InterGlobal

Channel Islands Ultra**Care** plan

Individual application

Full Medical Underwriting (FMU)

Need help completing this application?
Please contact either your advisor or us. You can find our contact details on our website at www.interglobalpmi.com

IMPORTANT – PLEASE READ

Completing this application

Please make sure you complete all sections. We may contact you if information is missing or with further questions. If you have any questions on completing this application or the information required, please contact us or your broker.

The questions in this application, the additional questionnaires (as applicable) and any other information we ask for are essential for us to be able to assess whether to offer you (and your dependants) insurance, on what terms and at what price. Please take reasonable care to answer all the questions we ask honestly and to the best of your and your dependant's (if applicable) knowledge. If you do not answer the questions correctly, it may:

- entitle us to avoid the relevant member's coverage under the plan, refuse all claims the relevant member has made under the plan and retain any premium paid in relation to that member,
- result in us applying different terms to the relevant member's coverage under the plan, or
- result in us reducing a claim payment due to the relevant member to reflect the different premium which we would have charged in relation to that member.

We will not carry out any searches or contact any other person (including your doctor) to check your answers or the information you provide with this application.

You should keep a record of all information that you have provided to us. If any of the details that you give in this application are different from those that you gave when you received your initial quotation, your premium may change and special terms may be applied.

What happens next?

Once we have all the information needed to consider your application we will either:

- agree to accept all the medical conditions you have declared and may charge an increased premium,
- agree to accept some of the declared medical conditions and may charge an increased premium. The declared conditions we do not accept will be excluded,
- exclude all of the declared medical conditions, or
- decline the application.

Your Certificate of insurance will specify any excluded conditions. All other terms and conditions of your Policy Documentation will still apply.

Please complete this application clearly in BLOCK CAPITALS.

A Your personal details (the planholder)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Channel Island where you live:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[1]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F
Height (cm): or Height (inches):	Weight (kg): or Weight (pounds):

[1] Some occupations may have an increased premium. Please contact us for more information.

Your address[2]

[2] We will send all correspondence to this address unless you have completed the correspondence address on the next page.
You must tell us immediately about any changes to your contact or personal details. A change in circumstances may affect our ability to cover you and/ or the terms of which we cover you.

Address:	
Postcode:	Channel Island:
Phone:	Mobile:
Email:	

A Your personal details (the planholder) (continued)

Correspondence address – if different from your address on the previous page

Address:	
Postcode:	Channel Island/Country:
Phone:	Mobile:
Email:	

B Dependants to be covered

You do not need to complete the height and weight sections for dependants aged 17 years or younger.

Dependant 1

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:
Height (cm): or Height (inches):	Weight (kg): or Weight (pounds):

Dependant 2

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:
Height (cm): or Height (inches):	Weight (kg): or Weight (pounds):

Dependant 3

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Country where they live[1]:	Nationality on passport:
Occupation[2]:	Relationship to you:
Height (cm): or Height (inches):	Weight (kg): or Weight (pounds):

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

C Cover start date

The plan is a yearly contract. Your cover will begin when we have received your signed acceptance of the special terms offered by our underwriters. We cannot backdate cover under any circumstances.

D Your cover options

Level of cover and type of plan

Please tell us the type of Channel Islands UltraCare plan that you need. Please make sure that you have read the plan summary and Table of benefits before making your choice. You must make sure the plan meets your needs. Please contact us if you need copies of these documents.

☐ **Channel Islands UltraCare Prime**	☐ **Channel Islands UltraCare Plus**

Area of cover

Your area of cover under the Channel Islands UltraCare plan will be Area 1 Europe.

E Medical questionnaire

Please answer all questions in this section.

For the purpose of this application, diseases and disorders include any abnormality, injury, disability, illness or sickness, whatever the cause.

For the purpose of this application, medication includes the use of any substance:

- whatever the means of delivery; and
- whether or not a prescription is needed;

including, but not limited to, vitamins, minerals and supplements, oral and injected medicines and drugs, suppositories, patches, creams, lotions, ointments, gels, drops, sprays and lozenges.

This does not include skin moisturisers, sun protection products, shampoo or mouthwash, unless used in relation to a symptom, disease or disorder.

If a medical professional has confirmed that you, or any of your dependants in this application, have a disease or disorder, we will treat this as a diagnosed medical condition, whether or not they have confirmed the diagnosis to you or your dependant in writing, and regardless of whether or not treatment, medication or a special diet was needed or received following the diagnosis. This includes diseases or disorders diagnosed as the result of routine health or wellness checks.

