

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.

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 the state of health of any of **Your** 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 submit it along with **Your** incorporation certificate (trade license) 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, P.O. Box 334337, Dubai, United Arab Emirates. **You** can also scan and email it to MEAQuotes@worldcare.ae.

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:	
Trading name(s) if applicable:	
Registered office address:	
Office location address (if different from above):	
Company registration number:	
Company establishment number:	
Tax registration number (TRN):	
Other countries where You do business/have operations:	
Company website address:	Business activity:
Incorporating body:	
Incorporation number:	
Incorporation date (dd/mm/yyyy): / /	
Legal form of Your firm (e.g. Limited Liability Company):	

Is the Company, any party connected to the Company or any employees, their family members or close associates, a politically exposed person?
 Is any party connected to the Company, any employees, their family members or close associates, a politically exposed person? Yes No

Are all directors included in **Your** intended membership? (If not please list all additional directors) Yes No

Are all Ultimate Beneficial Owners of the Company included in the intended membership? (If not please list all Ultimate Beneficial Owners) (natural persons owning more than 25%): Yes No

Is **Your** firm owned, in whole or in part, by another? Yes No

If yes, please state the name(s) and registration and incorporation jurisdiction(s) of the organization(s) together with the percentage of ownership and the type of business carried on by it (or each of them) and whether it is DFSA regulated. Please provide a copy of the company structure chart (if applicable) and registration certificate of each one of these organisations.

Details of Shareholders

Please state the full name(s) of the firm's shareholders/partners holding more than 25% of issued capital together with their nationality, date of birth and the percentage of their corresponding ownership. If a shareholder owns the controlling stake, in the case of a company please provide details of the ultimate owner.

Name	Nationality	Date of birth (dd/mm/yyyy)	Shareholding Percentage
		/ /	
		/ /	
		/ /	

If a shareholder owns the controlling stake, in the case of a company please provide details of the **ultimate owner**. Please provide the full name, nationality, date of birth and current domicile.

Name	Nationality	Date of birth (dd/mm/yyyy)	Address	Shareholding Percentage
		/ /		
		/ /		
		/ /		

Details of Board Members

Please provide the full name(s), nationality, date of birth and current domicile of all Board Members.

Name	Nationality	Date of birth (dd/mm/yyyy)	Address	Shareholding Percentage
		/ /		
		/ /		
		/ /		

Is **Your** firm a regulated entity? (If yes, please complete the below information) Yes No

Please provide the name and country of **Your** firm's national regulator:

Date and number of **Your** firm's licensing/registration by the regulator:

Date of Registration: _____ Number: _____

If **Your** firm is FATCA Registered, GIIN Number:

Section 3: Company Plan Administrator details

First name(s):

Family name:

What do **You** like to be called?

*(If **You** 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: Our environmental policy – Your document delivery settings



You can use **You** secure online portfolio to view and download **Your Plan** documents, including **Your Certificate of Insurance**



You can use **You** secure online portfolio to download **Your** virtual membership card.



Add **You** membership card to **You** smartphone wallet

Section 5: Group Plan options

For detailed information about the **Group Plan** choices available, please refer to SimpleCare **Benefit Schedule**. Please indicate **Your Group Plan** choice, any **Out-Patient** option and/or Additional option.

5.1 Choice of Group Plan

Benefit	SimpleCare CORE #	SimpleCare 100 †	SimpleCare 250 †
Annual Maximum Plan Limit	USD 1,000,000	USD 1,500,000	USD 1,500,000
Area of Cover: Worldwide Excluding USA Residents of the UAE			
Default Out-Patient Co-Insurance	(i) For Treatment inside SimpleCare UAE Network	N/A	(i) Tier 1 medical providers: 20% Tier 2 medical providers: 15% Tier 3 medical providers: 0%
	(ii) For Treatment outside SimpleCare UAE Network	N/A	(ii) 20%
In-Patient and Day-Patient care	▶	▶	▶
Day-Patient or Out-Patient surgery	▶	▶	▶
Cancer Treatment	▶	▶	▶
Organ Transplant	▶	▶	▶
Congenital cover	▶	▶	▶
Rehabilitation	▶	▶	▶
Evacuation and Repatriation	▶	▶	▶
Out-Patient fees (for Treatment outside the UAE)	▶	▶	▶
Dental Treatment	▶	▶	▶
Please Choose	○	○	○

▶ Full refund ▶ Not covered ▶ Limited cover

5.2 Out-Patient option		SimpleCare CORE #	SimpleCare 100 ‡	SimpleCare 250 ‡
Co-Insurance Out-Patient Treatment - option 1	(i) For Treatment inside SimpleCare UAE Network	N/A	(i) Tier 1 medical providers: 10% Tier 2 medical providers: 10% Tier 3 medical providers: 0%	(i) Tier 1 medical providers: 10% Tier 2 medical providers: 10% Tier 3 medical providers: 0%
	(ii) For Treatment outside SimpleCare UAE Network	N/A	(ii) 10% <input type="radio"/>	(ii) 10% <input type="radio"/>

SimpleCare CORE is not available to **Insured Persons** with residence visas in the Emirates of Dubai and Abu Dhabi. SimpleCare CORE is a non-DHA compliant plan.

