



International Healthcare Plan – Continuous Transfer Form

Aetna Global Benefits®

EXPLANATORY NOTES: Please use 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 Us or Your agent.

Aetna Global Benefits Limited
PO Box 6380
Dubai, UAE

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

Please check all respective boxes which apply to You.		
<input type="checkbox"/> Apply to transfer from another insurer to an Aetna Global Benefits group Policy	<input type="checkbox"/> Apply to transfer from another insurer to an Aetna Global Benefits individual Policy	<input type="checkbox"/> Apply to transfer from an existing Aetna Global Benefits group Policy to an Aetna Global Benefits individual Policy

Section 1 – Applicant’s Information

Family Name				Title	
First Name(s)					
Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	Nationality	
Residential Address				Zip/Postal Code	
				Country of Residence	
Occupation			Telephone		
Email			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 <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	Nationality	
	Country of Residence		Occupation			

continued

Please Retain a Copy for Your Records

Policies issued outside UAE but within Middle East and Africa are issued by Aetna Life & Casualty (Bermuda) Ltd. and administered by Aetna Global Benefits Limited, an Aetna Company. Aetna Global Benefits Limited registered address: Unit 101, Gate Village, Building No. 7, Dubai International Financial Centre, PO Box 6380, Dubai, UAE.

Section 2 – Dependant(s) Information (Continued)

Dependant 2	Relationship to person named in Section 1		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 3	Relationship to person named in Section 1		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 4	Relationship to person named in Section 1		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		

Section 3 – Cover Details (For more information about the various product options available, please refer to the plan schedule of **Benefits**.)

Please check all respective boxes which apply to You .					
Product Option:		Excess Option:		Additional Option:	
<input type="checkbox"/> Major Medical	<input type="checkbox"/> Lifestyle	<input type="checkbox"/> _____	<input type="checkbox"/> 005	<input type="checkbox"/> 008	<input type="checkbox"/> 011
<input type="checkbox"/> Foundation	<input type="checkbox"/> Lifestyle Plus	<input type="checkbox"/> US\$	<input type="checkbox"/> 006	<input type="checkbox"/> 009	
			<input type="checkbox"/> 007	<input type="checkbox"/> 010	

Section 4 – Medical Questionnaire (When completing **Section 4**, 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 Aetna Global Benefits office.)

Please complete the following questions by checking Yes or No.			Yes	No
a.	Have You , or anyone to be included under this application, been admitted to a Hospital or other similar establishment in the past five years?		<input type="checkbox"/>	<input type="checkbox"/>
b.	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?		<input type="checkbox"/>	<input type="checkbox"/>
c.	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?		<input type="checkbox"/>	<input type="checkbox"/>
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.				

Please Retain a Copy for Your Records

Section 5 – 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 Global Benefits 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 Global Benefits, 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, 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 Global Benefits 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 Global Benefits 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 Global Benefits 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 Global Benefits for the purpose of defrauding or attempting to defraud Aetna Global Benefits. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna Global Benefits' participating providers are independent contractors and are not agents or employees of Aetna Global Benefits or any affiliated Aetna Entity.

I declare that the answers to the above questions are, to the best of my belief, full, complete, accurate, and true.

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 Global Benefits.

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