

Change of contact information form

For company use – intermediary details and stamp

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

Please complete this form in BLOCK CAPITALS and send it to **Us** via **Your** intermediary, or direct to Arabia Insurance Company S.A.L., c/o Now Health International Gulf Third Party Administrators LLC, Offices 10, 11 and 12, Block D3, Xavier Business Centre, Level M2, Burj Nahar Mall, Deira, PO Box 334337, Dubai, United Arab Emirates.

You can also scan and email it to CustomerService@now-health.com or fax it to +971 (0) 4450 1416.

Section 1: Planholder's details

First name(s):	Family name:
Membership number:	

Section 2: What would You like to change?

Family name <input type="checkbox"/>	Address <input type="checkbox"/>	Email address <input type="checkbox"/>
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Family name

Old name:	New name:
Date the change to take effect from (dd/mm/yyyy): / /	

*Please note that **We** need a copy of the official document e.g. marriage certificate to update **Our** records*

Address

Old name:
New address:
Date the change to take effect from (dd/mm/yyyy): / /

Address

Old email address:	New email address:
Date the change to take effect from (dd/mm/yyyy): / /	

Section 3: Important notes

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 Personal 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 administering **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**.

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 General 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

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**.

Signature (Insured/main applicant):

Date (dd/mm/yyyy):

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