

# International Healthcare Plan (Core, Essential, Plus, Elite) – Group Formation Form

**Explanatory Notes:** This form should be completed by the **group administrator** authorised to accept a quotation and set up a plan for the **plan sponsor**. Please use BLOCK CAPITALS and check boxes as appropriate, and return this completed form to **us** or your agent.

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This form should be read in conjunction with the International Healthcare Plan (IHP) brochure and quotation summary.

Words and phrases in bold font have specific meanings and are defined in the member handbook.

Aetna reserves the right to amend or withdraw its offer of **cover** should there be any material change to the original risk. Commencement of this **policy** is subject to review by **our underwriters** and screening of the **group** under the company's anti-money laundering **policy**.

For **groups** of less than 10 **employees**, we require a completed group member application form for each **employee**.

## Section 1 – Plan Sponsor Details

Plan Sponsor Name and Registered Address	Postal Code
Name(s) of Any Subsidiary Company/Companies to be Included	
Type of Business	
Correspondence Address for all Documentation (if different from above)	Postal Code

## Section 2 – Group Administrator's Details

Group Administrator's Name	Job Title	
Telephone	Fax	E-mail
Intermediary/Agent Name (if applicable)		

## Section 3 – Intermediary or Agent Details

Named Contact	Job Title	
Telephone	Fax	E-mail
Intermediary/Agent Name		

## Section 4 – Confirmation of Cover and Eligibility Definitions

Please provide the definition of those members of staff to be covered in each category (e.g., senior managers, all staff with more than one year's service, etc.) and return the completed quotation summary for each plan you wish to purchase.

Category 1
Category 2
Category 3

### Please Retain a Copy for Your Records

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**Section 5 - Member Packs and Membership Card Distribution**

To assist you in communicating your benefits plan to your employees and their dependants, we provide the following options:

1. For **member packs**, please advise which of the following delivery options you prefer:

I prefer that Aetna send **electronic member packs**.  
If you select this option, please provide the plan administrator's e-mail address here:  
\_\_\_\_\_

I prefer that Aetna send **printed copies** of the **member packs** to the plan administrator.  
If you select this option, please provide a mailing address here (including the plan administrator's or broker's name, as appropriate):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. For **membership ID cards**, please provide the desired central mailing address.  
If the mailing address and contact information is the same as above, please check the following box:   
Otherwise, please provide a mailing address here (including the plan administrator's name or broker's name, as appropriate):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Section 6 – Membership Adjustments**

Select one of the below options to adjust membership when **members** leave or join the plan:

**Pay As You Go** – Adjustments are credited or debited as adjustments are made.

**Periodic Adjustments** – We will adjust your instalment plan to incorporate membership adjustments.

**End of Year Adjustments** – We will reconcile your account at year end.

**Section 7 - Payment of Premiums**

All premium payments are to be paid by the **plan sponsor**. Please note that the **group** must fund 100% **cover** for **employees**.

	Category 1	Category 2	Category 3
Will the <b>group</b> fund <b>cover</b> for <b>dependants</b> ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Section 8 – Aetna Global Health Connections – Wellness Checkpoint® Health Risk Reporting**

**Plans sponsors** with more than 100 **members** can benefit from tailored and personalised Wellness Checkpoint reporting tools. In addition, **plan sponsors** of this size may customise certain sections of the Wellness Checkpoint tool. Please advise if you would like to work with **us** to tailor your **group's** reports and application.

We would like to develop a tailored Wellness Checkpoint application and reporting capabilities at this time.

We would like to defer tailoring our Wellness Checkpoint application and reporting to a later date.  
(If this option is selected, when shall **we** contact you again to follow up?) \_\_\_\_\_

We are happy to receive standardised comparative reporting and the standard Wellness Checkpoint application.

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**Section 9 – Premium Payment and Payment Frequency**

Please select the desired payment method and frequency.

