Executive Healthcare Plan Application Form

Aetna International

Explanatory Notes: Please read through the following before completing this application and complete in BLOCK CAPITALS or check boxes as appropriate.

All information supplied will be treated in strict confidence. All material facts (e.g., a pre-existing health condition or involvement in a hazardous activity), which may affect **our** assessment and consideration of this application, should be declared. Failure to do so may invalidate **your cover** under **the** plan. If **you** are in doubt as to whether a fact is material, then it should be disclosed.

As the applicant, **you** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **you** on request within three months of completion. **You** should keep a record of all information provided.

Please return this completed form to one of the following offices:

Executive Healthcare Solutions Limited
6th Floor, 9 West
Ring Road Parklands
PO Box 14680, 00800, Westlands
Nairobi, Kenya

T: (254 20) 291 0000
F: (254 20) 291 0600
E: **info@executive-healthcare.com**

Aetna Global Benefits Limited
PO Box 6380
Dubai, UAE

T: + 971 4 438 7600
F: + 971 4 428 7100
E: **MEASales@aetna.com**

Section 1 – Applicant's Details (First Person)

Family Name – As per Passport				Title
First Name(s) – As per Passport				
Marital Status	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
Industry		Occupation/Job Title		
Country of Nationality	Passport No./ID Card No.	**Country of Residence**		
Residential Address		Correspondence Address		
Town/City		Town/City		
Country/State		Country/State		
Postal Code		Postal Code		
Home Telephone		Business Telephone		
Mobile		Fax		
Home Email		Business Email		

Please Retain a Copy for Your Records

Policies issued in the Middle East and Africa but outside the United Arab Emirates (UAE) are insured by Aetna Life & Casualty (Bermuda) Limited and are administered by Aetna Global Benefits Limited – a company regulated by the DFSA. Registered address: Emirates Financial Tower, 1701 - F, 17th Floor, North Tower, DIFC, PO Box 6380, Dubai, UAE.

Section 2 – Dependant's Information (Please note children to be included under this plan must be under 18 years of age, or 26 years or under if they are in full-time education and are fully dependant upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.)

Dependant 1	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 2	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 3	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 4	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 5	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.

Section 3 – Commencement Date (Subject always to **Section 9** of this application form, the **commencement date** of this **policy** will be the date on which this application is accepted in writing by **us**. If **you** wish **your** cover to start later, please indicate below. Please note the **commencement date** can be no more than 30 days from the date of completion of this application by **you**. Under no circumstances will **policies** be backdated.)

Commencement Date (Day/Month/Year)

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Section 4 – Additional Options (The Executive Healthcare Plan enables **you** to choose various Standard Plan Designs and Optional Modules to suit **your** personal requirements. Please clearly check the Standard Plan Design you require, any Optional Modules **you** have selected and the **Excess you** require. **Your policy** will be issued on this basis. If no boxes are checked in this section, it will be assumed that cover required is Area 1 Foundation Plan with standard US$ Nil Policy Excess.)

Geographical Cover	**Product Selection**			
Core Products:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	Not Applicable	☐	☐

*(Excess options are limited to US$40, US$80, US$150)

Product Options:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Exclude Pregnancy Cover	Not Applicable	Not Applicable	☐	☐
☐ Wellness	Not Applicable	Not Applicable	☐	☐
☐ Routine Dental Treatment	Not Applicable	Not Applicable	☐	Standard

	Policy Excess:			
• **Major Medical**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Major Medical Plus**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Foundation**	☐ US$40	☐ US$80	☐ US$150	☐ US$250
• **Lifestyle**	☐ US$40	☐ US$80	☐ US$150	☐ US$250

Section 5 – Premium Payment and Payment Frequency (Please check which payment method **you** require and complete all details relevant to that method.)

Payment Frequency: Please declare the frequency of payment required. Note that, regardless of frequency, all contracts are annual. A bi-annual and quarterly payment frequency will carry an extra 5% loading and monthly payment frequency will carry an extra 8% loading. Please check as appropriate (if no indication is given an annual frequency will be assumed).

☐ Annual Payment ☐ Bi-Annual Payment ☐ Quarterly Payment ☐ Monthly Payment (Credit Card Only)

☐ a) **Banker's Draft:** All Banker's Drafts must be payable to "Aetna Global Benefits Limited". Please ensure that the name of the Policyholder (as declared in Section 1 of this form) is clearly stated on the reverse of the draft.

☐ b) **Bank Transfer:** Please ensure that the name of the **Policyholder** is clearly stated on any bank transfer. **Our** bank details are available on request by contacting our local representative office. **We** cannot accept liability for any bank transfer which does not clearly identify the **Policyholder**.

☐ c) **Credit Card (US Dollars only):** ☐ VISA ☐ MasterCard

1. Credit Card Number: | | | | | | | | | | | | | | | | |
2. Expiry Date (Day/Month/Year): _____
3. Cardholder's Name: _____
4. Cardholder's Statement Address: _____
5. Cardholder's Authorisation Signature: _____
6. Signature Date (Day/Month/Year): _____

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Section 5 – Premium Payment (Continued)

If paying by monthly credit card please read and complete the Recurring Transaction Authority below.

For payment method c, please note that **Your** premium will be collected upon receipt of this application which may be in advance of the **Commencement Date**. All transactions will be undertaken in UAE Dirhams at the prevailing rate.

If the annual premium exceeds USD 16,500, **We** are required to carryout identity checks of the **Policyholder** by collecting his/ her copy valid photo identity documents- passport, driving license, national identity card or any other photo identity document issued by Government. Kindly attach a copy of the same with this application.

