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Aetna International

International Healthcare Plan (Core, Essential, Plus, Elite or Custom) – Member Application Form – Group Plans

Explanatory Notes: Please read the following before completing this application. Please use BLOCK CAPITALS or check boxes as appropriate.

Terms and Conditions: 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 a **Group** plan. If **You** are in doubt as to whether a fact is material, then it should be disclosed.

If **You** were covered under a similar **Policy** immediately prior to **Your** application for inclusion under this **Group** plan, please include a copy of **Your** current **Certificate of Insurance**, as **Your Plan Sponsor** may have requested **Continuous Transfer Terms**.

If **You** run out of space please use a separate sheet of paper where necessary to provide full details. All information supplied will be treated in strict confidence.

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 **Us** or **Your** agent.

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To help **You** understand **Your Cover**, the words and phrases that are capitalised and in bold in **Your Policy Documentation** have specific meanings, and are defined in the International Healthcare Plan (IHP) **Member** Handbook.

Section 1 – Plan Sponsor's Details

Plan Sponsor Name		**Policy** Number	
Address			Postal Code
Telephone	Fax	E-mail Address	

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Section 2 – Applicant Details (Employee)

Family Name				Title
First Name(s)				
Marital Status	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
Industry		Occupation/Job Title		
Date of Employment (Day/Month/Year)	Eligibility Category		Date First Eligible to Join Plan (Day/Month/Year)	
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 E-mail		Business E-mail		

Section 3 – Dependant's Details

Dependants can only be included if their **Country of Residence** is the same as the Applicant's. Children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full-time education and are fully dependent 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.

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Policies issued outside of mainland China, Hong Kong, Singapore and Indonesia but within Asia Pacific are issued by Aetna Insurance (Singapore) Pte. Ltd, registered Address 158 Cecil Street, #11-01, Singapore 069545, Company Registration No. 201200834H or by Aetna Life & Casualty (Bermuda) Ltd. administered by Aetna Global Benefits (Asia Pacific) Limited, registered address Suite 401-403, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong, HKFI Insurance Agency Registration No. 02905813.

Section 4 – 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 **Treatment** or **Advice** was given with respect to that **Medical Condition** or any **Related Condition**.

Members applying for Continuous Transfer Terms:

Where **Continuous Transfer Terms** are accepted by **Us**, the previous underwriting applied in respect of **Your** existing **Cover** will apply. **We** reserve the right to apply additional terms. **You** should attach a copy of **Your** existing **Certificate of Insurance**, detailing any endorsements and the original **Commencement Date** of the expiring plan (or **Cover**).

Section 5 – 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, been admitted to **Hospital** or other similar establishment in the last five years?	☐	☐
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.

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 6 – Applicant's 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 International 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 International, whether contained in this application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, 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 International 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 International 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 International 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 International for the purpose of defrauding or attempting to defraud Aetna International. Penalties may include imprisonment, fines, denial of **Cover**, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna International participating providers are independent contractors and are not agents or employees of Aetna International or any affiliated Aetna entity.

I understand and accept Section 4 on Pre-existing Condition(s) and I have declared all material facts which relate to this application.

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 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 International 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 International in respect of such medical **Treatment** not covered by the **Policy**, Aetna International 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 International 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.

Additional Provisions for Members applying for Continuous Transfer Terms

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, and any **Benefits** shall be forfeited and recoverable by Aetna International.

Where **You** transfer to the International Healthcare Plan from any other of **Our** existing plans or, whilst covered under the International Healthcare Plan, **You** receive any enhanced **Cover** (such as inclusion of an option at any **Renewal Date**), any enhanced **Cover** or maximum refundable amounts are restricted to new **Medical Conditions** which have not been previously suffered from, whether or not diagnosed, after the date of transfer.

Transfer of any similar private medical **Cover** provided by any other insurer is subject to submission of a copy of the **Certificate of Insurance** and subject to there being no break in **Cover**. **We** reserve the right at all times to decline an application without giving any reason and/or to offer alternative terms.

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

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