<input type="checkbox"/>	<p><b>a) Cheque Payment</b></p> <p>Please make cheques payable to “Aetna Global Benefits (Europe) Limited”. Please ensure the name of the <b>group</b> (as declared in <b>Section 1</b> of this form) is clearly stated on the back.</p> <p>Payment Frequency:            <input type="checkbox"/> Annual            <input type="checkbox"/> **Semi-Annual            <input type="checkbox"/> **Quarterly</p>
<input type="checkbox"/>	<p><b>b) Bank Transfer</b></p> <p><b>Our</b> bank details for bank transfer are available upon request by contacting <b>our</b> Croydon office. Please ensure the name of the <b>group</b> (as declared in <b>Section 1</b> of this form) is clearly stated on any transfer. <b>We</b> cannot accept liability for any bank transfer that does not clearly identify the <b>group</b> and applicant.</p> <p>Payment Frequency:            <input type="checkbox"/> Annual            <input type="checkbox"/> **Semi-Annual            <input type="checkbox"/> **Quarterly</p>
<input type="checkbox"/>	<p><b>c) Direct Debit</b> (Restricted to UK bank account holders, sterling accounts only.)</p> <p>Payment Frequency:            <input type="checkbox"/> Annual            <input type="checkbox"/> **Semi-Annual            <input type="checkbox"/> **Quarterly            <input type="checkbox"/> **Monthly</p> <p><b>Direct Debit Mandate</b></p> <p>Name(s) of Accountholder(s): 1. _____ 2. _____</p> <p>Name and full postal address of <b>plan sponsor’s</b> Bank or Building Society:</p> <p>To: <b>The Manager, Bank/Building Society</b></p> <p>Address: _____ _____ _____</p> <p>Postcode: _____</p> <p>Bank/Building Society Account Number (8-digits): _____</p> <p>Branch Sort Code (6-digits): _____</p> <p>Originator’s Reference Number: <b>684431</b></p> <p>Reference: _____</p> <p><b>Instruction to your Bank or Building Society to pay by Direct Debit:</b>  <i>“Please pay Aetna Global Benefits (Europe) Limited 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 (Europe) Limited and, if so, details will be passed electronically to my Bank/Building Society.”</i></p> <p>Signature(s): _____</p> <p>Signature Date (Day/Month/Year):    __ __ / __ __ / __ __</p> <p><b>The Direct Debit Guarantee</b></p> <p>This guarantee should be detached and retained by the _____</p> <ul style="list-style-type: none"> <li>▪ 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 <b>plan sponsor’s</b> own Bank or Building Society.</li> <li>▪ If the amounts to be paid or the payment dates change, Aetna will notify the <b>plan sponsor</b> 10 working days in advance of an account debit or as otherwise agreed.</li> <li>▪ If an error is made by Aetna or the <b>plan sponsor’s</b> Bank or Building Society, it is guaranteed a full and immediate refund from <b>plan sponsor’s</b> branch of the amount paid.</li> <li>▪ The <b>plan sponsor</b> can cancel a Direct Debit at any time by writing to its Bank or Building Society. Please also send a copy of your letter to <b>us</b>.</li> </ul>

For payment method by c), please note your premium will be collected upon 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 upon what time of the month your billing takes place.

\*\*A surcharge will apply. Please contact Aetna Global Benefits (Europe) Limited for further details.

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## Section 10 – General Terms and Conditions

