Executive Healthcare Plan (EHP)
Individual Application Form
Full Medical Underwriting (FMU)

Completing this application

Please make sure you complete all sections. The questions should be considered carefully and answered as fully as possible. We will not be able to process your application if information is missing.

If we need more information from your doctor and they charge for this, you must pay the costs. Once we have all the information needed to consider your application we will either:

- agree to accept all of these declared medical conditions and may charge an increased premium,
- agree to accept some of these declared medical conditions and may charge an increased premium. The declared conditions we do not accept will be excluded and specified on your Certificate of insurance,
- exclude all of the declared medical conditions. These will be specified on your Certificate of insurance, or
- decline the application.

All other terms and conditions of the Handbook still apply.

IMPORTANT - PLEASE READ – YOUR DUTY OF DISCLOSURE

The questions in this application and any other information we ask for are essential for us to underwrite and administer your plan. You must take reasonable care to accurately and fully answer any questions that we ask you.

You must also exercise reasonable care to make sure that all information or material facts that you supply to us are true and correct, whether or not we have asked you a question about such facts.

Material facts are those which we take into account in assessing whether to offer you insurance and, if so, at what premium and on what terms. If you have any doubt as to whether certain facts are material, please ask us or your insurance broker or intermediary if you have one.

Failure to exercise reasonable care may:

- entitle us to treat your plan as if it had never existed,
- result in different terms being applied to your plan, or
- result in a claim not being paid in full or at all.

Please do not assume that we will carry out any searches or contact any other person (including any medical practitioner) to check the answers to any of the questions we ask you or the information you provide on this application. It remains your responsibility to fill in the application and check that the information within it is accurate.

You should keep a record of all information that you have provided to us in respect of this insurance. If any of the details that you give on this application are different from the details that you gave when you received your quotation, your premium may be different.

Please return this completed form to one of the following offices:

Executive Healthcare Solutions Limited
6th Floor, 9 West
Ring Road Parklands
PO Box 14680, 00800, Westlands
Nairobi, Kenya

T: (254 20) 291 0000
F: (254 20) 291 0600
E: info@executive-healthcare.com

Aetna Global Benefits Limited
PO Box 6380
Dubai, UAE

T: + 971 4 438 7600
F: + 971 4 428 7100
E: MEASales@aetna.com

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Section 1 – Applicant's Details (First Person)

Family Name – As per Passport				Title
First Name(s) – As per Passport				
Marital Status	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
Industry		Occupation/Job Title		
Country of Nationality	Passport No./ID Card No.	**Country of Residence**		
Residential Address		Correspondence Address		
Town/City		Town/City		
Country/State		Country/State		
Postal Code		Postal Code		
Home Telephone		Business Telephone		
Mobile		Fax		
Home Email		Business Email		

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Section 2 – Dependant's Information (Please note children to be included under this plan must be under 18 years of age, or 26 years or under if they are in full-time education and are fully dependant upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.)

Dependant 1	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 2	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 3	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 4	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.
Dependant 5	Family Name			First Name(s)	
	Other Initials	Title	Gender ☐ M ☐ F	Height (cms/ins)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation/Job Title			**Country of Nationality**	Passport No./ID Card No.

Section 3 – Commencement Date (Subject always to **Section 8** of this application form). The **commencement date** of this **policy** will begin when we have received, in writing, your acceptance of the special terms. Under no circumstances will **policies** be backdated.)

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Section 4 – Additional Options (The Executive Healthcare Plan enables **you** to choose various Standard Plan Designs and Optional Modules to suit **your** personal requirements. Please clearly check the Standard Plan Design you require, any Optional Modules **you** have selected and the **Excess you** require. **Your policy** will be issued on this basis. If no boxes are checked in this section, it will be assumed that cover required is Area 1 Foundation Plan with standard US$ Nil Policy Excess.)

Geographical Cover	**Product Selection**			
Core Products:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	Not Applicable	☐	☐

*(Excess options are limited to US$40, US$80, US$150)

Product Options:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Exclude Pregnancy Cover	Not Applicable	Not Applicable	☐	☐
☐ Wellness	Not Applicable	Not Applicable	☐	☐
☐ Routine Dental Treatment	Not Applicable	Not Applicable	☐	Standard

	Policy Excess:			
• **Major Medical**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Major Medical Plus**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Foundation**	☐ US$40	☐ US$80	☐ US$150	☐ US$250
• **Lifestyle**	☐ US$40	☐ US$80	☐ US$150	☐ US$250

Section 5 – Premium Payment and Payment Frequency (Please check which payment method **you** require and complete all details relevant to that method.)

Payment Frequency: Please declare the frequency of payment required. Note that, regardless of frequency, all contracts are annual. A bi-annual and quarterly payment frequency will carry an extra 5% loading and monthly payment frequency will carry an extra 8% loading. Please check as appropriate (if no indication is given an annual frequency will be assumed).

☐ Annual Payment ☐ Bi-Annual Payment ☐ Quarterly Payment ☐ Monthly Payment (Credit Card Only)

☐ a) **Banker's Draft:** All Banker's Drafts must be payable to "Aetna Global Benefits Limited". Please ensure that the name of the Policyholder (as declared in Section 1 of this form) is clearly stated on the reverse of the draft.

☐ b) **Bank Transfer:** Please ensure that the name of the **Policyholder** is clearly stated on any bank transfer. **Our** bank details are available on request by contacting our local representative office. **We** cannot accept liability for any bank transfer which does not clearly identify the **Policyholder**.

☐ c) **Credit Card (US Dollars only):** ☐ VISA ☐ MasterCard

1. Credit Card Number: | | | | | | | | | | | | | | | |
2. Expiry Date (Day/Month/Year): _____
3. Cardholder's Name: _____
4. Cardholder's Statement Address: _____
5. Cardholder's Authorisation Signature: _____
6. Signature Date (Day/Month/Year): _____

continued

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Section 5 – Premium Payment (Continued)

If paying by monthly credit card, please read and complete the Recurring Transaction Authority below.

For payment method c, please note that **Your** premium will be collected upon receipt of this application which may be in advance of the **Commencement Date**. All transactions will be undertaken in UAE Dirhams at the prevailing rate.

If the annual premium exceeds USD 16,500, **We** are required to carryout identity checks of the **Policyholder** by collecting his/ her copy valid photo identity documents- passport, driving license, national identity card or any other photo identity document issued by Government. Kindly attach a copy of the same with this application.

Section 6 – Recurring Transaction Authority

Your authority to Aetna to claim amounts due from **your** VISA or MasterCard account and signature:

I authorise **you** to charge to my above chosen card an unspecified amount in respect of medical insurance premiums as and when they become due. I understand that Aetna will advise me of the amount to be paid and the dates on which payment is due and that Aetna may only change these after giving me prior notice. I understand that this authority in favour of Aetna will remain in force until such a time as I cancel it in writing/email instruction to Aetna.

Cardholder's Authorisation Signature	Date (Day/Month/Year)

Email (where signing online)

Section 7 – Medical Questionnaire

Please answer all questions in this section.

For the purpose of this application, diseases and disorders include any abnormality, injury, disability, illness or sickness, whatever the cause.

For the purpose of this application, medication includes the use of any substance:

- whatever the means of delivery, and
- whether or not a prescription is needed,

including, but not limited to, vitamins, minerals and supplements, oral and injected medicines and drugs, suppositories, patches, creams, lotions, ointments, gels, drops, sprays and lozenges.

This does not include skin moisturisers, sun protection products, shampoo or mouthwash, unless used in relation to a symptom, disease or disorder.

If a medical professional has confirmed that you, or any of your dependants in this application, have a disease or disorder, we will treat this as a diagnosed medical condition, whether or not they have confirmed the diagnosis to you or your dependant in writing, and regardless of whether or not treatment, medication or a special diet was needed or received following the diagnosis. This includes diseases or disorders diagnosed as the result of routine health or wellness checks.

1. In the last five years, have you, or any of your dependants in this application:

- needed or had any medical investigations, diagnostic tests or procedures for, or in relation to,
- been diagnosed with,
- needed or received any treatment, medication or a special diet for, or in relation to,
- needed or had any follow-up consultations, tests or procedures for, or in relation to,

any one or more of the following:

	Planholder		**Dependant 1**		**Dependant 2**		**Dependant 3**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
1.1 Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐
1.2 Cardiovascular diseases?**	☐	☐	☐	☐	☐	☐	☐	☐
1.3 Diabetes?	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 1, please also fill in the additional Cancer, Cardiovascular diseases and disorders and Diabetes questionnaires as applicable.

