Archipelago
Life Insurance Limited

UltraCare plan

Group member application

For office use only: CPME

InterGlobal Limited has changed its name to Aetna Global Benefits (UK) Limited.

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.

You must tell us about all material facts before we accept an application or renew the plan. A material fact is information likely to influence us in assessing and accepting the insurance. If you do not tell us all material facts or if you misrepresent any material facts, this may render the insurance voidable from inception (the start of the contract) and enable us to repudiate liability (entitle us not to pay your claims). If there is any doubt about whether a fact is material, for your own protection, you must tell 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:

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:

B Dependants to be covered (continued)

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 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 H Medical details.

F 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 relevant legislation, medical confidentiality guidelines 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 agents, other Aetna entities or third parties acting on our behalf. 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. 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 the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

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.

We may, from time to time, provide you with marketing information about our products and services and those of any associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box. ☐

G Declaration

I am applying to be covered under the UltraCare plan or plans together with the dependants listed in this application.

I have read, understood and agree to keep to the terms and conditions shown in the Plan guide, along with all eligible dependants included in this application or any dependants I enrol in the future after the start date of the plan. I confirm that I have authority to give Archipelago Life Insurance Limited and/or Aetna information about my dependants referred to in this application and where necessary that I have checked with them that the information I have provided is correct. I confirm that to the best of my knowledge, the information I have provided on this application is complete and accurate and that it contains all the information required.

By agreeing to the UltraCare terms and conditions, I consent to any personal data, including medical information, that you may collect about me and my dependants, being processed by Archipelago Life Insurance Limited and/or Aetna.

I authorise and request the doctors 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 this plan, to give you or the insurer's medical co-ordinator any information they may need in connection with any claim made under this plan.

I understand that if I do not provide the information asked for in sections C, D, E and H (if applicable), and I or any of my dependants included under this plan make a claim, which you view as being treatment for a pre-existing medical or related medical condition, my claim may be rejected.

I understand that should I or one of my dependants attend a hospital/clinic/medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Archipelago Life Insurance Limited and/or Aetna has the right to recover the full amount of the ineligible claim from myself, the dependant/s or the planholder.

I declare that the information I have provided in this application is correct in all respects.

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

I understand and agree that this declaration and the information in this application will form the basis of the cover provided.

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.

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

H 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.