1. In the last five years, have you, or any of your dependants in this application:

- needed or had any medical investigations, diagnostic tests or procedures for, or in relation to;
- been diagnosed with;
- needed or received any treatment, medication or a special diet for, or in relation to;
- needed or had any follow-up consultations, tests or procedures for, or in relation to;

any one or more of the following:

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
1.1 Cancer?*								
1.2 Cardiovascular diseases or disorders?**								
1.3 Diabetes?								

If the answer is 'Yes' for any part of question 1, please also complete the additional Cancer, Cardiovascular diseases and disorders and Diabetes questionnaires as applicable.

2. Were you, or any of your dependants in this application, diagnosed with any one or more of the following more than five years ago?

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
2.1 Cancer?*								
2.2 Cardiovascular diseases or disorders?**								

If the answer is 'Yes' for any part of question 2, please also complete the additional Cancer and Cardiovascular diseases and disorders questionnaires as applicable.

** Including, but not limited to, bowel cancer, brain tumours, leukaemia, melanoma, myeloma and sarcoma.*

*** Including, but not limited to, hypertension or high blood pressure, hypotension or low blood pressure, hypercholesterolaemia or high cholesterol, abdominal aortic aneurysm (AAA), angina, atrial fibrillation (AF), stroke including transient ischaemic attack (TIA) and cerebrovascular accident (CVA), and supra ventricular tachycardia (SVT).*

3. In the last five years, have you, or any of your dependants in this application:

- needed or had any medical investigations, diagnostic tests or procedures for, or in relation to;
- been diagnosed with;
- needed or received any treatment, medication or a special diet for, or in relation to;
- needed or had any follow-up consultations, tests or procedures for, or in relation to, any one or more of the following, that you have not already told us about in questions 1-2:

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
3.1 Diseases or disorders of the brain, nervous system or nerves? *Including, but not limited to, encephalitis, epilepsy, migraines, multiple sclerosis (MS), myalgic encephalomyelitis (ME), sciatica and trapped nerves.*								
3.2 Diseases or disorders of the mouth, tongue, jaw, teeth or gums? *Including, but not limited to, abscesses, gingivitis, impacted teeth, temporomandibular joint (TMJ) and tongue-tie.*								

E Medical questionnaire (continued)

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
3.3 Diseases or disorders of one or both eyes or ears, the nose or throat? *Including, but not limited to, adenoids, blindness, cataracts, deafness, detached retina, deviated septum, glaucoma, glue ear, iritis, keratoconus, macular degeneration, otitis, sinusitis, tinnitus and tonsillitis.*								
3.4 Diseases or disorders of one or both lungs, the trachea, bronchial tree or diaphragm? *Including, but not limited to, asthma, chest infections, chronic obstructive pulmonary disease (COPD), emphysema and tuberculosis (TB).*								
3.5 Diseases or disorders of the oesophagus, stomach or duodenum? *Including, but not limited to, Barrett's oesophagus, duodenal ulcers, gastric ulcers, gastritis, gastro-oesophageal reflux disease (GORD) and oesophagitis.*								
3.6 Diseases or disorders of the bowel, small intestine, appendix, large intestine, rectum or anus? *Including, but not limited to, anal fissures, colonic polyps, Crohn's disease, diverticulitis, haemorrhoids or piles, irritable bowel syndrome (IBS), pilonidal sinus and ulcerative colitis.*								
3.7 Diseases or disorders of the liver, pancreas, spleen or gall bladder? *Including, but not limited to, enlarged spleen, gallstones, hepatitis and pancreatitis.*								
3.8 Diseases or disorders of one or both kidneys, the bladder or urinary tract? *Including, but not limited to, cystitis, kidney stones, pyelonephritis, urinary incontinence, urinary retention and urinary tract infections (UTI).*								
3.9 Diseases or disorders of the male reproductive system, genitals or prostate? *Including, but not limited to, balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility or infertility, phimosis and prostatitis.*								
3.10 Diseases or disorders of the female reproductive system, genitals or breasts? *Including, but not limited to, abnormal menstrual cycle or periods, abnormal PAP or smear test results, abnormal vaginal bleeding, endometriosis, fertility or infertility, fibroids, polycystic ovaries and uterine polyps.*								
3.11 Complications during pregnancy or childbirth? *Including, but not limited to, Caesarean sections, ectopic pregnancies and pre-eclampsia.*								
3.12 Diseases or disorders of the bones, body tissues, muscles, joints, cartilage, ligaments or tendons? *Including, but not limited to, back pain, cellulitis, fractured or broken bones, ganglions, gout, hallux valgus or bunions, joint pain, joint replacements, neck pain, osteoarthritis, plantar fasciitis, repetitive strain injuries (RSI), rheumatoid arthritis, slipped discs, sprains, tendonitis and tennis elbow.*								
3.13 Diseases or disorders of the fingernails, toenails, hair or skin, including moles and birthmarks? *Including, but not limited to, alopecia, eczema, ingrowing toenails, moles that have changed in appearance, port-wine stains, psoriasis and venous ulcers.*								
3.14 Diseases or disorders of the blood or veins? *Including, but not limited to, anaemia, deep vein thrombosis (DVT), factor V Leiden, haemochromatosis, haemophilia and other blood clotting diseases or disorders, thalassaemia and varicose veins.*								
3.15 Diseases or disorders of glands, including hormone imbalance? *Including, but not limited to, Addison's disease, hyperhidrosis or excessive sweating, hyperthyroidism, hypothyroidism and parathyroiditis.*								

