

Channel Islands UltraCare plan

Individual application

Transfer

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

InterGlobal Insurance Company Limited has changed its name to Aetna Insurance Company Limited. The company will continue to trade under the 'InterGlobal' brand until further notice. InterGlobal Limited has changed its name to Aetna Global Benefits (UK) Limited. The words 'Aetna' and 'other Aetna entities' when used in this document mean Aetna Insurance Company Limited and include any other Aetna International Inc. group company as the context requires.

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 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 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.

Please complete this application clearly in BLOCK CAPITALS.

A Your personal details (the planholder)

Current plan and underwriting terms:	
Plan number(s):	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> F

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

Your address²

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

Dependant 1

Current plan and underwriting terms:	
Plan number(s):	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Channel Island/Country where they live:	Nationality on passport:
Occupation ¹ :	Relationship to you:

Dependant 2

Current plan and underwriting terms:	
Plan number(s):	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Channel Island/Country where they live:	Nationality on passport:
Occupation ¹ :	Relationship to you:

Dependant 3

Current plan and underwriting terms:	
Plan number(s):	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Channel Island/Country where they live:	Nationality on passport:
Occupation ¹ :	Relationship to you:

B Dependants to be covered (continued)

Dependant 4

Current plan and underwriting terms:	
Plan number(s):	
Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Channel Island/Country where they live:	Nationality on passport:
Occupation ¹ :	Relationship to you:

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 start on the expiry date of your existing UltraCare plan. We cannot backdate cover under any circumstances.

Date your existing UltraCare plan started (dd/mm/yyyy):

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.

<input type="checkbox"/> Channel Islands UltraCare Prime	<input type="checkbox"/> Channel Islands UltraCare Plus
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Area of cover

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

E 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tell us which type:	<input type="checkbox"/> Planholder only <input type="checkbox"/> Planholder and all dependants
Maternity add-on plan	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please tell us which level of co-insurance you have chosen for each person:	<input type="checkbox"/> No co-insurance <input type="checkbox"/> 10% <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If yes, please select 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	Dependant 4: 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.

F 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Every three months	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>
Every month	<input type="checkbox"/>	N/A	N/A	<input type="checkbox"/>

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).

<input type="checkbox"/> Yearly	<input type="checkbox"/> Same as UltraCare plan (if every month or every three months)
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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

We can only accept direct debits from UK bank accounts for plans in GB pounds (£). To make a payment please complete the direct debit form we provide to you.

G 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:

H Medical questionnaire

We assess your Transfer application based on your answers to the following questions:

1. Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint disorder, psychiatric or mental illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. In the last 12 months have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you or any of your dependants have any long-term, ongoing or chronic condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. If you are applying for the Maternity add-on plan, is anyone to be covered on this plan currently pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. In the last 2 years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions 1-4 above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answer yes to any of the above questions, please provide details in section M Medical details.

I Pre-existing medical conditions

You must read and sign this section if you are transferring moratorium underwriting terms or if you have chosen Travel or Maternity add-on plans in section E.

You must read and sign this section if an application to transfer existing underwriting terms has been declined and you or your dependant(s) wish to apply for moratorium underwriting terms from the start date shown in section C.

Please read this declaration carefully before applying, these plans are subject to moratorium underwriting terms as explained in the Plan guide. Please refer to benefit exclusion BE1 for the UltraCare plan or 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(s).

This declaration applies to you and to any eligible dependants you have included in the application that are applying for moratorium underwriting terms.

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):
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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 G 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:

