# International Healthcare Plan for Individuals and Families – Application Form

**Explanatory Notes:** Please read the following before completing this application. Please use BLOCK CAPITALS or tick boxes as appropriate.

**Terms and Conditions:** All material facts (e.g., a pre-existing health condition, or involvement in a hazardous activity or resident in an area of **conflict/civil unrest**), which may affect **our** assessment and consideration of this application, should be declared. Failure to do so may invalidate **your cover**. If **you** are in doubt as to whether a fact is material, then it should be disclosed.

If **you** run out of space, please use a separate sheet of paper where necessary to provide full details. All information supplied will be treated in strict confidence.

As the applicant, **you** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **you** on request within three months of completion. **You** should keep a record of all information provided.

Please return this completed form to **us**, or **your** nominated agent**.**


Aetna Global Benefits (Middle East) LLC
**PO Box 6380**
Dubai,UAE

**T:** +971 4 438 7500
**F:** +971 4 428 7100
**E:** **MEAHealth@ae.rsagroup.com**


**Your Agent or Broker Details (if applicable)**

| Broker/Agent Name | Telephone |
|---|---|
| Address | |
| E-mail | Stamp |

To help **you** understand **your cover**, the words and phrases in bold have specific meanings, and are defined in the International Healthcare Plan (IHP) for Individuals and families member handbook.

**Section 1 – Your Plan Details**

**1.a Select Your Plan**
Please refer to the IHP Individuals and families Pre-sell brochure.

Plans
☐ Major Medical ☐ Foundation ☐ Lifestyle ☐ Lifestyle Plus

**1.b Select Your Benefit Options**
Please note **our** standard **Area of cover** is Worldwide excluding USA Elective **Treatment**. Should **you** wish to receive **Elective Treatment** in the USA please select the relevant option below.

| | Major Medical | Foundation | Lifestyle | Lifestyle Plus |
|---|---|---|---|---|
| **Extended Evacuation** | ☐ | ☐ | N/A Cover included | N/A Cover included |
| **Outpatient Direct Settlement Network - nil excess** This **benefit** is available where a Nil or $100 **policy excess** has been selected. | Not applicable | ☐ | ☐ | ☐ |
| **USA Elective Treatment** * | Not applicable | ☐ | ☐ | ☐ |

* The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance **cover** mandated therein.


Policies issued in the United Arab Emirates (UAE) are insured by Royal & Sun Alliance (Middle East) Ltd, E.C. and are administered by Aetna Global Benefits (Middle East) LLC. Aetna Global Benefits (Middle East) LLC registered address: 28th Floor, Media One Tower Building Dubai Media City, PO BOX 6380, Dubai, UAE.
Royal & Sun Alliance Insurance (Middle East) Ltd EC registered under UAE Federal Law dated April 1, 1997 (Registration No 65).
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**1.c Select Your Policy Excess**

| Excess Options | Major Medical | Foundation | Lifestyle | Lifestyle Plus |
|---|---|---|---|---|
| Standard | ☐ Nil | ☐ $100 | ☐ $100 | ☐ $100 |
| Options | ☐ $1,000<br>☐ $5,000 | ☐ Nil<br>☐ $50<br>☐ $250<br>☐ $500<br>☐ $1,000<br>☐ $2,000<br>☐ $5000 | ☐ Nil<br>☐ $50<br>☐ $250 | ☐ Nil<br>☐ $50<br>☐ $250 |

**1.d Commencement Date**

Subject to Section 7 of this application form, the **commencement date** of this **policy** will be the date on which this application is accepted by **us** in writing. If **you** wish **your cover** to start later, please indicate below. Please note the **commencement date** can be no more than 30 days from the date **you** complete this application form. Under no circumstances will applications be backdated.

| Commencement Date |
|---|
| |

**1.e Underwriting**

If **you** were covered under a similar **policy** immediately prior to **your** application for inclusion in this **policy**, please include a copy of **your** current **certificate of insurance**, if **you** wish to request **continuous transfer terms**. Please note Medical History Disregarded (MHD) is not available to Individuals.

Please tick which applies.

☐ Switching from another insurer or plan
MHD terms not included.
☐ 2 Year Moratorium
☐ Medical Underwriting

**1.f Contact Preferences**

Please tick which applies.