(continued)

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Section 7 – Medical Questionnaire *(continued)*

2. Were you, or any of your dependants in this application, diagnosed with any one or more of the following more than five years ago?

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
2.1 Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐
2.2 Cardiovascular diseases or disorders?**	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 2, please also fill in the additional Cancer and Cardiovascular diseases and disorders questionnaires as applicable.

** Including, but not limited to, bowel cancer, brain tumours, leukaemia, melanoma, myeloma and sarcoma.*

*** Including, but not limited to, hypertension or high blood pressure, hypotension or low blood pressure, hypercholesterolaemia or high cholesterol, abdominal aortic aneurysm (AAA), angina, atrial fibrillation (AF), stroke including transient ischaemic attack (TIA) and cerebrovascular accident (CVA), and supra ventricular tachycardia (SVT)*

3. In the last five years, have you, or any of your dependants in this application:

- needed or had any medical investigations, diagnostic tests or procedures for, or in relation to,
- been diagnosed with,
- needed or received any treatment, medication or a special diet for, or in relation to,
- needed or had any follow-up consultations, tests or procedures for, or in relation to any one or more of the following, that you have not already told us about in questions 1-2:

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
3.1 Diseases or disorders of the brain, nervous system or nerves? *Including, but not limited to, encephalitis, epilepsy, migraines, multiple sclerosis (MS), myalgic encephalomyelitis (ME), sciatica and trapped nerves.*	☐	☐	☐	☐	☐	☐	☐	☐
3.2 Diseases or disorders of the mouth, tongue, jaw, teeth or gums? *Including, but not limited to, abscesses, gingivitis, impacted teeth, temporomandibular joint (TMJ) and tongue-tie.*	☐	☐	☐	☐	☐	☐	☐	☐
3.3 Diseases or disorders of one or both eyes or ears, the nose or throat? *Including, but not limited to, adenoids, blindness, cataracts, deafness, detached retina, deviated septum, glaucoma, glue ear, iritis, keratoconus, macular degeneration, otitis, sinusitis, tinnitus and tonsillitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.4 Diseases or disorders of one or both lungs, the trachea, bronchial tree or diaphragm? *Including, but not limited to, asthma, chest infections, chronic obstructive pulmonary disease (COPD), emphysema and tuberculosis (TB).*	☐	☐	☐	☐	☐	☐	☐	☐
3.5 Diseases or disorders of the oesophagus, stomach or duodenum? *Including, but not limited to, Barrett's oesophagus, duodenal ulcers, gastric ulcers, gastritis, gastro-oesophageal reflux disease (GORD) and oesophagitis.*	☐	☐	☐	☐	☐	☐	☐	☐

(continued)

Please Retain a Copy for Your Records

Section 7 – Medical Questionnaire *(continued)*

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
3.6 Diseases or disorders of the bowel, small intestine, appendix, large intestine, rectum or anus? *Including, but not limited to, anal fissures, colonic polyps, Crohn's disease, diverticulitis, haemorrhoids or piles, irritable bowel syndrome (IBS), pilonidal sinus and ulcerative colitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.7 Diseases or disorders of the liver, pancreas, spleen or gall bladder? *Including, but not limited to, enlarged spleen, gallstones, hepatitis and pancreatitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.8 Diseases or disorders of one or both kidneys, the bladder or urinary tract? *Including, but not limited to, cystitis, kidney stones, pyelonephritis, urinary incontinence, urinary retention and urinary tract infections (UTI).*	☐	☐	☐	☐	☐	☐	☐	☐
3.9 Diseases or disorders of the male reproductive system, genitals or prostate? *Including, but not limited to, balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility or infertility, phimosis and prostatitis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.10 Diseases or disorders of the female reproductive system, genitals or breasts? *Including, but not limited to, abnormal menstrual cycle or periods, abnormal PAP or smear test results, abnormal vaginal bleeding, endometriosis, fertility or infertility, fibroids, polycystic ovaries and uterine polyps.*	☐	☐	☐	☐	☐	☐	☐	☐
3.11 Complications during pregnancy or childbirth? *Including, but not limited to, Caesarean sections, ectopic pregnancies and pre-eclampsia.*	☐	☐	☐	☐	☐	☐	☐	☐
3.12 Diseases or disorders of the bones, body tissues, muscles, joints, cartilage, ligaments or tendons? *Including, but not limited to, back pain, cellulitis, fractured or broken bones, ganglions, gout, hallux valgus or bunions, joint pain, joint replacements, neck pain, osteoarthritis, plantar fasciitis, repetitive strain injuries (RSI), rheumatoid arthritis, slipped discs, sprains, tendonitis and tennis elbow.*	☐	☐	☐	☐	☐	☐	☐	☐
3.13 Diseases or disorders of the fingernails, toenails, hair or skin, including moles and birthmarks? *Including, but not limited to, alopecia, eczema, ingrowing toenails, moles that have changed in appearance, port-wine stains, psoriasis and venous ulcers.*	☐	☐	☐	☐	☐	☐	☐	☐
3.14 Diseases or disorders of the blood or veins? *Including, but not limited to, anaemia, deep vein thrombosis (DVT), factor V Leiden, haemochromatosis, haemophilia and other blood clotting diseases or disorders, thalassaemia and varicose veins.*	☐	☐	☐	☐	☐	☐	☐	☐