E Medical questionnaire (continued)

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
3.16 Hernias, lumps, cysts or benign tumours that you have not already told us about in questions 3.1-3.15?								
3.17 HIV or AIDS, auto-immune conditions or allergies that you have not already told us about in questions 3.1-3.16? *Including, but not limited to, food allergies, insect allergies, lupus, myasthenia gravis and prescription drug allergies.*								
3.18 Psychiatric, psychological or behavioural disorders? *Including, but not limited to, anxiety, attention deficit hyperactivity disorder (ADHD), depression, eating disorders and stress.*								
4. Do you, or any of your dependants in this application, have any one or more chronic, long-term or recurrent diseases or disorders that we have not asked you about in questions 1-3?								
5. In the last two years, have you, or any of your dependants in this application, had any abnormal test results that you have not already told us about in questions 1-4?								
6. Have you, or any of your dependants in this application, ever had any joint replacements that you have not already told us about in questions 1-4?								
7. Have you, or any of your dependants in this application, ever had any cosmetic treatment that you have not already told us about in questions 1-4?								
8. In the last two years, have you, or any of your dependants in this application, sought medical advice for any one or more symptoms***, but not had a disease or disorder diagnosed as a result of the advice?								
9. In the last two years, have you, or any of your dependants in this application, had one or more symptoms*** but not sought medical advice?								

*** *Including, but not limited to, abdominal pain, back pain, change in bowel habit, chest pain, dizziness, fainting, fatigue, joint pain, neck pain, persistent cough, rectal bleeding, recurrent headaches, shortness of breath and weight loss or gain.*

10. In the last two years, have you, or any of your dependants in this application, regularly used any medication that you have not already told us about in questions 1-9?								

If the answer is 'Yes' for any part of questions 3-10, please also complete the Additional medical information questionnaire as applicable.

E Medical questionnaire (continued)

Additional medical information

Name of applicant	Question number	What is the name of the disease or disorder (including joint replacements and cosmetic treatment), symptom(s) or complication(s) and when did it start? (dd/mm/yyy)	If you answered 'Yes' to question 5, what abnormal test results have you had and when were they done? (dd/mm/yyy)	What treatment, medication or special diet have you been given? Please specify names of drugs and dosage required.	What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended? Please give details including dates where necessary.	Do you still have this disease or disorder (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests?	What date did you last see any health care professional for this disease or disorder, (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests? (dd/mm/yyy)	If you answered 'Yes' to question 10, what medication are you regularly using and why do you take it?

F Doctor's or medical practitioner's details

Please give the contact details of any family doctor or medical practitioner who has treated you or your dependants in the last two years. If you do not provide this information, it may result in a delay in processing any claims and/or your claim may be rejected.

Name:	Name:
Hospital, clinic or practice:	Hospital, clinic or practice:
Phone:	Phone:
Fax:	Fax:
Email:	Email:
Address:	Address:
Postcode:	Postcode:

G Add-on plans and benefits

The Travel and Maternity add-on plans are only available with moratorium underwriting terms. Please read and sign the declaration in section I of this application if you choose one of these add-on plans.

Do you want to add any of the following?

