



International Healthcare Plan – Application Form

Aetna Global Benefits®

Please read through the following before completing this application and complete in BLOCK CAPITALS.

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy**. A material fact is one which is likely to influence the assessment and acceptance of this application (e.g. a pre existing health condition or involvement in hazardous activities). If **You** are in any doubt whether a fact is material, 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 (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

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

Aetna Global Benefits (Europe) Limited
2nd Floor
8 Eastcheap
London EC3M 1AE
United Kingdom

T: +44 870 442 2676
F: +44 870 442 4377
E: EuropeSales@aetna.com

Section 1 – Applicant’s Details (First Person)

Family Name				Title	
First Name(s)					
Marital Status	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	
Industry		Occupation			
Nationality		Country of Residence			
Residential Address		Correspondence Address			
Town/City		Town/City			
Country/State		Country/State			
Zip/Postal Code		Zip/Postal Code			
Home Telephone		Business Telephone			
Mobile		Fax			
Home Email		Business Email			

Please Retain a Copy for Your Records

Policies are issued and underwritten or reinsured in Europe by Aetna Health Insurance Company of Europe, Limited, Aetna Life & Casualty (Bermuda) Ltd. and issued and administered by Aetna Global Benefits (Europe) Limited, an Aetna Company and regulated by the Financial Services Authority. Registered address: 76 Shoe Lane, London EC4A 3JB. Registered in England & Wales. Registered No. 04548434.

Section 2 – Dependant’s Detail (Please note 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 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 <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation			Nationality	
Dependant 2	Family Name			First Name(s)	
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation			Nationality	
Dependant 3	Family Name			First Name(s)	
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation			Nationality	
Dependant 4	Family Name			First Name(s)	
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation			Nationality	

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 – 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	£65 or €/\$100	£65 or €/\$100	£65 or €/\$100
Maximum Benefit per Insured Person per Period of Cover	£1,000,000 or €/\$1,600,000	£1,000,000 or €/\$1,600,000	£1,000,000 or €/\$1,600,000	£1,000,000 or €/\$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	Subject to Limits	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currency of Policy - Please check Your choice <input type="checkbox"/> £ <input type="checkbox"/> € <input type="checkbox"/> \$ Please note the currency of Your Policy will determine the Benefit limits and the Excess of Your Policy . 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£30/€50/\$50	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£155/€250/\$250	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
£300/€500/\$500	N/A	<input type="checkbox"/>	N/A	N/A
£625/€1,000/\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
£1,250/€2,000/\$2,000	N/A	<input type="checkbox"/>	N/A	N/A
£3,000/€5,000/\$5,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A

C) Additional (Please check Your choices.)				
USA Elective Treatment - [005]	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semi-Private Room Restriction - [006] <i>Only available to residents of Hong Kong.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
China Private Room Restriction - [007] <i>Only available to residents of mainland China.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct Settlement Network - [008] <i>Only available with standard Excess. Available in certain countries. Please check with Your local sales centre.</i>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation - [009]	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Medical History Disregarded - [010] <i>Only available to compulsory group schemes of 10 employees or more.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extension to Lifestyle Plus - [011] <i>Only available to compulsory group schemes of five employees or more.</i>	N/A	N/A	N/A	<input type="checkbox"/>

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

a) **Cheque Payment (annual only).** All cheques must be payable to “Aetna Global Benefits (Europe) Limited”. Please ensure that the name of the applicant (as declared in **Section 1** of this form) is clearly stated on the reverse of the cheque.

b) **Bank Transfer (annual only).** 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** London office. **We** cannot accept liability for any bank transfer which does not clearly identify the applicant.

c) **Credit Card (annual and monthly).** VISA MasterCard AMEX (annual and monthly)

1. Credit Card Number:

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2. Cardholder’s Name: _____

3. Expiry Date (Month/Year): _____

4. Cardholder’s Statement Address: _____

5. Currency of Payment: Euro Sterling Dollar

6. Type of Payment: Annual Monthly (If paying by monthly credit card please read and complete the Recurring Transaction Authority below.)

7. Cardholder’s Authorisation Signature: _____

8. Signature Date (Day/Month/Year): _____

d) **Direct Debit (annual and monthly).** Restricted to UK bank account holders, sterling accounts only.
 Type of Payment: Annual Monthly If paying by Direct Debit, please complete the Direct Debit Mandate at the end of this form.

