InterGlobal

UltraCare plan

Group member application

For office use only: CPME

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.

Cover start date (dd/mm/yyyy):

The plan is a yearly contract. Your cover will start on the expiry date of your existing plan. We cannot backdate cover under any circumstances.

Date existing cover ends (dd/mm/yyyy):

Date existing medical insurance was first taken out with the current insurer (dd/mm/yyyy):

A copy of the current certificate of insurance must be provided for each member applying for CPME terms.

Please complete this application clearly in BLOCK CAPITALS and tick the boxes where needed.

IMPORTANT – PLEASE READ

Completing this application

The questions in this application and any other information we ask for are essential for us to be able to assess whether to add you (and any of your dependents) to the UltraCare plan (and any applicable add-on plans), 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 dependent'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.

A Your personal details

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Date of birth (dd/mm/yyyy):	Sex: ☐ M ☐ F
Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Country where you live:	Nationality on passport:
Occupation:	

B Dependants to be covered

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:	Nationality on passport:
Occupation:	Relationship to you:

B Dependants to be covered (continued)

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:	Nationality on passport:
Occupation:	Relationship to you:

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:	Nationality on passport:
Occupation:	Relationship to you:

Dependant 4

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:	Nationality on passport:
Occupation:	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 Doctor's or medical practitioner's details in your home country

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 delay us in processing any claims.

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

D Doctor's or medical practitioner's details in the country where you live

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 delay us in processing any claims.

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

E Add-on plans and benefits

Travel add-on plan	☐ Yes ☐ No	
If yes, please tell us which type:	☐ Main member only	☐ Main member and all dependants
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.

Main member: 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 any member on this application engages in any hazardous pursuit or occupation which puts them 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 Medical questionnaire

We assess your CPME application based on your answers to the following questions and the information on your current certificate of insurance. Your current certificate of insurance must show your current insurance arrangements.

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 replacement, psychiatric or mental illness?	☐ Yes	☐ 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?	☐ Yes	☐ No
3. If your Group's plan includes Maternity cover, are you or any of your dependants currently pregnant?	☐ Yes	☐ No

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

G Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with The General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679), medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Aetna entities or third parties acting on our behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, your personal data will be protected by a strict code of secrecy and security which we and any third parties working on our behalf are subject to and will only be used in accordance with our instructions.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

In order to assess the terms of the contract of insurance, including specific medical exclusions, or to administer claims, we may collect medical information which The General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679) defines as Special Categories of Personal Data. Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your group's agent or broker if you have requested them to assist you in handling your claims and you have authorised us to provide them with such medical information.

We will not disclose your medical information to any other individual without your explicit consent. If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

All membership documents will be sent to the planholder.

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

You have the right to see personal information about you held by us. There may be a charge for this. Please write to: Data Protection Officer, Aetna Insurance Company Limited, 25 Templer Avenue, IQ Farnborough, Farnborough, Hampshire, GU14 6FE, United Kingdom.

H Declaration

I am applying to be covered under the UltraCare plan (and any applicable add-on plans) 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 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 H, on their behalf.

I consent, on my own behalf and on behalf of my dependants, to any personal data, including medical information, that Aetna may collect about me and my dependants being used in the way described in section G.

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

I understand and agree that, unless the agreed premium, the completed group formation application and the details of all scheme members have been received from the planholder, no claims treatment will be authorised for payment by the insurer.

For your own benefit and protection, you should read this application and the terms and conditions shown in the Plan guide carefully before signing this declaration. If you do not understand any point, please ask your plan administrator or us for more information.

Name:	Signature:
Date (dd/mm/yyyy):	

I Medical details

Name	Question number	Symptom and/or medical condition	When did the symptoms start?	What treatment did you receive and when? (Please include dates and any medication prescribed)	What was the outcome of the treatment? (e.g. ongoing, still under review, complete recovery, recurrent or likely to recur?)

If you require more space, please give us details on a separate sheet of paper and send it to us with this application.

Whenever coverage provided by any insurance policy would be in violation of any US, UN or EU economic or trade sanctions, such coverage shall be null and void. For example, we cannot pay for health care services provided in a country under sanction by the United States unless permitted under a written Office of Foreign Asset Control (OFAC) license. Learn more on the US Treasury's website at: www.treasury.gov/resource-center/sanctions.

Plans are underwritten by Aetna Insurance Company Limited, registered in England (Company Registration No. 05956141), which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No. 458505). Plans are administered on behalf of the insurer by Aetna Global Benefits (UK) Limited, registered in England (Company Registration No. 03554885), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 312279). Both companies are registered at 50 Cannon Street, London, EC4N 6JJ, United Kingdom.