Aetna Global Benefits®

International Healthcare Plan – Group Plans – Formation and Medical Declaration

Explanatory Notes: Please use BLOCK CAPITALS or check boxes as appropriate.

Note 1: The group administrator name given should be the person who will be the company's regular contact for correspondence and administration purposes.

Note 2: The definition of those members of staff to be covered under the plan could for example be – "senior managers, all staff with more than one year's service," etc.

If defining more than two categories, please provide details on a separate sheet of paper.

Note 3: Where an employee's child **Dependants** are to be included under the group plan, all children must be unmarried and under the age of 18 years (or 23 years of age or under if in full-time education).

Note 4: The details shown in **Section 3** should match the group quotation terms proposed/accepted by Aetna Global Benefits.

Aetna Global Benefits reserves the right to amend or withdraw its offer of cover should there be any material change to the original risk.

Note 5: A loading will apply for MHD.

Note 6: A loading for installment payments will be applied. Please contact **Your** insurance advisor for details.

Please return this completed form to **Us** or **Your** agent.

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Section 1 – Group Details

Company Name			
Name(s) of Any Subsidiary Company/ Companies To Be Included			
Type of Business			
Address			Zip/Postal Code
Group Administrator ***(see Note 1 above)***		Job Title	
Telephone	Fax	Email	
Intermediary (if applicable)			

Section 2 – Cover Details

Preferred Commencement Date (Day/Month/Year)	To Be Insured (see Note 3) ☐ Employees Only ☐ Employees and Dependants
Participation: ☐ Non-Contributory ☐ Contributory* *If contributory, please state details: _____	
Movement between Sub-groups (if applicable) allowed upon Mid-term ☐ Yes ☐ No	
Coverage Commencement Date ☐ Immediate Cover ☐ First Day Following _____ month(s) probation	
Number of Employees To Be Insured	Definition of Staff (see Note 2)

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Section 3 – Underwriting

(see Note 4)	Previously Uninsured Group	Previously Insured Group	Additional New Members
Two Year Moratorium (MORI)	☐	☐	☐
Continuous Transfer Terms (CTT)	**N/A**	☐	☐
Medical History Disregarded (MHD)	☐	☐	☐

Section 4 – Options (The table below is for guidance only. Please refer to the full **Benefit Schedule** and **Policy Wording** for a detailed description of the **Benefits** of each plan option.)

A) Product (This plan enables **You** to choose various options to suit **Your** personal requirements. Please clearly check the option **You** have selected. **Your Policy** will be issued on this basis.)

Benefits	Major Medical OPTION 001	Foundation OPTION 002	Lifestyle OPTION 003	Lifestyle Plus OPTION 004
Standard **Excess**	NIL	$100	$100	$100
Maximum **Benefit** per **Insured Person** per **Period of Cover**	$1,600,000	$1,600,000	$1,600,000	$1,600,000
In-Patient and **Day-Patient** Care	Full Refund	Full Refund	Full Refund	Full Refund
Oncology, CT and MRI Scans	Full Refund	Full Refund	Full Refund	Full Refund
Complications of Pregnancy	Full Refund	Full Refund	Full Refund	Full Refund
Parent Accommodation	Full Refund	Full Refund	Full Refund	Full Refund
Evacuation	Full Refund	Full Refund	Full Refund	Full Refund
Out-Patient Care	Subject to Limits	Full Refund	Full Refund	Full Refund
Emergency Dental **Treatment**	Full Refund	Full Refund	Full Refund	Full Refund
Daily Hospital Cash **Benefit**	Subject to Limits	Subject to Limits	Subject to Limits	Subject to Limits
AIDS/HIV	Subject to Limits	Subject to Limits	Subject to Limits	Subject to Limits
Extended **Evacuation**	Optional	Optional	Full Refund	Full Refund
Routine Management of **Chronic** Conditions	No Cover	No Cover	Subject to Limits	Subject to Limits
Routine Pregnancy and Childbirth	No Cover	No Cover	No Cover	Subject to Limits
Routine and Restorative Dental Care	No Cover	No Cover	No Cover	Subject to Limits
Your Selection – please check **Your** choice	☐	☐	☐	☐

ALL limits and **Excesses** expressed in $ shall in all instances mean US$.

B) Excess (Please select where **You** wish to change from the standard **Excess** applicable by checking the appropriate box.)

Nil	Standard	☐	☐	☐
$50	N/A	☐	☐	☐
$250	N/A	☐	☐	☐
$500	N/A	☐	N/A	N/A
$1,000	☐	☐	N/A	N/A
$2,000	N/A	☐	N/A	N/A
$5,000	☐	☐	N/A	N/A

continued

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Section 4 – Options (Continued)

C) Additional (Please check **Your** choices.)				
USA **Elective** Treatment - [005]	N/A	☐	☐	☐
Direct Settlement Network - [008] *Only available with standard **Excess**.* *Available in certain countries.* *Please check with **Your** local sales centre.*	N/A	☐	☐	☐
Extended **Evacuation** - [009]	☐	☐	N/A	N/A
Medical History Disregarded - [010] *Only available to compulsory group schemes of 10 employees or more.*	☐	☐	☐	☐
Extension to Lifestyle Plus - [011] *Only available to compulsory group schemes of five employees or more.*	N/A	N/A	N/A	☐

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

☐ a) **Payment Frequency** ☐ Annual ☐ Semi-annually ☐ Quarterly

☐ b) **Cheque Payment.** All cheques must be payable to "PT. Asuransi Central Asia". Please ensure that the name of the **Policyholder** (as declared in **Section 1** of this form) is clearly stated on the reverse of the cheque. We will only accept US Dollar cheques.

☐ c) **Bank Transfer.** Please ensure the name of the applicant (as declared in **Section 1** of this form) is clearly stated on any transfer. **Our** bank details for bank transfer are available on request by contacting **Our** Jakarta office. **We** cannot accept liability for any bank transfer which does not clearly identify the **Policyholder**.

☐ d) **Credit Card.** ☐ VISA ☐ MasterCard ☐ AMEX

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

For payment method by d, please note **Your** premium will be collected on receipt of this application, which may be in advance of the **Commencement Date**. If **You** opt for the monthly payment plan, **We** may in some circumstances, debit two month's premium in **Your** first month. This is dependent on what time of the month **Your** billing takes place.

Section 6 – Expiring Insurance Plan Details

Is the Group Currently Insured? ☐ Yes ☐ No	Name of Insurer	
Current Plan Name		Expiry Date (Day/Month/Year)
Expiring Underwriting Terms	Variations to Standard Terms	

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Section 7 – General Terms and Conditions

1. This document forms part of the contract and must be read together with the **Policy Wording**, **Policy Schedules** and Application Form(s), where applicable.
2. This Contract of Insurance will take effect on the **Commencement Date** and shall continue for a period of 12 months or until the next **Renewal Date** or until the **Policy** is cancelled for whatever reason, whichever is sooner.
3. Group Eligibility
   a) A group can only be made up of employees of the same company or members of an existing and registered affinity group.
   b) For a group that consists solely of members of the same family, it must be fully substantiated that such members are all working for the same employer.
   c) Where a husband and wife are both employed by the same company, they are deemed to be one employee plus eligible **Dependant** NOT two employees.
   d) The minimum size of a group at inception or renewal is three current employees or affinity members. If the membership is below three at inception or at a subsequent **Renewal Date**, then the group cannot continue.
4. The inception premium must be received within a maximum of 30 working days from the **Commencement Date** of the **Policy**. No claims will be paid until this is received.
5. Renewal premiums must be received by **Renewal Date**. If full renewal premium and any applicable taxes or local levies are not received by **Renewal Date**, claims will be suspended and cover will lapse. Aetna Global Benefits may, at their discretion, reinstate cover if full premium and any applicable taxes or local levies are subsequently received.
6. Cover is only provided for group members (and eligible **Dependants**) where declared and accepted by Aetna Global Benefits.
   a) New group members (and eligible **Dependants**) can be added to the **Policy** mid-term subject to the following:
      i) For affinity, voluntary groups and compulsory company paid groups with less than 20 employees, a Group Application Form or Continuous Transfer Form must be completed by each and every group member.
   b) For compulsory company paid groups with more than 20 employees, the group administrator may supply the Information electronically, in a format approved by Aetna Global Benefits. If the group administrator is not able to supply the required eligibility and enrollment information ("Information"), a separate Group Application Form or a Continuous Transfer Form must be completed by each applicant. If Group chooses to enroll electronically, Group shall:
      i) Maintain a reasonably complete record of the enrollment and eligibility information ("Information"). The records may be filed and kept under any acceptable and commercially reasonable format and they shall meet reasonable standards of availability, authenticity, non-repudiation, and integrity (the "Records"). The Records shall include any original forms, including member enrollment applications containing the signature of covered members which provide consent for Aetna Global Benefits to process personal and health information. The Records should also contain sufficient documentation to support coverage requests for students or handicapped dependants requesting coverage through an eligible employee and beneficiary designations;
      ii) produce the Records upon reasonable request;
      iii) transmit the Information in the exact way that it is contained in the Records;
      iv) obtain from its employees and their **Dependants**, information including authorisations, reasonably necessary for Aetna Global Benefits to perform its obligations for the Group and its employees;
      v) use Aetna Global Benefit's enrollment and change forms in paper or electronic format, or must incorporate the following points into the enrollment materials:
         a. Name(s) of the Aetna Company offering the insurance coverage
         b. A statement that the terms of the insurance documents will govern the member's rights and responsibilities; and
         c. An acknowledgement that participating providers are not agents or employees of Aetna Global Benefits and that network composition can change.
         d. A written authorisation from the employee indicating that they authorise Aetna Global Benefits to process the personal/health information of their spouse, competent adult **Dependants**, and themselves; they have discussed the terms of the authorisation with their spouse and competent adult **Dependants** and have obtained their authorisation to release/process their personal/health information; that the information may be shared with affiliates, government authorities with appropriate jurisdiction, and third parties with whom Aetna contracts worldwide, for activities related to the operation of the health plan and other insurance operations. Notification that the employee may revoke this authorization at any time, to the extent it has not been relied upon by Aetna or other party; opt out of any direct marketing campaigns; and decline to provide Aetna Global Benefits with consent to process personal or healthcare information; however, such failure to provide consent may result in declination of coverage.

