Aetna®

International Healthcare Plan – Application for Agency Facilities

Aetna Global Benefits®

Please return this completed form to **Us** or **Your** agent.

Aetna Global Benefits Limited
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Dubai, UAE

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E: **MEASales@aetna.com**

A. Broker Facilities Detail

1a. Broker Trading Name			1b. Trade License Number
1c. Full Company Name – As per Trade License – Kindly attach a copy of valid Trade License			
2a. Company Address			Zip/Postal Code
Telephone	Fax	Email Address	
2b. Registered Address (if different from above)			Zip/Postal Code
Telephone	Fax	Email Address	
3. Occupational/Nature of Business			

4 a) Company's Paid-up Share Capita _____

b) Is **Your** agency:

1) authorised and regulated by any regulatory companies? If Yes, please provide:

i) date of registration (Day/Month/Year): _____

ii) name of authorising body and registration number: _____

If No, please state if: i) an application is pending: _____

ii) an application has not been made: _____

If You have insufficient space in any section, please provide full details on separate sheet. Kindly attach a copy of the registration certificate for Our reference and record.

c) a member or registered with any official insurance institution? ..... ☐ Yes ☐ No

If Yes, please name institution. _____

d) or has it been subject to any regulatory enforcement action? ..... ☐ Yes ☐ No

5. a) How many years has **Your** organisation been established? _____

b) Please provide the full name and address of **Your** agency's ultimate holding company:

_____

_____

_____

c) Has **Your** organisation enforced documented **Policies** and procedures for all of it's activities? ..... ☐ Yes ☐ No

d) Is **Your** agency registered with it's regional data privacy registrar? ..... ☐ Yes ☐ No

If Yes, please state it's number: _____

e) Is **Your** organisation, it's contractors, sub agents or customers connected to a government agency? .. ☐ Yes ☐ No

f) Does **Your** organisation have enforced procedures to prevent inducements being offered or received to generate business by it, it's staff or associates? ..... ☐ Yes ☐ No

g) How many employees including executive directors? _____

h) How many individuals are actively selling international medical insurance in **Your** organisation? _____

continued

Please Retain a Copy for Your Records

A. Broker Facilities Detail (Continued)

6. If **Your** business has been established for less than two years, please state the following:

   a) Name of previous business enterprise or previous employer's name:

   _____

   b) Number of years business was established or duration of employment: _____

   c) Contact name, if any: _____

   d) Address: _____

   _____

   _____

   Zip/Postal Code: _____

   Telephone: _____

   Fax: _____

7. a) Please provide full names and home addresses and qualifications of all the director(s)/partner(s)/secretary/shareholder(s) involved in **Your** organisation. Also, provide **Us** with the shareholding pattern.

   b) Do any of the above named have outstanding legal judgements (including criminal records) against them or have they ever been the subject of regulatory, insolvency or bankruptcy proceedings? If Yes, please give full details. If No, please write "none".

continued

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A. Broker Facilities Detail (Continued)

8. Do **You** have professional indemnity cover? ☐ Yes ☐ No

*If Yes, please send a copy of **Your** certificate, which should state:*

a) With Whom: _____

b) Certificate Number: _____

c) Limit of Indemnity: _____

d) **Excess** Level, if any: _____

9. a) The annual written premium income for **Your** private medical insurance portfolio is in the range (check applicable premium):

i) ☐ US$ 0m - US$ 0.5m

ii) ☐ US$ 0.5m - US$ 1m

iii) ☐ US$ 1m - US$ 5m

iv) ☐ US$ 5m - US$ 10m

v) ☐ US$ 10m +

b) The approximate breakdown in percentage terms or **Your** international medical insurance portfolio is (write in applicable percentage):

i) _____% Individual Business

ii) _____% Company Paid Small Group Business

iii) _____% Company Paid Large Group Business

iv) _____% Optional Group Business

v) _____% Groups in "Trust"

10. Please give the name and address of three other Insurers with whom **You** have broker/agency facilities in respect of private medical insurance (and from whom **We** will take references), the date from which they become effective and **Your** approximate premium income with each of them.

a) Name: _____ Address: _____

Date (Day/Month/Year): _____

Written Premium: _____

b) Name: _____ Address: _____

Date (Day/Month/Year): _____

Written Premium: _____

a) Name: _____ Address: _____

Date (Day/Month/Year): _____

Written Premium: _____

11. Have broker/agency or collection facilities ever been refused or withdrawn? ☐ Yes ☐ No

If Yes, by whom and for what reason:

_____

_____

B. Bank Details (Completion is optional*)

12. Bank Sort Code: _____ Bank Address: _____

Bank Account Number: _____

Bank Name: _____

Bank Telephone: _____ Bank Fax Number: _____

** Aetna Global Benefits has facility to direct credit commissions payable to **Your** Bank Account.*

13. If available, please supply a copy of **Your** corporate brochure explaining the nature and scope of **Your** operations.

C. Declaration

I/**We** apply for an appointment to represent Aetna Global Benefits as an Agent. I/**We** agree that, if this application is accepted, the appointment shall be governed by the terms of Aetna Global Benefits (including acceptance of the terms of it's agency agreement) in accordance with FSA regulations.

I/**We** understand that references will be sought for My/**Our** application and to My/**Our** best knowledge and belief the above details are true and accurate. Any attempt to mislead or supply false information to Aetna Global Benefits will result in the voiding of the application/agency.

Print Applicant's Name	Position in Organisation

Company Stamp

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