EXECUTIVE HEALTHCARE SOLUTIONS

Executive Healthcare Plan Continuous Transfer Form

Aetna International

EXPLANATORY NOTES: Please read through the following before completing this application and complete in BLOCK CAPITALS or check boxes as appropriate.

TERMS AND CONDITIONS: You must complete this form in full and **You** should attach a copy of **Your** existing **Policy Schedule**, detailing any endorsements and the original **Commencement Date** of the expiring plan.

Continuous transfer can be offered where the **Benefits** of the plan for which **You** are applying are similar to those of **Your** current **Policy**. These terms and conditions must be read in conjunction with the **Policy Wording**.

All material facts (e.g. a pre-existing health condition or involvement in a hazardous activity), which may affect **Our** assessment and consideration of this application, should be declared.

If **You** are in doubt as to whether a fact is material, then it should be disclosed. Please use a separate sheet of paper if necessary.

Please return this completed **Continuous Transfer Form** together with **Your** current valid certificate of insurance (where applicable) to one of the following offices:

Executive Healthcare Solutions Limited
10th Floor, IPS Building
Kimathi Street
PO Box 51343, 00200- City Square
Nairobi, Kenya

T: (254 20) 221 9621/9826
F: (254 20) 222 9006
E: info@executive-healthcare.com

Aetna International
PO Box 6380
Dubai, UAE

T: + 971 4 433 0400
F: + 971 4 428 7100
E: MEASales@aetna.com

Please check all respective boxes which apply to You.

☐ Apply to transfer from another insurer to an Aetna International group **Policy**

☐ Apply to transfer from another insurer to an Aetna International individual **Policy**

☐ Apply to transfer from an existing Aetna International **Policy** to a new Aetna International **Policy**

Section 1 – Applicant's Information

Family Name				Title
First Name(s)				
Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
Residential Address				ZIP/Postal Code
				Country of Residence
Occupation			Telephone	
E-mail			Company Name (if applicable)	

Section 2 – Dependant(s) Information

Dependant 1	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		

continued

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Section 2 – Dependant(s) Information (Continued)

Dependant 2	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 3	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 4	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 5	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		

Section 3 – Commencement Date (Subject always to **Section 9** of this application form, the **Commencement Date** of this **Policy** will be the date on which this application is accepted in writing by **Us**. Please note the **Commencement Date** can be no more than 30 days from the date of completion of this application by **You**. Under no circumstances will **Policies** be backdated.)

Commencement Date (Day/Month/Year)

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**	**Foundation**	**Lifestyle**
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	☐	☐

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

continued

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Section 4 – Additional Options (Continued)

Product Options:	Major Medical	Foundation	Lifestyle
☐ Exclude Pregnancy Cover	Not Applicable	☐	☐
☐ Routine Management of Chronic Conditions*	Not Applicable	☐	Not Applicable
☐ Medical History Disregarded**	☐	☐	☐
☐ Wellness*	Not Applicable	☐	☐
☐ Routine Dental Treatment*	Not Applicable	☐	Not Applicable
☐ Vision Care***	Not Applicable	☐	☐

* For compulsory groups of three or more employees only
** For compulsory groups of ten or more employees only
*** For compulsory groups of five or more employees only

Policy Excess:

- **Major Medical** ☐ US$250 ☐ US$750 ☐ US$1,500 ☐ US$4,000
- **Foundation** ☐ US$40 ☐ US$80 ☐ US$150 ☐ US$250
  ☐ US$400 ☐ US$750 ☐ US$1,500 ☐ US$4,000
- **Lifestyle** ☐ US$40 ☐ US$80 ☐ US$150 ☐ US$250

Section 5 – Premium Payment (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 Cheque:** All Banker's Cheques must be payable to **"Aetna Global Benefits"**. Please ensure that the name of the **Policyholder** (as declared in **Section 1** of this form) is clearly stated on the reverse of the cheque.

☐ 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): _____

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.

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Section 6 – Recurring Transaction Authority

Your authority to Aetna International 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 International will advise me of the amount to be paid and the dates on which payment is due and that Aetna International may only change these after giving me prior notice. I understand that this authority in favour of Aetna International will remain in force until such a time as I cancel it in writing/e-mail instruction to Aetna International.

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

E-mail (where signing online)

Section 7 – Medical Practitioner Details (Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application. Please use a separate sheet if this space is insufficient.)

Section 8 – Medical Questionnaire (When completing **Section 8,** please ensure that **You** declare all material facts for both **Your** own and all **Dependants** to be included under this application. Failure to do so could result in a claim not being paid. Should **You** have any doubt as to what information is required, please speak to **Your** health insurance advisor or contact the Executive Healthcare Solutions office.)

Please complete the following questions by checking Yes or No.	**Yes**	**No**
a. Have **You**, or anyone included in this application, ever been admitted to a **Hospital** or other similar establishment?	☐	☐
b. Have **You**, or anyone to be included under this application, been prescribed with a course of any drugs or medication, or **Treatment** for a period in excess of seven days in the last two years?	☐	☐
c. Have **You**, or anyone to be included under this application, any known or foreseeable need to consult with a **Medical Practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **Hospital** or other similar establishment?	☐	☐
d. Are **You**, or anyone to be included under this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?	☐	☐

If **You** have answered Yes to any of the questions above, please provide further details below or on a separate sheet of paper if there is insufficient space.

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Section 9 – Declaration

My spouse, competent adult **Dependants**, and I (those who are applying for coverage under this Application) authorise any physician, healthcare professional, **Hospital**, other healthcare institution (“Providers”), and my employer to disclose, to the extent allowed by applicable law, to Aetna International or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this Application, including those services involving dental, substance abuse and HIV/AIDS ("healthcare information").

I confirm and agree that personal information and/or healthcare information collected or held by Aetna International, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to my employer, Aetna affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants, Executive Healthcare Solutions and 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 International may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, **Policy** issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of **Benefits**; 3) administer coverage; 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 healthcare information pursuant to this authorisation. I understand that I may decline to provide Aetna International with consent to process my personal or healthcare information; however, this may result in declination of coverage.

I understand that I may review and offer corrections to my personal or healthcare 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 International 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 coverage 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 International for the purpose of defrauding or attempting to defraud Aetna International. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna International’s participating providers are independent contractors and are not agents or employees of Aetna International or any affiliated Aetna Entity.

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 ‘***Benefit Schedule***’ 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 **Policyholder**, shall be fully responsible for reimbursement to Aetna International 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 International in respect of such medical **Treatment** not covered by the **Policy**, the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Aetna International and in the event that funds so due from me to Aetna International have been outstanding and unpaid for a period in excess of 14 days, exclusion 1 of the **Policy Wording** shall be re-applied to the **Policy** with effect from the date of full receipt by Aetna International of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met.

I further accept that where funds have been outstanding to Aetna International 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 International.

Employee/Applicant’s Signature	Date (Day/Month/Year)

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Policies issued outside the United Arab Emirates (UAE) are insured by Aetna Life & Casualty (Bermuda) Limited or by another insurance company as stated in your policy schedule. Policies issued outside the UAE are administered by Aetna Global Benefits Limited - A Company Regulated by DFSA and Aetna Health Services (Middle East) FZ LLC.