InterGlobal

UltraCare International Schools plan

Individual application
Continuation of Personal Medical Exclusions (CPME) transfer

Need help completing this application?
Please contact either your advisor or us directly. 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 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.

If you have received a quotation from us, please write the quotation number and option number if you have one:

Quotation number:	Option number:

A Details of your school

Name of international school:	
Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

B Your personal details (the planholder)

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms	Other:
Family name (surname):	First name(s):
Country where you live[1]:	How long have you lived there?
Home country:	Nationality on passport:
Occupation[2]:	Date of birth (dd/mm/yyyy): Sex: ☐ M ☐ F

[1] The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on the country where you live. Please speak to your advisor or contact us if you are unsure whether your premium will be affected. Please make sure that your plan meets the requirements of the country where you live.

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

B Your personal details (the planholder) (continued)

Your address[3]

[3] We will send all correspondence to this address unless you have completed the details below for a correspondence address. 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:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

Correspondence address – if different from your address above

Address:	
Town:	City:
Postcode:	Country:
Phone:	Mobile:
Email:	

C 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[1]:	Nationality on passport:
Occupation[2]:	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[1]:	Nationality on passport:
Occupation[2]:	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[1]:	Nationality on passport:
Occupation[2]:	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[1]:	Nationality on passport:
Occupation[2]:	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.

D Cover start date

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.

E Your cover options

Level of cover and type of plan

Please tell us the type of UltraCare International Schools 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.

☐ UltraCare International Schools Bronze	☐ UltraCare International Schools Silver	☐ UltraCare International Schools Gold

Area of cover

Choose the area of cover from the descriptions below based on the country where you live and your home country if you need the option of returning to your home country for treatment. Please see the 'Individual eligibility' section in the Plan guide for restrictions on US citizens. You and your dependants must have the same area of cover.

☐ **Area 1** Europe
☐ **Area 2** Worldwide, not including the USA
☐ **Area 3** Worldwide

Excess options (deductibles)

If you want to change the excess from the standard excess shown, please tick the appropriate box below.

Excess options	UltraCare International Schools Bronze	UltraCare International Schools Silver	UltraCare International Schools Gold
No excess	N/A	☐ 15% premium increase	☐ 15% premium increase
$50 or £30	Standard	Standard	Standard
$85 or £50	N/A	☐ 5% premium discount	☐ 5% premium discount
$170 or £100	N/A	☐ 10% premium discount	☐ 10% premium discount
$425 or £250	N/A	☐ 15% premium discount	☐ 15% premium discount
$850 or £500	☐ 10% premium discount	☐ 20% premium discount	☐ 20% premium discount
$1,700 or £1,000	☐ 20% premium discount	☐ 25% premium discount	☐ 25% premium discount
$4,250 or £2,500	☐ 30% premium discount	☐ 30% premium discount	☐ 30% premium discount
$8,500 or £5,000	☐ 40% premium discount	☐ 40% premium discount	☐ 40% premium discount

UltraCare International Schools Bronze plan

You must pay a standard excess amount of $50 or £30 for each medical condition in each plan year for all out-patient medical treatment claims.
If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including organ transplants.

UltraCare International Schools Silver and Gold plans

You must pay a standard excess amount of $50 or £30 for each medical condition in each plan year for all out-patient medical treatment claims, including HIV or AIDS and maintenance of chronic medical conditions.
If you choose a voluntary excess, this will apply for each medical condition in each plan year for all in-patient, daycare and out-patient medical treatment, including organ transplants, HIV or AIDS, emergency medical treatment outside your area of cover and maintenance of chronic medical conditions.

Co-insurance (deductibles)

UltraCare International Schools Silver and Gold plans

You must pay 25% of all out-patient dental treatment claims. The maximum amount we will pay to you for out-patient dental treatment will be 75% of each eligible claim. The total amount we will pay to you for an eligible claim for out-patient dental treatment will be 75% of the limit shown on your Table of benefits. You cannot remove this co-insurance.

UltraCare International Schools Gold plan

You must pay 20% of all normal pregnancy and childbirth claims. The total amount we will pay to you for an eligible claim for normal pregnancy and childbirth will be 80% of the limit shown on your Table of benefits. You cannot remove this co-insurance.

F Add-on plans and benefits

The Travel add-on plan is only available with moratorium underwriting terms. Please read and sign the declaration in section G of this application if you choose this add-on plan.

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
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	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.

G Pre-existing medical conditions for add-on plans

You must read and sign this section if you have chosen a Travel add-on plan in section F.

Please read this declaration carefully before applying for any Travel add-on plan. These plans are subject to moratorium underwriting terms as explained in the Plan guide. Please refer to benefit exclusion 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 UltraCare International Schools 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 this application.

Signature:	Date (dd/mm/yyyy):

H 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

In which currency do you want to pay your premiums?

☐ US dollars ($)	☐ GB pounds (£)

The currency of your benefit limits will depend on the currency in which your premiums are paid.

Payment options

You can pay yearly or every three months. 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 three months will be higher than if you pay the premiums every year (about 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	☐

Add-on plans and benefits

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

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.

US dollar ($) Account		GB pound (£) Account	
Bank:	HSBC Bank plc	Bank:	HSBC Bank plc
Address:	8 Canada Square London E14 5HQ United Kingdom	Address:	8 Canada Square London E14 5HQ United Kingdom
Account No:	67348768	Account No:	41611593
Sort code:	40-05-15	Sort code:	40-21-05
Swift Code:	MIDL GB22	Swift Code:	MIDL GB22
IBAN No:	GB68 MIDL 400515 67348768	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 in the currency of your plan and 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 (£). Please complete the direct debit form attached to this application.

I 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:

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

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?	☐ 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. Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for?	☐ Yes	☐ No
4. If you are applying for the Maternity add-on plan, is anyone to be covered on this plan currently pregnant?	☐ Yes	☐ 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?	☐ Yes	☐ No

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

K 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.

K Data Protection (continued)

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

L Plan Information

How do you want to receive plan information?

We consent to the plan sponsor and members receiving information by electronic means instead of paper. ☐

By consenting to this, the plan sponsor and members will receive information about the plan by email, online and through our secure member website instead of by way of a paper copy. You are still entitled to request to receive information in a paper copy free of charge at any time.

OR

We would like the plan sponsor and members to receive information by way of paper copy. ☐

M 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 M, on their behalf.

I authorise the doctor(s) named in section I 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.

N Broker details

Broker's or advisor's details if applicable:

O 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.

25 May 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 *(please tick)*:

☐ Yearly ☐ Every three months

☐ US dollars ($) ☐ GB pounds (£)

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):