continued

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Section 7 – General Terms and Conditions (Continued)

e. NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

c) Group may receive certain **Benefit** Plan information and documentation (the "Material") electronically and may publish the Material on its internal website. Group shall, with respect to the Material to be electronically published or provided to its employees:
   i) give access and distribute the Material only to covered members.
   ii) place the Material only on its internal website (if applicable), which shall be available and accessible to authorized company personnel.
   iii) place in the electronic memo or on the internal website (if applicable) a disclaimer stating: "This information/material is provided solely for general guidance about the terms of **Your Benefit** plan. In the event of any conflict between this information and terms and conditions of the **Policy** and related plan documents delivered to the employer, the **Policy** and related plan documents will govern."

d) Group agrees that in placing the Material on its internal website, it shall not make any change to the terms of the **Policy**, plan forms, or related plan documents, and shall promptly amend such information to correct errors or reflect changes in any plan term or form. Group further agrees to take appropriate steps to prevent improper access, changes or usage of the material by unauthorized personnel no matter the means distributed. Furthermore, Group agrees to mitigate, to the extent practicable, any harmful effect of an improper access, changes or usage of the material by unauthorised personnel.

e) Group shall retain all information required by this Form for a period of not less than seven (7) years.

f) Group agrees to indemnify, and hold Aetna harmless from any costs, expenses, claims or judgments, including counsel fees that Aetna incurs as a result of Customer's failure to comply with the terms of this Agreement.

g) Payment for additions must be received within 14 days of acceptance date. If these conditions are not met, all cover will be deemed null and void without further notice. For additions to plans that have opted for end of year adjustments, six monthly payments or quarterly payments, the funds must be received by due dates otherwise all cover will be deemed null and void.

h) Group members and/or their eligible **Dependants** can be deleted from the date of notification in writing by the group administrator for which a pro rata return of premium will be calculated. Notification may be given to Aetna Global Benefits by the group administrator of a future deletion(s) date(s) no more than 30 days in advance.

7. Accountability for any misuse of individual membership cards issued by Aetna Global Benefits or the insurers to employees (and their eligible **Dependants**) lies with the group administrator, on behalf of the group, who holds responsibility to gather and return such cards upon deletion of employees (and their eligible **Dependants**) from cover.

   In the event of being unable to return the **Direct Settlement Network** card for deleted group members, the group administrator, on behalf of the group, acts as guarantor that any claims incurred against such members' cards after their individual deletion dates, will be borne by the group.

8. Where medical **Treatment** is received within the **Provider Network** by group members and/or their eligible **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy**, the **Policyholder** shall be fully responsible for reimbursement to Aetna Global Benefits within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment**. If there is no repayment of funds disbursed by Aetna Global Benefits in respect of such medical **Treatment** not covered by the **Policy**, the **Policy** shall be suspended until the date of full settlement of all outstanding amounts due from the **Policyholder** to Aetna Global Benefits and in the event that funds so due from the **Policyholder** to Aetna Global Benefits have been outstanding and unpaid for a period in excess of 30 days exclusion 1 of the **Policy** wording could be re-applied to the **Policy** with effect from the date of full receipt by Aetna Global Benefits of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met. Moreover, should the funds have been outstanding to Aetna Global Benefits for a period in excess of 45 days from notification, the **Policy** would be cancelled as if I had no cover in place from the start, without refund of premium.

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Section 8 – Declaration

I declare that I am authorised by the Company to enter into this Contract of Insurance with PT. Asuransi Central Asia which is administered by PT Aetna Global Benefits Indonesia, an Aetna Company.

I declare that I have understood and accepted the General Terms and Conditions in Section 7 of this Group Formation Form.

I understand that subscriptions due under the group plan must be paid in full by the agreed due date to Aetna Global Benefits.

In the event that premiums are not paid by the due date, I understand that cover will be automatically cancelled.

I declare that the transfer by the Company of personal data to Aetna Global Benefits, including information relating to employees insured under the group plan, will not result in violation of the Data Protection Act 1998. For Data Protection Act purposes, Aetna Global Benefits will hold and process personal data, including personal sensitive data, provided by Company for the purpose of insurance administration and other activities related to this Contract of Insurance. This information may be passed worldwide to select third parties.

I declare that the information given to Aetna Global Benefits for the purpose of entering into this Contract of Insurance is true and complete and that no material facts have been withheld.

The below is applicable to Compulsory Groups with 20 employees and above only:

I/**We** hereby declare to the best of my/**Our** knowledge that no **Insured Person** has received **In-Patient Treatment** of any kind within the last three months, and that no **Insured Person** or potential **Insured Person** has any on-going or planned **In-Patient Treatment** of any kind.

Furthermore, I/**We** declare that to the best of my/**Our** knowledge, no **Insured Person** or potential **Insured Person** has any on-going or planned **Treatment** in respect of cancer, heart, lung, orthopedic or psychiatric related conditions.

I/**We** accept that any personal exclusions/limitations relating to an **Insured Person's** or potential **Insured Person's** existing cover will be maintained by Aetna Global Benefits.

For Data Protection Act purposes, Aetna Global Benefits will hold and process **Your** personal data for insurance administration. The information may only be passed to selected third parties and re-insurers.

You consent to **Our** processing sensitive data about **You** and other **Insured Persons** or potential **Insured Persons** who may be included in the **Policy**. **You** understand that all personal data **You** supply must be accurate and **You** have the specific consent of those **Insured Persons** or potential **Insured Persons** to disclose their personal data. Telephone calls may be monitored and/or recorded.

Policyholder's Signature	Date (Day/Month/Year)
Policyholder's Name (Please Print)	Position in Company

Section 9 – Group Medical Declaration

The below is applicable to Compulsory Groups with 20 employees and above only:

I/**We** hereby declare to the best of my/**Our** knowledge that no **Insured Person** has received **In-Patient Treatment** of any kind within the last three months, and that no **Insured Person** or potential **Insured Person** has any on-going or planned **In-Patient Treatment** of any kind.

Furthermore, I/**We** declare that to the best of my/**Our** knowledge, no **Insured Person** or potential **Insured Person** has any on-going or planned **Treatment** in respect of cancer, heart, lung, orthopedic or psychiatric related conditions.

I/**We** accept that any personal exclusions/limitations relating to an **Insured Person's** or potential **Insured Person's** existing cover will be maintained by Aetna Global Benefits.

For Data Protection Ordinance purposes, Aetna Global Benefits will hold and process **Your** personal data for insurance administration. The information may only be passed to selected third parties and re-insurers.

You consent to **Our** processing sensitive data about **You** and other **Insured Persons** or potential **Insured Persons** who may be included in the **Policy**. **You** understand that all personal data **You** supply must be accurate and **You** have the specific consent of those **Insured Persons** or potential **Insured Persons** to disclose their personal data. Telephone calls may be monitored and/or recorded.

Policyholder's Signature	Date (Day/Month/Year)
Policyholder's Name (Please Print)	Position in Company

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GR-68583-29 **IHPJ-ACA** (9-10)