1. This document forms part of the contract and must be read together with the **certificate of insurance**, member handbook, any application form(s) and other **policy documentation**, 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.
  - 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**. 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 the **renewal date**. If the full renewal premium and any applicable taxes or local levies are not received by the **renewal date**, claims will be suspended and **cover** will lapse. Aetna 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.
  - a. New **group members** (and eligible **dependants**) can be added to the **policy** mid-term subject to the following:
    - i. For **groups** with less than 10 **employees**, a group member application form must be completed by each and every **group member**.
    - ii. For **groups** with more than 10 **employees**, the **group administrator** may supply the information electronically, in a format approved by Aetna. If the **group administrator** is not able to supply the required eligibility and enrolment information ("Information"), a separate group member application form must be completed by each applicant. Regardless of format, any **employee** or **dependant** not enrolled within 30 days will be subject to individual underwriting. If the **group** chooses to enrol electronically, the **group** shall:
      - i. Maintain a reasonably complete record of the enrolment 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 enrolment applications containing the signature of covered **members**, which provide consent for Aetna to process personal and health information. The Records should also contain sufficient documentation to support **cover** requests for students or handicapped **dependants** requesting **cover** 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 to perform its obligations for the **group** and its **employees**;
      - v. Use Aetna's enrolment and change forms in paper or electronic format, or they must incorporate the following points into the enrolment materials:
        - a) Name(s) of the Aetna company offering the insurance **cover**;
        - b) A statement that the terms of the insurance documents will govern the **member's** rights and responsibilities;
        - c) An acknowledgement that participating **providers** are not agents or employees of Aetna and that **network** composition can change; and
        - d) A written authorisation from the **employee** indicating that they authorise Aetna 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 third parties with whom Aetna contracts worldwide, and their employer, for activities related to the operation of the health plan and other insurance operations; and notification that the **employee** may revoke this authorisation 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 with consent to process personal or health care information; however, such failure to provide consent may result in declination of **cover**.

*continued*

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**Section 10 – General Terms and Conditions (Continued)**

- c. The **group** may receive certain **benefit** plan information and documentation (the “Material”) electronically and may publish the material on its internal website. The **group** shall, with respect to the Material to be electronically published or provided:
- Give access and distribute the Material only to covered **members**;
  - Place the Material only on its internal website (if applicable), which shall be available and accessible to authorised company personnel; and
  - 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 the **benefit** plan your employer has made available to you. In the event of any conflict between this information and terms and conditions of the **policy** and related **policy documentation** delivered to the employer, the **policy** and related **policy documentation** will govern.”
- d. The **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 **policy documentation**, and shall promptly amend such information to correct errors or reflect changes in any plan term or form. The **group** further agrees to take appropriate steps to prevent improper access, changes or usage of the material by unauthorised personnel no matter the means distributed. Furthermore, the **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. The **group** shall retain all information required by this form for a period of not less than seven (7) years.
- f. The **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. The **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 by the **group administrator** of a future deletion(s) date(s) no more than 30 days in advance.
- i. The **group** understands 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.
- j. Please note it is not possible to change categories mid-term unless an **employee** is promoted and he/she clearly fits within the definition of an alternate but existing **employee** category. For example, a member of the “staff” category is promoted and joins the **policyholder’s** management team and therefore is eligible for inclusion in an existing and defined category for managers and directors. This may incur premium adjustment(s).

**Section 11 – Declaration**

This document serves as a contract between the **group** and Aetna, and must be read together with the **certificate of insurance**, any application forms, the member handbook and other **policy documentation**, as applicable.

The **plan sponsor** understands that premiums due under the **group** plan must be paid in full by the agreed due date to Aetna. In the event that premiums are not paid by the due date, **cover** may be terminated.

The **plan sponsor** declares that the transfer by the **group** of personal data to Aetna, including information relating to **members** insured under the **group** plan, will not result in violation of applicable privacy and data protection laws. Aetna will hold and process personal data, including personal sensitive data, provided by the **group** 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.

The **plan sponsor** declares that the information given to Aetna for the purposes of entering in to this contract of insurance is true and complete and that no material facts have been withheld.

The **plan sponsor** acknowledges that both parties under this insurance arrangement shall be responsible for complying with applicable anti-corruption and anti-money laundering laws, and certifies that it has neither received nor been promised any improper benefit, payment or advantage in connection with this insurance arrangement.

As **group administrator**, I declare that I am authorised to enter into this contract of insurance with Aetna Health Insurance Company of Europe Limited on behalf of the **plan sponsor**.

Authorised Signatory Signature (**Group Administrator**)

Date (Day/Month/Year)

Please Print Authorised Signatory’s Name

Position in Company

Company Stamp

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