☐ I would like to receive policy documentation by e-mail
☐ I would like to receive my renewal by e-mail
☐ I would like to hear about promotions products and services including mobile applications, provider updates and regulatory updates

**Please contact me by**

E-mail _____ Mobile _____

## Section 2. – Primary Applicant Details

As the primary applicant **you** are applying to be the **policyholder** and will be responsible for paying the premium.

| | | | | |
|---|---|---|---|---|
| Family Name/Surname | | | | **Mr/Mrs, Miss, Ms, Other** |
| First Name(s) | | | | Other Initials |
| Occupation/Job Title | Date of Birth (Day/Month/Year) | Gender ☐ M ☐ F | Height (cms/ins) | Weight (kgs/lbs) |
| **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 | | Mobile | | |
| E-mail address | | Fax | | |

## Section 3 – Dependant's Details

**Dependants** can only be included if their **country of residence** is the same as the applicant's. 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 dependent 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. |

**Section 4 – Medical Questionnaire**

**Pre-existing Conditions**
**Benefits** will not be available for any **medical condition** or **related condition** for which **you,** or anyone included in this application, have sought medical **advice** or received medical **treatment** for, had symptoms of, or to the best of **your** knowledge existed, prior to **your date of entry** until two consecutive years have elapsed after the **date of entry**, during which no t**reatment** or **advice** was given with respect to that **medical condition** or any **related condition**.

**Switching from another insurance policy**
Where **applicants** are applying fo**r continuous transfer terms** and these are accepted by **us**, the previous underwriting applied in respect of **your** existing **cover** will apply (with the exception of MHD terms which is not available under Individual cover). **We** reserve the right to apply additional terms. **You** should attach a copy of **your** existing **certificate of insurance**, detailing any endorsements and the original **commencement date** of the expiring plan (or **cover**).

Please reply to the following questions by ticking Yes or No.

| **Where Yes, has been answered for any of these questions please provide all relevant details in the space below.** | Primary applicant (Policyholder) | Applicant 2 | Applicant 3 | Applicant 4 | Applicant 5 |
|---|---|---|---|---|---|
| a) Have **you**, or anyone included in this application, been admitted to a **hospital** or other similar establishment in the last five years? | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ |
| b) Have **you**, or anyone included in this application, been prescribed with a course of any drugs or medication, or **treatments** for a period in excess of seven days in the last two years? | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ |
| c) Have **you**, or anyone included in 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? | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ |
| d) Are **you**, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above? | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ |
| e) Are there any other material facts, for instance but not limited to hazardous activities, occupational risks, lifestyle risks or any relevant medical details not already stated? | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ | Y ☐ N ☐ |
| Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space. | | | | | |

Please give details of **your** usual **medical practitioner.**

On behalf of all members of this application I authorize this doctor to provide Aetna International with any information it asks for in connection with this application and any claims, past, present or future. Please supply details of additional medical practitioners if some family members have a different Medical Practitioner.

**Medical Practitioner** Name

**Medical Practitioner** Address

Additional Information

**Section 5 – Data Privacy**

**Data Protection**

We consider 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 European Data Protection Directive (Directive 95/46/EC), and the UK Data Protection Act 1998.
We may use and disclose your Information during the course of running our health business.

**Payment**

To help pay for **your** covered services, **we** may use and disclose **your** Information in a number of ways – in conducting utilization and medical necessity reviews; coordinating care; determining eligibility; determining formulary compliance; collecting premiums; calculating cost-sharing amounts; and responding to complaints, appeals and requests for external review.

**Treatment**

**We** may disclose Information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of **you**.

**Disclosures to Other Covered Entities**

**We** may disclose Information to other insurers, healthcare providers, or business associates of those entities for treatment, payment and certain health care operations purposes.

**Disclosure to Others Involved in Your Health Care**

**We** may disclose health information about **you** to a relative, a friend, or any other person **you** identify, provided the Information is directly relevant to that person's involvement with **your** health care or payment for that care.

**Uses and Disclosures Requiring Your Written Authorization**

In all situations **we** will ask for **your** written authorization before using or disclosing Information about **you**. If **you** have given **us** an authorization, **you** may revoke it at any time, if **we** have not already acted on it. If **you** have questions regarding authorizations, please call the Member Services number on **your** ID card.