For payment method by c) and 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 – Recurring Transaction Authority

Your authority to Aetna Global Benefits to claim amounts due from **Your** VISA, AMEX 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 Global Benefits will advise me of the amount to be paid and the dates on which payment is due and that Aetna Global Benefits may only change these after giving me prior notice. I understand that this authority in favour of Aetna Global Benefits will remain in force until such a time as I cancel it in writing/email instruction to Aetna Global Benefits.

Cardholder’s Authorisation Signature	Date (Day/Month/Year)
Email (where signing online)	

Section 7 – Medical Practitioner Details (Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application. Please use a separate sheet if this space is insufficient.)

Please Retain a Copy for Your Records

Section 8 – Pre-existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** 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 in respect of that **Medical Condition** or any **Related Medical Condition**.

Section 9 – Medical Questionnaire

Please reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.

	Yes	No
a. Have You , or anyone included in this application, been admitted to Hospital or other similar establishment in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are You , or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>

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

Section 10 – Direct Debit Mandate

Name(s) of Account Holder(s)

1. _____
2. _____

Name and full postal address of Your Bank or Building Society

To: The Manager, Bank/Building Society

Address		Postcode
Bank/Building Society Account Number (8-Digits)	Branch Sort Code (6-Digits)	Originator's Reference Number 684431

Reference

Instruction to Your Bank or Building Society to pay by Direct Debit:

Please pay Aetna Global Benefits Direct Debits from the account detailed in the Instruction subject to the safeguards assured by the Direct Debit Guarantee. I understand that this Instruction may remain with Aetna Global Benefits and, if so, details will be passed electronically to my Bank/Building Society.)

Signature(s)	Date (Day/Month/Year)
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Section 11 – The Direct Debit Guarantee

This guarantee should be **detached** and retained by the _____.

- This Guarantee is offered by all Banks and Building Societies that take part in the Direct Debit Scheme. The efficiency and security of the Scheme is monitored and protected by **Your** own Bank or Building Society.
- If the amounts to be paid or the payment dates change, Aetna Global Benefits will notify **You** 10 working days in advance of **Your** account being debited or as otherwise agreed.
- If an error is made by Aetna Global Benefits or **Your** Bank or Building Society, **You** are guaranteed a full and immediate refund from **Your** branch of the amount paid.
- **You** can cancel a Direct Debit at any time by writing to **Your** Bank or Building Society.

Please also send a copy of **Your** letter to **Us**.

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Section 12 – Agent/Broker Name/Stamp

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Section 13 – Declaration

My spouse, competent adult **Dependants**, and I (those who are applying for coverage under this Application) authorise any physician, healthcare professional, **Hospital**, and other healthcare institution ("Providers"), to disclose, to the extent allowed by applicable law, to Aetna Global Benefits or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this Application, including those services involving dental, substance abuse and HIV/AIDS ("healthcare information").

I confirm and agree that personal information and/or healthcare information collected or held by Aetna Global Benefits, 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, and 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 Global Benefits may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, **Policy** issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of **Benefits**; 3) administer coverage; 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 healthcare information pursuant to this authorisation. I understand that I may decline to provide Aetna Global Benefits with consent to process my personal or healthcare information; however, this may result in declination of coverage.

I understand that I may review and offer corrections to my personal or healthcare 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 Global Benefits 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 coverage 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 Global Benefits for the purpose of defrauding or attempting to defraud Aetna Global Benefits. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna Global Benefits' participating providers are independent contractors and are not agents or employees of Aetna Global Benefits or any affiliated Aetna Entity.

I understand and accept **Section 8** on Pre-existing Condition(s).

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 '*Key Facts*', '*Policy Wording*' and '*Benefit Schedule*' 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 **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**.

I understand and confirm that where I have not made 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 my full settlement of all outstanding amounts due from me to Aetna Global Benefits and in the event that funds so due from me to Aetna Global Benefits have been outstanding and unpaid for a period in excess of 14 days, exclusion 1 of the **Policy Wording** shall 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.

I further accept that where funds have been outstanding to Aetna Global Benefits 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.

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