Travel add-on plan	☐ Yes ☐ No
If yes, please tell us which type:	☐ Planholder only ☐ Planholder and all dependants
Maternity add-on plan	☐ Yes ☐ No
If yes, please tell us which level of co-insurance you have chosen for each person:	☐ No co-insurance ☐ 10% ☐ 20%

The Maternity add-on plan is only available for female members. The minimum age at entry for this plan is 18. The maximum age at entry is 44. Cover only becomes available for treatment received 12 months after the start date of this add-on plan.

Personal accident add-on plan	☐ Yes ☐ No

If yes, please circle the number of Personal accident units you need for each person as set out in the Personal accident add-on plan Table of benefits. You must be aged 18 to 74 when joining this plan.

Planholder:	1	2	3	4	5	Dependant 1:	1	2	3	4	5	Dependant 2:	1	2	3	4	5	Dependant 3:	1	2	3	4	5

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

The Personal accident add-on plan provides cover for managerial, clerical and administrative occupations only. The plan does not cover claims arising from engaging in manual or dangerous occupations or hazardous pursuits. If you or any dependants on this application engage in any hazardous pursuit or occupation which puts you at greater risk of a bodily injury caused by an accident, please give full details on a separate sheet and include it with this application. If you are in any doubt as to whether an occupation is manual or dangerous or a pursuit is a hazardous one, please tell us. If we agree to provide cover, extra premiums may apply.

H Pre-existing medical conditions for add-on plans

You must read and sign this section if you have chosen Travel or Maternity add-on plans in section H.

Please read this declaration carefully before applying for any Travel or Maternity add-on plans. These plans are subject to moratorium underwriting terms as explained in the Plan guide. Please refer to benefit exclusion BE1 for the Maternity add-on plan and BET2 for the Travel add-on plan.

You must sign this section to show that you understand and accept our 24-month moratorium. We will not process your application unless you have signed this section as well as the declaration section on this application.

It is important that you read, understand and accept all of the paragraphs in the following declaration for your plan.

This declaration applies to you and to any eligible dependants you have included in the application.

The 24-month moratorium is a waiting period of 24 months from your date of joining, or the date shown on the special terms section of your Certificate of insurance, that must have passed before claims for pre-existing medical conditions may be eligible under the plan.

A pre-existing medical condition or related medical condition is one that, within a 24-month period before the date of joining, or the date shown on the special terms section of your Certificate of insurance, has one or more of the following characteristics:

- was foreseeable;
- clearly showed itself;
- you had signs or symptoms of;
- you asked for advice about;
- you received treatment for;
- to the best of your knowledge, you were aware you had.

Pre-existing medical conditions or related medical conditions may be covered after you have had 24 months' continuous cover under the plan and within that time you have not:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet.

If you have:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication or a special diet;

then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Pre-existing medical conditions or related medical conditions may then be covered. This is the rolling part of the moratorium.

I confirm that I have read, understood and accept this moratorium underwriting clause about pre-existing medical conditions and that it applies to any eligible dependants included in the application.

Signature:	Date (dd/mm/yyyy):

I Paying your premiums

To enjoy the full benefit of the plan, you must make sure the premiums are paid on or before the premium due date. You must tell us about any changes to your payment details to make sure that we can continue to collect any premiums due.

You can find full payment details and information on unpaid or late payments in the Plan guide. If you have not paid the premiums, we will suspend all claims until the premiums are up to date.

Currency

Premiums must be paid in GB pounds (£).

Payment options

You can pay yearly, every three months or every month. Please choose how often you want to pay your premiums and tick the relevant method applicable to it. We cannot accept payment by bank transfer, cheque or banker's draft if you are paying by instalments. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% more if you pay every month and 7.5% if you pay every three months).

	Card	Bank transfer	Cheque or banker's draft	Direct debit
Yearly	☐	☐	☐	☐
Every three months	☐	N/A	N/A	☐
Every month	☐	N/A	N/A	☐

Add-on plans and benefits

Travel and Personal accident add-on plan premiums can only be paid yearly.

If you have chosen the Maternity add-on plan, please tell us how often you want to pay your Maternity add-on plan premiums. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% if you pay every month and 7.5% if you pay every three months).

☐ Yearly	☐ Same as UltraCare plan (if every month or every three months)

Payment details

Card

We can accept card payments by Visa or MasterCard. Please complete the Credit card authority attached to this application. Please make sure that your card is valid for at least three months from the start date of your plan.