Section 6 – Recurring Transaction Authority

Your authority to Aetna to claim amounts due from **your** VISA or MasterCard account and signature:

I authorise **you** to charge to my above chosen card an unspecified amount in respect of medical insurance premiums as and when they become due. I understand that Aetna will advise me of the amount to be paid and the dates on which payment is due and that Aetna may only change these after giving me prior notice. I understand that this authority in favour of Aetna will remain in force until such a time as I cancel it in writing/email instruction to Aetna.

Cardholder's Authorisation Signature	Date (Day/Month/Year)

Email (where signing online)

Section 7 – Pre-existing Condition(s)

Benefits will not be available for any **medical condition** or **related condition** for which **you,** or anyone included in this application, have sought medical **advice** or received medical **treatment** for, had symptoms of, or to the best of **your** knowledge existed, prior to **your date of entry** until two consecutive years have elapsed after the **date of entry**, during which no t**reatment** or **advice** was given with respect to that **medical condition** or any **related condition**.

Section 8 – Medical Questionnaire

Please reply to the following questions by checking Yes or No.

Where you have checked Yes, please provide all relevant details in the space below.

	Yes	No
a) Have **you**, or anyone included in this application ever been admitted to a **hospital** or other similar establishment?	☐	☐
b) Have **you**, or anyone included in this application, been prescribed with a course of any drugs or medication, or **treatments** for a period in excess of seven days in the last two years?	☐	☐
c) Have **you**, or anyone included in this application, any known or foreseeable need to consult with a **medical practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **hospital** or other similar establishment?	☐	☐
d) Are **you**, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	☐	☐

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.

continued

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Section 8 – Medical Questionnaire (Continued)

Please give details of **your** usual **medical practitioner**, and in respect of anyone else included in this application.
Medical Practitioner Name
Medical Practitioner Address
Additional Information

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Section 9 – Declaration

My spouse, competent adult **dependants**, and I (who are applying for **cover** under this application) authorise any physician, health care professional, **hospital**, other health care institution ("Providers"), and my employer to disclose, to the extent allowed by applicable law, to Aetna or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **treatment** provided to anyone listed on this application, including dental, substance abuse and HIV/AIDS services ("health care information").

I confirm and agree that personal information and/or health care information collected or held by Aetna, whether contained in this application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates including Executive Healthcare Solutions - Kenya, MIC Global Risks (Tanzania) Limited and EHS Limited, providers, payors, other insurers, third party administrators, vendors, consultants, and/or governmental authorities with appropriate jurisdiction, when necessary for care or **treatment**, payment for services, and activities related to the operation of my health plan.

I understand that Aetna may rely on such information to: 1) underwrite this application for **cover**, including, as needed, making eligibility, risk rating, and enrolment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for **cover** and provisions of **benefits**; 3) administer **cover**; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.

I have discussed the terms of this authorisation with my spouse and competent adult **dependants**, and I have obtained their consent to the release of their health care information pursuant to this authorisation. I understand that I may decline to provide Aetna with consent to process my personal or health care information; however, this may result in declination of **cover**.
I understand that I may review and offer corrections to my personal or health care information, to the extent allowed by law, receive a copy of this authorisation upon request, and that a photocopy is as valid as the original; and I may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna or other party. I also have the right to opt out of any direct marketing campaigns.

This authorisation shall remain valid for the term of this cover or for so long as allowed by law.
I understand it is unlawful for me or my **dependants** to knowingly provide false, incomplete or misleading facts or information to Aetna for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of **cover**, rescission of **benefits**, and legal damages.
I acknowledge that Aetna's participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna entity.
I understand and accept Section 7 on Pre-existing Condition(s) and I have declared all material facts that relate to this application.

Any change of occupation, hazardous pursuits and change of residential address or area should promptly be notified in writing to Aetna.

Commencement of this Policy is subject to screening of members as per company's Anti Money Laundering Policy.

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

I have declared all material facts which relate to this application.

I declare that I have read and understand the documents '**Policy Wording**' and agree to accept and conform to the terms of the **policy**, unless I cancel this **policy** within 15 days from the **commencement date**. I am satisfied that the product selected meets my requirements at this time.

I agree that where medical **treatment** is received within the **provider network** by myself or any of my **dependants** and it is substantiated that the **treatment** or **medical condition** is not refundable within the terms and conditions of the **policy**, that I, as the **member**, shall be fully responsible for reimbursement to Aetna within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **treatment.**

I understand and confirm that where I have not made repayment of funds disbursed by Aetna in respect of such medical **treatment** not covered by the **policy**, Aetna shall use all available means to recover owed funds and will suspend **cover** for the **member** until the date of full settlement of all outstanding amounts due from the **member** to Aetna, at which point **cover** shall be reinstated on the same basis as immediately prior to the suspension. In no event shall any claim for **treatment** received during any period of suspension be made or met.

I further accept that where funds have been outstanding to Aetna for a period in excess of 15 days from notification, my **policy** will be cancelled as if I had no cover in place from the start, without refund of premium.

I understand that if any statement made above or, if accepted for cover, if any subsequent claims made are found to be fraudulent or unfounded my cover will be cancelled as if I had no cover in place from the start, without refund of premium and any **benefits** shall be forfeited and recoverable by Aetna.

I understand that Aetna may not be able to conduct business and/or pay claims in locations or with/to people or groups that are listed by the European Union, the United States of America and/or the United Nations as sanctioned countries or prohibited groups. Wherever **cover** provided by this insurance contract is in violation of applicable trade or economic sanctions, such **cover** shall be null and void.

Applicant's Signature	Date (Day/Month/Year)

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