

WorldCare continuous transfer form: Group Employee

For company use – intermediary details and stamp

Intermediary company:

Fax number:

Email address:

Contact name:

Official stamp:

Telephone number:

If **You** are applying for one of **Group Plans** with **Benefits** similar to those of **Your** current policy, **We** may be able to offer **You** a continuous transfer, which **Our** means that **We** will not ask for full details about **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 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 **Group Plan**.

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

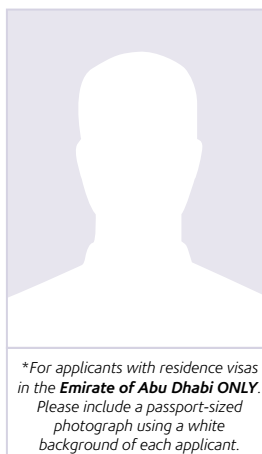
A deliberate or reckless misrepresentation by **You** may lead to **Us** voiding **Your** membership. Where **You** make a careless misrepresentation **We** may void **Your Group Plan** or decline or reduce related claim payments. A misrepresentation is an untrue statement of fact relied on by one party, 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 **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.

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 photograph(s) along with a copy of **Your** government issued identity document 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 MEAQuotes@worldcare.ae.



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: 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

Company name:

Group Plan number:

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 <input type="checkbox"/> Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy):	/	/
Marital status:	Married <input type="checkbox"/> Unmarried <input type="checkbox"/>	Country of Residence:		
Residential region: (e.g. Umm Suqeim First)	Nationality:			
Passport number:	UID (Visa) number:			
Emirates ID number: (000-0000-0000000-0)	Emirate of Visa issuance:			
Height (cm/ft):	Weight (kg/lbs):			
Occupation:	Occupation industry:			
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED <input type="checkbox"/>	4000 < 12,000 AED <input type="checkbox"/>	> 12,000 AED <input type="checkbox"/>	Unsalariated <input type="checkbox"/>
Commission based salary:	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are You 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"/>				

2.3 Spouse and Dependant details

Spouse details				
First name(s):	Family name:			
What does he/she like to be called?				
Email address:	Phone number:			
Gender:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of birth (dd/mm/yyyy):	/ /
Marital status:	Married <input type="checkbox"/>	Unmarried <input type="checkbox"/>	Country of Residence:	
Residential region: (e.g. Umm Suqeim First)	Nationality:			
Passport number:	UID (Visa) number:			
Emirates ID number: (000-0000-0000000-0)	Emirate of Visa issuance:			
Height (cm/ft):	Weight (kg/lbs):			
Occupation:	Occupation industry:			
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED <input type="checkbox"/>	4000 < 12,000 AED <input type="checkbox"/>	> 12,000 AED <input type="checkbox"/>	Unsalariated <input type="checkbox"/>
Commission based salary:	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?				
Email address:				

Phone number:				
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):	/ /	/ /	/ /	/ /
Marital status:	Married <input type="checkbox"/> Unmarried <input type="checkbox"/>	Married <input type="checkbox"/> Unmarried <input type="checkbox"/>	Married <input type="checkbox"/> Unmarried <input type="checkbox"/>	Married <input type="checkbox"/> Unmarried <input type="checkbox"/>
Country of Residence:				
Residential region: (e.g. Umm Suqeim First)				
Nationality:				
Passport number:				
Emirates ID number: (000-0000-0000000-0)				
UID (Visa) number:				
Emirate of Visa issuance:				
Height (cm/ft):				
Weight (kg/lbs):				
Relationship to Planholder :				
Occupation (ages 16+):				
Occupation industry:				
Work region: (e.g. Oud Metha)				
Monthly salary:	< 4,000 AED <input type="checkbox"/> 4000 < 12,000 AED <input type="checkbox"/> > 12,000 AED <input type="checkbox"/> Unsalaries <input type="checkbox"/>	< 4,000 AED <input type="checkbox"/> 4000 < 12,000 AED <input type="checkbox"/> > 12,000 AED <input type="checkbox"/> Unsalaries <input type="checkbox"/>	< 4,000 AED <input type="checkbox"/> 4000 < 12,000 AED <input type="checkbox"/> > 12,000 AED <input type="checkbox"/> Unsalaries <input type="checkbox"/>	< 4,000 AED <input type="checkbox"/> 4000 < 12,000 AED <input type="checkbox"/> > 12,000 AED <input type="checkbox"/> Unsalaries <input type="checkbox"/>
Commission based:	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"/>

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** or hayfever.

	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 <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"/>
2.4.2 Have You ever been diagnosed with, hospitalised for, received Treatment , tests or investigations for any type of disease, physical impairment, congenital or had signs or symptoms of or hereditary disorder, disability, recurrent illness, currently pregnant, termination of pregnancy, major injury or Medical Condition ?	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"/>
2.4.3 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 <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"/>
<input type="checkbox"/> I understand and acknowledge any pregnancy not declared at the time of this application's coverage will be at the sole discretion of Arabia Insurance Company S.A.L. Arabia Insurance Company S.A.L. has the right to not cover any maternity claims to any undeclared pregnancy. I also acknowledge and understand any pregnancy, which arises within forty calendar days from the date of this application; coverage will also be at the discretion of Arabia Insurance Company S.A.L.						

Additional information

If **You** answered 'Yes' to any of questions 2.4.1 to 2.4.3, 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)

2.5 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

Patient/Healthcare Provider Details	
Name:	Telephone number:
Address:	
Date of last attendance and reason:	

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**.

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 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.

*As per the Dubai Health Authority circular, **We** cannot back date cover for Dubai resident visa holders (only in exceptions for new born and this is limited to up to 7 days

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 4: Declaration and authorisation

I hereby apply for cover on behalf of all the persons named in this application form for a WorldCare **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, **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 or my **Dependants** to knowingly provide false, incomplete or misleading facts or information (ie. misrepresentation) for the purpose of defrauding or attempting to defraud Arabia Insurance Company S.A.L. Penalties may include imprisonment, fines, denial of coverage, loss of premium, loss of **Benefits** and legal damages.
- I understand that I must notify 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 any information which may be required in connection with **Treatment** related to any claim under this **Group 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
 - law and jurisdiction of the **Group Plan**
 - language of the **Group Plan** and **Our** service
 - compensation arrangements
 - Now Health International Gulf Third Party Administrators LLC is acting on behalf of Arabia Insurance Company S.A.L. for the purpose of administering **Group Plans**.
- I and those to be covered under this **Group Plan** acknowledge and agree to our personal data being processed by Arabia Insurance Company S.A.L., its administrator or its group companies and those other parties, wherever located, for the purpose of administering my **Group Plan**.
- I understand that Arabia Insurance Company S.A.L. cannot be liable and therefore will not pay claims if my **Group Plan** is lapsed should Arabia Insurance Company S.A.L. be unable to collect my premium for whatever reason and I do not provide an alternate method of payment within seven days of receiving 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 Arabia Insurance Company S.A.L., it is determined that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Group Plan**, I agree that I am liable to Arabia Insurance Company S.A.L. 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 Arabia Insurance Company S.A.L. in respect of non-covered medical **Treatment**, valid claims may be offset against outstanding funds due to Arabia Insurance Company S.A.L. and/or my **Group Plan** may be suspended until the outstanding amounts have been settled in full.
- I acknowledge that if it is determined by Arabia Insurance Company S.A.L. that a claim was fraudulent my Membership of the **Group 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, Arabia Insurance Company S.A.L. 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 WorldCare **Group Plan**.

Signature (Insured Person):

Date (dd/mm/yyyy):

/ /