Bank transfers

Bank transfers must be in the currency of your plan. Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer. Please send your payment to 'Aetna Insurance Company Limited' and to the corresponding details below.

Bank:	HSBC Bank plc
Address:	8 Canada Square London E14 5HQ United Kingdom
Account No:	41611593
Sort code:	40-21-05
Swift Code:	MIDL GB22
IBAN No:	GB84 MIDL 402105 41611593

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'PAY FULL AMOUNT' or 'Bank Charges Debit Account'.

Cheque or banker's draft

Cheques and banker's drafts must be payable to 'Aetna Insurance Company Limited'. Please make sure that your full name and quotation or plan number are clearly shown on the back of the cheque or banker's draft in case your payment becomes separated from this application.

Direct debit

Please complete the direct debit form attached to this application.

J Data Protection

Aetna Global Benefits (UK) Limited ('Aetna', 'we') is the data controller of personal data collected and processed for the purposes set out in this document. Aetna considers personal data or personal 'information' to be confidential. We protect the privacy of that information in accordance with applicable privacy laws and regulations, as well as our own company privacy policies.

These laws and regulations include, but are not limited to, the Health Insurance Portability and Accountability Act Privacy Rules (HIPAA Privacy Rules), the General Data Protection Regulation (GDPR), the UK Data Protection Act 2018 and any applicable EU member state legislation and derogations.

We will use your personal data to determine eligibility and provide a quotation to you or to your broker; onboarding you to the plan, process payments, premiums and claims; managing, administering and improving your policy; investigating and responding to complaints; contact you with information about your plan and for the purposes of providing healthcare or wellness advice; fraud prevention together with any other regulatory checks; establish, exercise or defend legal claims or rights and to protect, exercise and enforce our rights, property or safety.

Where your health data is used for any of the above we rely on the insurance condition provided under the UK Data Protection Act 2018, which means we don't need to acquire your consent for the processing.

We retain your personal data for as long as necessary to provide you the benefits under your insurance plan, until such time as any claim under the insurance policy is concluded, until the limitation for exercising any legal rights has expired or for compliance with any legal or regulatory requirements.We may disclose information about you in various ways, including, but not limited to: health care operations, treatment, disclosure to other covered entities, plan administration, research, business associates, industry regulation, law enforcement, legal proceedings and public welfare.

In all situations other than those described above, we will ask for your written authorization before using or disclosing information about you.

We will not send any personal data or health information outside the EEA unless the appropriate protections are in place, or unless there are emergency medical ground for doing so.

To help us make sure that your personal information remains accurate and up-to-date, please inform us of any changes.

You have the right to access to your personal information, to request correction, erasure, restriction of processing, transfer of your information, and object to the processing of your personal data.

If you would like to exercise any of your rights relating to your personal data, or enquiry any further information, please contact our designated Data Protection Officer:

Data Protection Officer
50 Cannon Street,
London EC4N 6JJ
United Kingdom
Or
dpo@aetna.com

You can find our full terms and conditions and details of our privacy policy at https://www.aetnainternational.com/en/about-us/legal-notices.html

K Declaration

I am applying to be covered under the UltraCare plan and any add-on plans I have chosen together with the dependants listed in this application, which are subject to the terms and conditions of the relevant Plan Documentation.

I confirm that I have read this application in full, understand it, have followed its instructions and agree to all of its terms.

I declare that I will inform Aetna if the answers to the questions set out in this application or in the questionnaires, or any other information I provide to Aetna in response to its questions, as applicable, change between the date of signing of this declaration and the date the cover commences.

I confirm that where the plan to which I am subscribing provides cover for a dependant, I have checked with that dependant that the information relating to him or her which I have provided you with is answered honestly to the best of my and his or her knowledge, having taken reasonable care, and that I have their consent to (i) provide the information about them in this application and (ii) make the declaration in this section K, on their behalf.

I authorise the doctor(s) named in section F or any other medical establishment, including any other health professional who has treated me and any of my dependants included under this plan, to give you any information you may need in connection with this application, your plan(s) or any claim made under your plan(s).

I am satisfied that the products I have chosen meet my needs at this time.

For your own benefit and protection, you should read the terms and conditions shown in the Plan guide carefully before signing this declaration. If you do not understand any point, please ask for more information.
You can find our full terms and conditions and details of our privacy policy at www.interglobalpmi.com

Signature:	Date (dd/mm/yyyy):

Cancellation

If you feel this plan does not meet your needs, you may cancel it. You must tell us in writing by letter, fax or email and return all membership cards and Certificates of insurance within 30 days of the date of joining or receiving the plan documents, whichever is later.

