be passed to Now Health group companies administering **Your Plan, Underwriters**, **Medical Practitioners**, Medical Assistance Companies and Claims Administrators for these purposes, including those located outside Singapore. The same duty of confidentiality is required of any third parties to whom the administration of **Your Plan** may be subcontracted, including those based outside Singapore. **Your** personal details will not be disclosed to other organisations 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.

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.

Now Health International group companies providing IPMI products may contact **You** by letter, SMS or email with details of other IPMI or related products and services, which may be of interest to **You**. If **You** wish this to happen please tick this box ☐. **You** may opt out of future marketing by contacting **Us** at any time. A list of Now Health group companies, their contact details and **Our** Data Privacy Policy is available at www.now-health.com.

Section 9: Declaration and authorisation

Section 9a: Declaration and authorisation for individuals and families

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, rescission of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Singapore) Pte. Ltd. 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 "Your Guide to Health Insurance" Booklet, and the Members' Handbook which contains Product Information and Key Product Provisions, details of my rights and **Your** obligations to me:
  – cancellation and termination rights
  – complaints procedures
  – law and jurisdiction of the **Plan**
  – language of the **Plan** and **Our** service
  – compensation arrangements
  – **Plans** are underwritten by Tenet Sompo Insurance Pte. Ltd. and Now Health International (Singapore) Pte. Ltd. is acting on behalf of Tenet Sompo Insurance Pte. Ltd. for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- 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 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 have consent from all my dependants covered under the **Plan** to administer additions and deletions and review claim payment reports on their behalf.
- I acknowledge that if it is determined by Now Health International that a claim was fraudulent my **Plan** may be terminated 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 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**.

Section 9b: Declaration and authorisation for companies

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, rescission of **Benefits** and legal damages.
- I understand that I must notify Now Health International (Singapore) Pte. Ltd. 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 "Your Guide to Health Insurance" Booklet, Group Agreement and the Members' Handbook which contains Product Information and Key Product Provisions, details of my rights and **Your** obligations to me:
  – cancellation and termination rights
  – complaints procedures
  – law and jurisdiction of the **Group Plan**
  – language of the **Group Plan** and **Our** service
  – compensation arrangements
  – **Plans** are underwritten by Tenet Sompo Insurance Pte. Ltd. and Now Health International (Singapore) Pte. Ltd. is acting on behalf of Tenet Sompo Insurance Pte. Ltd. for the purposes of issuing and administering **Plans**, receiving premiums and paying claims.
- I have consent from all my dependants covered under the **Plan** to administer additions and deletions and review claim payment reports on their behalf.
- 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 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**.

Signature (Insured/main applicant for individual Plans)
(Authorised person/Plan Administrator for company Plans):

Date (dd/mm/yyyy): / /

Signature & Name of Adviser: /

Date (dd/mm/yyyy): / /

Now Health International (Europe) Limited can arrange annual international private medical insurance products through Now Health International (Singapore) Pte. Ltd and will collect payment by credit card for onward settlement to them. Now Health International (Europe) Limited is authorised and regulated by the Financial Conduct Authority (FCA). **Our** FCA registered number is 7121668. This information can be checked at the FCA website at: http://www.fsa.gov.uk/register/home.do

Now Health International (Europe) Limited can offer the products of a single but distinct insurer in each region in which **We** have group companies. **You** will not receive advice or a recommendation from **Us** on the policies **We** offer. **We** may ask questions to narrow down the selection of products that **We** will provide details on. **You** will then need to make your own choice about how to proceed.

