

UltraCare plan

Group member application

For office use only: MORI

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

Cover start date (dd/mm/yyyy):

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: <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
Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Country where you live:	Nationality on passport:
Occupation:	

B Dependants to be covered

Dependant 1

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
Country where they live:	Nationality on passport:
Occupation:	Relationship to you:

Dependant 2

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
Country where they live:	Nationality on passport:
Occupation:	Relationship to you:

Dependant 3

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
Country where they live:	Nationality on passport:
Occupation:	Relationship to you:

B Dependants to be covered (continued)

Dependant 4

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
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 Pre-existing medical conditions

We will not cover you or any of your dependants under this plan for treatment of any pre-existing medical conditions or related medical conditions, as set out in benefit exclusion BE1 of the Plan guide. We may place a moratorium period on your plan after which you may be eligible for treatment for a pre-existing medical condition.

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. Please read benefit exclusion BE1 in the Plan guide. The moratorium also applies to add-on plans.

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.

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 and D, 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):	

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.

All plans are underwritten by Archipelago Life Insurance Limited and administered 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), Woolmead House East, The Woolmead, Farnham, Surrey, GU9 7TT, United Kingdom.

Archipelago Life Insurance Limited is licensed by Labuan FSA, Company No. LL09829, Licence No. IS2013141.

Registered office address: Level 1, Lot 7, Block F, Saguking Commercial Building, Jalan Patau-Patau, 87000 Labuan FT, Malaysia.

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