‡ SimpleCare 100 and SimpleCare 250 is not available to **Insured Persons** with residence visas in the Emirate of Abu Dhabi.

5.3 Additional Options	SimpleCare CORE #	SimpleCare 100 ‡	SimpleCare 250 ‡
Removal of Drugs and Dressings Limit (for compulsory Group Plans 3+ employees)	N/A	N/A	<input type="radio"/>
Wellness & Vaccinations - Option 1 (combined limit up to USD 150) (for compulsory Group Plans 3+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
Wellness & Vaccinations - Option 2 (combined limit up to USD 250) (for compulsory Group Plans 3+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
Maternity - Option 1 (Normal Pregnancy and Childbirth up to USD 5,000) (for compulsory Group Plans 10+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
Maternity - Option 2 (Normal Pregnancy and Childbirth up to USD 7,000) (for compulsory Group Plans 10+ employees)	N/A	<input type="radio"/>	<input type="radio"/>
Dental Care - Option 1	N/A	<input type="radio"/>	Already Covered
Dental Care - Option 2	N/A	<input type="radio"/>	<input type="radio"/>

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
Bank transfer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	N/A

Bank transfer: Please make sure **You** tell **Us Your** family name in the transfer details and send it to the appropriate bank account below:

USD account	
Bank	Citibank
Bank account name	Arabia Insurance Company SAL (Dubai Branch)
Account number	0110555237
Address	PO Box 749, Oud Metha Road, Dubai, United Arab Emirates
Swift code	CITIAEAD
IBAN number	AE49021100000110555237

For USD bank account	Correspondent Bank: "Citibank N.A., New York, USA. SWIFT: CITIUS33"	For transfer to banks in the UAE:	Code	INS
			Description	Insurance Services

Section 7: Medical Insurance Details

7.1 Do **You** currently provide private medical insurance for **Your** group members? Yes No

If yes, please give details below:

Policy no.: _____ Date cover expires/expired (dd/mm/yyyy): / /

Name of Insurer:

7.2 Do **You** intend to continue with the existing insurance? Yes No

Section 8: Group Medical Declaration

Details of any known or planned **In-Patient Treatment** in the last three years for any on-going **Treatment** for but not limited to; cancer, heart conditions, psychiatric disorders, congenital conditions, renal failure or back disorders:

* Please note that if a **Medical Condition** is declared that the terms originally offered by the previous medical insurance are subject to underwriting review and approval which may require new underwriting conditions for the effectivity period of this application.

Please complete the following if **You** have previously had private medical insurance for **Your** group members. Otherwise please go to section 9.

Policy no.: _____ Date cover expires/expired (dd/mm/yyyy): / /

Name of Insurer:

Section 9: Underwriting Options

Full Medical Underwriting (FMU) Default

Medical History Disregarded (MHD) (for compulsory **Group Plans** 10+ employees)

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 SimpleCare application form for group employees and send it 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, P.O. Box 334337, Dubai, United Arab Emirates.

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 employees.

Please note that the waiting period does not apply to either Maternity or Dental Care benefits if Medical History Disregarded is selected.

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 +971 (0) 4450 1428).

- | | |
|--|---|
| <ol style="list-style-type: none"> 1. First name(s) 2. Family name 3. What do they like to be called?
<i>(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.)</i> 4. Gender 5. Date of birth (dd/mm/yyyy) 6. Marital Status 7. Residential region 8. Nationality 9. Passport number 10. UID (Visa) number 11. File number (Visa) 12. Emirates ID number 13. Emirate of Visa issuance 14. Emirate of work | <ol style="list-style-type: none"> 15. Occupation 16. Occupation industry 17. Work region (e.g. Oud Metha) 18. Emirate of residence 19. Monthly salary range:
 <4,000 AED / 4,000<12,000AED / >12,000 AED /
 Unsalariated 20. Commission based salary: Yes / No 21. Employee category 22. Entry Date – first day of cover (dd/mm/yyyy) 23. Country of Residence 24. Email address 25. Telephone no. 26. Relationship to primary insured 27. Dependants to be included 28. Start date of employment (employees only) |
|--|---|

Section 10: Eligibility

Please define the member category:

Name of category e.g. directors, managers, general employees	All members	Number of members
	<input type="radio"/>	
	<input type="radio"/>	
	<input type="radio"/>	
	<input type="radio"/>	
	<input type="radio"/>	

Compulsory or Voluntary Start Date for New Employees:
 Employees only or Employees and **Dependants** First date of employment
Expatriates and/or Local Nationals 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 between 18 to 28 **We** may require written confirmation from their place of study that they are in full-time education.
 If **We** have accepted the **Group Plan** on the basis that it is compulsory group and subsequently find out that the **Group Plan** is on a voluntary basis;
We reserve the right to adjust the premium.

Section 11: Important notes

Quotations are valid for 30 days subject to the above details remaining the same and are issued in accordance with SimpleCare **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** SimpleCare **Group Plan** or if the number of members eligible to participate in the **Group Plan** is different to the original census provided that Arabia Insurance Company S.A.L. quoted on. 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.

* 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).

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 administrating **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.

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.