We will not charge **You** a fee without first disclosing and agreeing this with **You** in advance. **You** will receive a quotation in advance of purchasing a product.
If **You** wish to register a complaint, please contact:

The Managing Director
Now Health International (Europe) Limited
Suite G3/4, Coliseum Building
Watchmoor Park
Camberley
Surrey, GU15 3YL, United Kingdom
Tel: +44(0) 1276 602110
Fax: +44(0) 1276 602130
Email: EuropeService@now-health.com

If **You** cannot settle your complaint with **Us**, **You** may be entitled to refer it to the Financial Ombudsman Service who can be contacted at:

The Financial Ombudsman Service
South Quay Plaza
183 Marsh Wall
London E14 9SR
Telephone: 0845 080 1800
Email: complaint.info@financial-ombudsman.org.uk
Website: www.financial-ombudsman.org.uk

We are covered by the FSCS. **You** may be entitled to compensation from the scheme if **We** cannot meet **Our** obligations. This depends on the type of business and the circumstances of the claim. Insurance advising and arranging is covered for 90% of the claim, without any upper limit.

Where **We** act on your behalf **We** shall hold premiums due to insurers, any claims payments and/or premium refunds due to **You** as client money ("Client Money"). During the provision of the Services to **You**, **We** will deposit all payments received in respect of Client Money in a statutory trust bank account that complies with FCA Rules ("Trust Account"). These regulations seek to protect clients against any inability of an insurance broker to transfer premiums to an insurer or to transfer claims payments and/or premium refunds to the client.

Where **We** act on insurers' behalf **We** shall hold money as insurer money ("Insurer Money"). Premiums received by **Us** will be treated as having been received by insurers whereas claims payments and/or premium refunds will only be treated as having been received by **You** when they are actually paid to **You**. In the normal course of business and within the standard terms of **Our** Trust Account(s) arrangements, **We** may place part of the Trust Monies into money market funds. **We** shall retain sole rights to all interest and earnings received on Trust Monies rather than pay them to **You**. Under the terms of the Trust Account(s) **We** are responsible for meeting any trust fund shortfalls arising from this.

We will pay premiums directly to insurers and receive premium refunds and/or claim payments directly from insurers or their representatives except where **We** have engaged the services of another intermediary or settlement agent in which case settlements may then be transferred between **Us** and the other intermediary or settlement agent. Should such an intermediary or settlement agent be located outside of the United Kingdom, payments will be made to and from their jurisdiction and will be subject to a legal and regulatory regime different from that of the United Kingdom**.** In the event of a failure of the intermediary or settlement agent, the Client Money may be treated differently from the Treatment which would have applied if it were held by an intermediary in the United Kingdom. **You** may notify **Us** if **You** do not wish your money to be passed to a person in a particular jurisdiction and **We** will consider making a payment to an alternative jurisdiction.

We may deposit Client Money in a client bank account outside the United Kingdom, unless **You** notify Us that **You** do not wish your money to be held in a particular jurisdiction. In such circumstances, the legal and regulatory regime applying to the approved bank will be different from that of the United Kingdom and, in the event of a failure of the bank, your money may be treated in a different manner from that which would apply if the money were held by a bank in the United Kingdom.

We believe the above arrangements provide **You** with significant and effective protection for Client Money. **Your** agreement to all aspects of these arrangements will be assumed unless an objection is registered with **Us** prior to your first remittance being received by **Us**.

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Section 10: Credit card authority

Visa ☐ MasterCard ☐ American Express ☐

Card number as it appears on **Your** card:				
Cardholder's name:				
Expiry date:	Start date:	CCV code:		

Once **Your** payment details have been processed, **Your** credit card details will be destroyed by **Us**. Please charge the above card:

Annually ☐	Semi-annually ☐	Quarterly ☐	Monthly ☐

I hereby authorise that the card account specified above may be debited with the current premium due and all subsequent renewal premiums due as notified by Now Health International until I give notice in writing that I wish to terminate this agreement. I understand that Now Health International will give at least six weeks' notice of renewal and that the premiums may vary each year. I understand that Now Health International cannot be held liable if my **Plan/Group Plan** is lapsed should the credit card be declined and I do not respond to requests for alternative methods of payment.

Signature (Insured/main applicant):	**Date** (dd/mm/yyyy):
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