(continued)

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Section 7 – Medical Questionnaire *(continued)*

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
3.15 Diseases or disorders of glands, including hormone imbalance? *Including, but not limited to, Addison's disease, hyperhidrosis or excessive sweating, hyperthyroidism, hypothyroidism and parathyroiditis.*	☐	☐	☐	☐	☐	☐	☐	☐
3.16 Hernias, lumps, cysts or benign tumours that you have not already told us about in questions 3.1-3.15?	☐	☐	☐	☐	☐	☐	☐	☐
3.17 HIV or AIDS, auto-immune conditions or allergies that you have not already told us about in questions 3.1-3.16? *Including, but not limited to, food allergies, insect allergies, lupus, myasthenia gravis and prescription drug allergies.*	☐	☐	☐	☐	☐	☐	☐	☐
3.18 Psychiatric, psychological or behavioural disorders? *Including, but not limited to, anxiety, attention deficit hyperactivity disorder (ADHD), depression, eating disorders and stress.*	☐	☐	☐	☐	☐	☐	☐	☐
4. Do you, or any of your dependants in this application, have any one or more chronic, long-term or recurrent diseases or disorders that we have not asked you about in questions 1-3?	☐	☐	☐	☐	☐	☐	☐	☐
5. In the last two years, have you, or any of your dependants in this application, had any abnormal test results that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐
6. Have you, or any of your dependants in this application, ever had any joint replacements that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐
7. Have you, or any of your dependants in this application, ever had any cosmetic treatment that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐
8. In the last two years, have you, or any of your dependants in this application, sought medical advice for any one or more symptoms***, but not had a disease or disorder diagnosed as a result of the advice?	☐	☐	☐	☐	☐	☐	☐	☐
9. In the last two years, have you, or any of your dependants in this application, had one or more symptoms*** but not sought medical advice?	☐	☐	☐	☐	☐	☐	☐	☐

*** Including, but not limited to, abdominal pain, back pain, change in bowel habit, chest pain, dizziness, fainting, fatigue, joint pain, neck pain, persistent cough, rectal bleeding, recurrent headaches, shortness of breath and weight loss or gain.

	Planholder		Dependant 1		Dependant 2		Dependant 3	
	Yes	No	Yes	No	Yes	No	Yes	No
10. In the last two years, have you, or any of your dependants in this application, regularly used any medication that you have not already told us about in questions 1-9?	☐	☐	☐	☐	☐	☐	☐	☐
11. Are you or any of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of questions 3-10, please also fill in the Additional medical information questionnaire as applicable.

(continued)

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Section 7 – Medical Questionnaire *(continued)*

Additional medical information

Name of applicant	Question number	What is the name of the disease or disorder (including joint replacements and cosmetic treatment), symptom(s) or complication(s) and when did it start? (dd/mm/yyyy)	If you have ticked 'Yes' to question number 5, what abnormal test results have you had and when were they done? (dd/mm/yyyy)	What treatment, medication or special diet have you been given? Please specify names of drugs and dosage required.	What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended? Please give details including dates where necessary.	Do you still have this disease or disorder (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests?	What date did you last see any health care professional for this disease or disorder, (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests? (dd/mm/yyyy)	If you answered 'Yes' to question 10, what medication are you regularly using and why do you take it?