L Broker details

Broker's or advisor's details if applicable:

1 October 2018

InterGlobal

Direct debit mandate

Instruction to your bank or building society to pay by direct debit

DIRECT Debit

Originator's Identification:

2	4	2	5	8	4

We offer direct debit as an alternative form of payment to all planholders who take out a plan in GB pounds (£) and currently hold a UK bank or building society account. If you would like to take advantage of this facility for your regular payments, please complete the form below.

We must receive the original of this form in order to set up your direct debit payments as banks will not accept copies.

Please complete this form in BLOCK CAPITALS and send it to:

Aetna Insurance Company Limited,
25 Templer Avenue, IQ Farnborough, Farnborough, Hampshire, GU14 6FE, United Kingdom.

Name and full postal address of your bank or building society:

To: The Manager

Bank or building society name:

Address:

Postcode:

Name(s) of account holder(s):

If you are not the planholder, describe your relationship to the planholder:

Bank or building society account number:

Branch sort code:

Quotation number and option number if you have one:

and/or

Plan number:

Reference number *(for InterGlobal's use only)*:

Instruction to your bank or building society

Please pay Aetna Insurance Company Limited direct debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee.

I understand that this instruction may remain with Aetna Insurance Company Limited and, if so, details will be passed electronically to my bank or building society.

Signature(s):

Date (dd/mm/yyyy):

Banks and building societies may not accept direct debit instructions for some types of accounts.

DIRECT Debit

The Direct Debit Guarantee

This Guarantee should be detached and retained by the Payer.

- 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 Insurance Company Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Aetna Insurance Company Limited to collect payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made by Aetna Insurance Company Limited or your bank or building society you are guaranteed a full and immediate refund from your branch of the amount paid.
- If you receive a refund you are not entitled to, you must pay it back when Aetna Insurance Company Limited asks you to.
- 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.

InterGlobal

Credit card authority

We are committed to safeguarding your personal data. Your payment details will be processed securely in accordance with our strict safety procedures and relevant legislation. We can accept card payments by Visa or MasterCard. There are four ways to pay by card:

1. Log on to the website at https://www.aetnainternational.com/payonline/ and submit your card details using the secure payment system. Complete the section below notifying us of the date of submission or the reference number of the payment. You do not need to complete the Credit card authority section of this application. Send your application to us by post, email or fax.

Date submitted details online:	and/or	Reference number:

2. Complete the Credit card authority below in full and fax the application to: +44(0) 1252 745 928.
3. Complete the Credit card authority below in full and post.
4. Call us to make a payment by telephone. You do not need to complete this form.

Please do not send your card details to us by email. Email and internet messages cannot be guaranteed to be completely secure and can be intercepted, lost or stolen. We will not process card payments sent by email.

To Aetna Insurance Company Limited

Please complete in BLOCK CAPITALS.

Quotation number and option number if you have one:	and/or	Plan number:

Name(s) *(as shown on your card)*:

If you are not the planholder, describe your relationship to the planholder:

My card billing address is:

Postcode:

Please tick the appropriate box:

☐ Visa ☐ MasterCard

My card number is: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Issue date: ☐☐☐☐ Expiry date: ☐☐☐☐ Card security code: ☐☐☐

For your safety and security and to facilitate the processing of your payment, we require that you enter your card's verification number (card security code). The verification number is the last three digits of the number printed on the signature strip on the back of your card.

Your card details will be held and processed in accordance with strict data security regulations and guidelines which we adhere to. Once your payments have been initiated this number will be destroyed by us.

Please charge the above card in GB pounds (£) and *(please tick):*

☐ Yearly ☐ Every three months ☐ Every month

I hereby authorise the Card Account specified above to be debited with the current premium due, and all subsequent renewal premiums and other charges due as notified by Aetna Insurance Company Limited until I give notice in writing that I wish to withdraw my authorisation. I understand that Aetna Insurance Company Limited will give at least 4 weeks' notice of renewal, and that the premiums may vary each year. I understand that Aetna Insurance Company Limited cannot be held liable if my plan lapses as a result of the card being declined and I have not provided or responded to requests for alternative methods of payment.

Cardholder's signature(s):	Date (dd/mm/yyyy):