aetna®

Agency / Intermediary (Broker) Application

Aetna International

Please return this completed form to our Sales Department at the following e-mail address or mailing address:

E-mail: LatAmCaribbeanSales@aetna.com

Aetna International
PO Box 30545
Tampa, Florida 33630
USA

A. Agency Facilities Detail

1a. Agency Trading Name			1b. Company Number
1c. Full Company Name			
2a. Company Address			ZIP/Postal Code
Telephone	Fax	E-mail Address	
2b. Registered Address (if different from above)			ZIP/Postal Code
Telephone	Fax	E-mail Address	
3. Occupational/Nature of Business			

4. Is your agency:
   a) Authorized and regulated by a regulatory authority? If "Yes", please provide the following, along with a copy of your registration certificate or license:
      i) Date of registration (Day/Month/Year): _____
      ii) Name of authorizing body and registration number: _____
      If "No", please state if: i) an application is pending: _____
      ii) an application has not been made: _____
   b) A member or registered with any official insurance institution? ☐ Yes ☐ No
      If "Yes", please name institution. _____
   c) Or has it been subject to any regulatory enforcement action? ☐ Yes ☐ No

5. a) How many years has your organization been established? _____
   b) Please provide the full name and address of your agency's ultimate holding company:
      _____
      _____
      _____
   c) Is your brokerage/agency registered with its regional data protection registrar? ☐ Yes ☐ No
      If "Yes", please state the name of the authorizing body and/or provide a copy of the registration:
      _____
      If "No" , please explain:
      _____
   d) Is your agency or any of its contractors, sub-agents or customers affiliated with a government entity or agency? ☐ Yes ☐ No
   e) Does your brokerage/agency have enforced procedures to prevent inducements from being offered or received in order to generate business by it, its staff or associates? ☐ Yes ☐ No
   f) How many employees are employed at your agency, including executive directors? _____
   g) How many individuals are actively selling international medical insurance in your organization? _____

continued

Please Retain a Copy for Your Records

A. Agency Facilities Detail (Continued)

6. If your business has been established for less than two years, please state the following:
   a) Name of previous business enterprise or previous employer's name: _____
   b) Number of years business was established or duration of employment: _____
   c) Contact name, if any: _____
   d) Address: _____
   _____
   _____
   ZIP/Postal Code: _____
   Telephone: _____
   Fax: _____

7. a) Please provide full names and home addresses and qualifications of all the director(s)/partner(s)/secretary involved in your organization.
   _____
   _____
   _____
   _____
   _____
   _____
   b) Do any of the above named have outstanding legal judgments (including criminal records) against them or have they ever been the subject of regulatory, insolvency or bankruptcy proceedings? If "Yes", please give full details. If "No", please write "none".
   _____
   _____
   _____
   _____
   _____
   _____

8. Do you have professional liability / indemnity insurance coverage? ..... ☐ Yes ☐ No
   If "Yes", please send a copy of your certificate, which should state:
   a) Company providing coverage: _____
   b) Policy effective/expiration dates: _____
   c) Certificate Number: _____
   d) Limit of Indemnity: _____
   e) Excess Level, if any: _____

9. a) The annual written premium income for your private medical insurance portfolio is in the range (check applicable premium):
   i) ☐ US$ 0m - US$ 0.5m
   ii) ☐ US$ 0.5m - US$ 1m
   iii) ☐ US$ 1m - US$ 5m
   iv) ☐ US$ 5m - US$ 10m
   v) ☐ US$ 10m +

   b) The approximate breakdown in percentage terms or your international medical insurance portfolio is (write in applicable percentage):
   i) _____% Individual Business
   ii) _____% Company Paid Small Group Business
   iii) _____% Company Paid Large Group Business
   iv) _____% Optional Group Business
   v) _____% Groups in "Trust"

continued

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A. Agency Facilities Detail (Continued)

10. Please give the name and address of three other Insurers with whom you have agency facilities in respect of private medical insurance (and from whom we may take references), the date from which they become effective and your approximate premium income with each of them.

a) Name: _____ Address: _____

Date (Day/Month/Year): _____ _____

Written Premium: _____ _____

b) Name: _____ Address: _____

Date (Day/Month/Year): _____ _____

Written Premium: _____ _____

a) Name: _____ Address: _____

Date (Day/Month/Year): _____ _____

Written Premium: _____ _____

B. Bank Details (Completion is mandatory*)

11. Bank Sort Code: _____ Bank Address: _____

Bank Account Name: _____ _____

Bank Account Number: _____ _____

Bank Name: _____ Bank Fax Number: _____

Bank Telephone: _____

** Aetna Global Benefits has facility to direct credit commissions payable to your bank account.*

12. If available, please supply a copy of your corporate brochure explaining the nature and scope of your operations.

C. Declaration

I/we apply for an appointment to represent Aetna as an Agent. I/we agree that, if this application is accepted, the appointment shall be governed by the terms of Aetna (including acceptance of the terms of its agency agreement).

I/we understand that references may be sought for my/our application and to my/our best knowledge and belief the above details are true and accurate. Any attempt to mislead or supply false information to Aetna will result in the voiding of the application/agency.

Applicant's Signature	Position in Organization	Date (Day/Month/Year)

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