Please give details of **your** usual **medical practitioner**, and in respect of anyone else included in this application.
Medical Practitioner Name
Medical Practitioner Address

Please Retain a Copy for Your Records

Section 8 – Declaration

My spouse, competent adult **dependants**, and I (who are applying for **cover** under this application) authorise any physician, health care professional, **hospital**, other health care institution ("Providers"), and my employer to disclose, to the extent allowed by applicable law, to Aetna or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **treatment** provided to anyone listed on this application, including dental, substance abuse and HIV/AIDS services ("health care information").

I confirm and agree that personal information and/or health care information collected or held by Aetna, whether contained in this application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates including Executive Healthcare Solutions - Kenya, MIC Global Risks (Tanzania) Limited and EHS Limited, providers, payors, other insurers, third party administrators, vendors, consultants, and/or governmental authorities with appropriate jurisdiction, when necessary for care or **treatment**, payment for services, and activities related to the operation of my health plan.

I understand that Aetna may rely on such information to: 1) underwrite this application for **cover**, including, as needed, making eligibility, risk rating, and enrolment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for **cover** and provisions of **benefits**; 3) administer **cover**; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.

I have discussed the terms of this authorisation with my spouse and competent adult **dependants**, and I have obtained their consent to the release of their health care information pursuant to this authorisation. I understand that I may decline to provide Aetna with consent to process my personal or health care information; however, this may result in declination of **cover**.
I understand that I may review and offer corrections to my personal or health care information, to the extent allowed by law, receive a copy of this authorisation upon request, and that a photocopy is as valid as the original; and I may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna or other party. I also have the right to opt out of any direct marketing campaigns.

This authorisation shall remain valid for the term of this cover or for so long as allowed by law.
I understand it is unlawful for me or my **dependants** to knowingly provide false, incomplete or misleading facts or information to Aetna for the purpose of defrauding or attempting to defraud. Penalties may include imprisonment, fines, denial of **cover**, rescission of **benefits**, and legal damages.
I acknowledge that Aetna's participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna entity.

Any change of occupation, hazardous pursuits and change of residential address or area should promptly be notified in writing to Aetna.
Commencement of this Policy is subject to screening of members as per company's Anti Money Laundering Policy.
I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.
I have declared all material facts which relate to this application.
I declare that I have read and understand the documents '**Policy Wording**' and agree to accept and conform to the terms of the **policy**, unless I cancel this **policy** within 15 days from the **commencement date**. I am satisfied that the product selected meets my requirements at this time.
I agree that where medical **treatment** is received within the **provider network** by myself or any of my **dependants** and it is substantiated that the **treatment** or **medical condition** is not refundable within the terms and conditions of the **policy**, that I, as the **member**, shall be fully responsible for reimbursement to Aetna within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **treatment.**
I understand and confirm that where I have not made repayment of funds disbursed by Aetna in respect of such medical **treatment** not covered by the **policy**, Aetna shall use all available means to recover owed funds and will suspend **cover** for the **member** until the date of full settlement of all outstanding amounts due from the **member** to Aetna, at which point **cover** shall be reinstated on the same basis as immediately prior to the suspension. In no event shall any claim for **treatment** received during any period of suspension be made or met.
I further accept that where funds have been outstanding to Aetna for a period in excess of 15 days from notification, my **policy** will be cancelled as if I had no cover in place from the start, without refund of premium.
I understand that if any statement made above or, if accepted for cover, if any subsequent claims made are found to be fraudulent or unfounded my cover will be cancelled as if I had no cover in place from the start, without refund of premium and any **benefits** shall be forfeited and recoverable by Aetna.
I understand that Aetna may not be able to conduct business and/or pay claims in locations or with/to people or groups that are listed by the European Union, the United States of America and/or the United Nations as sanctioned countries or prohibited groups. Wherever **cover** provided by this insurance contract is in violation of applicable trade or economic sanctions, such **cover** shall be null and void.

Applicant's Signature	Date (Day/Month/Year)

Please Retain a Copy for Your Records

Policies issued in the Middle East and Africa but outside the United Arab Emirates (UAE) are insured by Aetna Life & Casualty (Bermuda) Limited and are administered by Aetna Global Benefits Limited – a company regulated by the DFSA. Registered address: Emirates Financial Tower, 1701 - F, 17th Floor, North Tower, DIFC, PO Box 6380, Dubai, UAE