**Aetna's Legal Obligations**

Privacy regulations require **us** to keep Information about **you** private, confidential, and secure, to give **you** notice of **our** legal duties and privacy practices, and to follow the terms of the Notice currently in effect.
Safeguarding **your** Information: **We** guard **your** information with administrative, technical, and physical safeguards to protect it against unauthorized access and against threats and hazards to its security and integrity.

To review all of **our** privacy policy please visit: http://www.aetnainternational.com/ai/mea/en/global/global_privacy.

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**Section 6 – Payment Options**

**6.a Cheque Payments (Annual only):**
All cheques should be made payable to Aetna Global Benefits (Europe) Ltd. Please ensure that the name of the primary applicant is clearly stated on the cheque to assist in processing documentation.

**6.b Bank Transfer (Annual only):**
Please ensure that the name of the primary applicant is clearly stated on any Bank Transfer to assist in processing documentation. Our bank details for bank transfers are as follows:

| Denomination | Dirham Account | US Dollar Account |
|---|---|---|
| Account Name | Royal & SunAlliance Insurance | Royal & SunAlliance Insurance |
| Bank Address | Citibank Dubai, UAE | Citibank Dubai, UAE |
| IBAN | AE430211000000500027126 | E210211000000500027134 |
| Account Number | 500027126 | 500027134 |
| Swift Code | citiaead | citiaead |

**6.c Credit Card Payments:**

**Credit Card:** (please tick)
☐ Visa ☐ MasterCard

**Payment Frequency (Please note a surcharge will apply for Monthly Payments)**
☐ Annually ☐ Monthly

| Card Number | Expiry Date (DD/MM/YYYY) |
|---|---|
| | |

Card Holder's Name

Cardholder's Statement Address

| Card Holder's Authorisation Signature | Date (DD/MM/YYYY) |
|---|---|
| | |

***AUTHORISATION TO COLLECT MONTHLY RECURRING TRANSACTION PREMIUMS ON YOUR CREDIT CARD***

I authorise you to charge the above named card an unspecified amount in respect of the International Healthcare Plan monthly premiums as and when they become due. I understand that Aetna Global Benefits (Middle East) LLC will advise me of the amount to be paid and the dates on which payment is due and that Aetna Global Benefits (Middle East) LLC may only change these after giving me prior notice. I understand that this authority in favour of Aetna Global Benefits (Middle East) LLC will remain in force until such time as I cancel it in writing or by e-mail instruction to Aetna Global Benefits (Middle East) LLC.

| Card Holder's Signature | Date (DD/MM/YYYY) |
|---|---|
| | |

**Section 7 – Applicant's 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"), to the extent allowed by applicable law, to Royal & SunAlliance and/or 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 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 Royal & SunAlliance and/or Aetna Global Benefits, whether contained in this application form or otherwise obtained, may be disclosed worldwide to Aetna affiliates, 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 Royal & SunAlliance and/or Aetna Global Benefits 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 Royal & SunAlliance and/or Aetna Global Benefits 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 Royal & SunAlliance and/or 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 **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 Royal & SunAlliance and/or Aetna Global Benefits 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 Global Benefits's participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna entity.

I understand and accept Section 4 on Pre-existing Condition(s) and I have declared all material facts that relate to this application.

**Additional Provisions for Applicants requesting Continuous Transfer Terms**

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, and any **benefits** shall be forfeited and recoverable by Royal & SunAlliance and/or Aetna.

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 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 Royal & SunAlliance 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 Royal & SunAlliance in respect of such medical **treatment** not covered by the **policy**, Royal & SunAlliance and/or 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 Royal & SunAlliance, 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 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.

Where **members** transfer to the International Healthcare Plan from any other of **our** existing plans or, whilst covered under the International Healthcare Plan, **you** receive any enhanced **cover** (such as inclusion of an option at any **renewal date**), any enhanced **cover** or maximum refundable amounts are restricted to new **medical conditions** not been previously suffered from, whether or not diagnosed, after the date of transfer.

Transfer from any similar private medical **cover** provided by any other insurer is subject to submission of a copy of the **certificate of insurance** and subject to there being no break in **cover**. **We** reserve the right at all times to decline an application without giving any reason and/or to offer alternative terms.

| Applicant's Name and Signature | Date (Day/Month/Year) |
|---|---|
| | |