



Regional Healthcare Plan Member Application Form

Aetna Global Benefits

This form should be completed by employee's applying to become a member of their employers Group Plan. Applicants should read the following before completing this application.

Eligible applicants are UAE residents only, excluding the Emirate of Abu Dhabi. Any persons living and/or working and /or have a residency visa issued in the Emirate of Abu Dhabi will need to complete a separate application form. Please contact **Us** directly regarding such applicants.

Terms and Conditions: 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. Failure to do so may invalidate the **Policy**. If **You** are in doubt as to whether a fact is material, then it should be disclosed.

As the applicant, **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. If **You** run out of space please use a separate sheet of paper to provide full details. All information supplied will be treated in strict confidence. 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 (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

Commencement of cover is subject to review by Our Underwriters and screening of members and the group company under the company's Anti Money Laundering Policy.

Please return this completed form to:

Aetna Global Benefits (Middle East) LLC, PO Box 6380, Dubai,
UAE or **Your** agent.

Affix Your Agent/Broker Name/Stamp here.

T: + 971 4 433 0400

F: + 971 4 428 7100

E: MEASales@aetna.com

Section 1 – Your Details

Title	Family Name	First Name(s)		
Marital Status	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
Industry	Occupation			
Employer Name	Employer Address			
Date of Employment	Eligibility Category*	Date first eligible to join plan		
Employer Telephone	Employer E mail	Employer Fax		
Nationality	Country of Residence	Date residence commenced		
Residential Address		Correspondence Address		
Town/City		Town/City		
Country/State	Zip/Postal Code	Country/State	Zip/Postal Code	
Home Telephone		Business Telephone		
Mobile	Fax			
Home Email	Business Email			

***Your** employer has provided **Us** with eligibility categories for certain employees in the group. Please contact **Your** Group Administrator as to the employee category that is applicable to **You**.

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

GR-68582-8 **RHPF** (6-10)

Section 2 – Continuous Transfer Terms

Continuous transfer can be requested if 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**. If **You** wish to apply for Continuous transfer **You** should attach a copy of **Your** existing **Policy Schedule**, detailing any endorsements and the original **Commencement Date** of the expiring plan. **You** only need to complete this section if **You** are applying for Continuous Transfer Terms. **You** should seek guidance from **Your** employer.

<input type="checkbox"/> I am applying to transfer from another insurer to an Aetna Global Benefits group Policy	<input type="checkbox"/> I am applying to transfer from an existing Aetna Global Benefits group Policy to another Aetna Global Benefits group Policy
Group Policy Name	Policy Number

Section 3 – Dependant’s Details

(Please note children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full time education and are fully dependant upon **You**.)

Dependant 1	Family Name		First Name(s)		
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Country of Residence		Occupation	Nationality	
Dependant 2	Family Name		First Name(s)		
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Country of Residence		Occupation	Nationality	
Dependant 3	Family Name		First Name(s)		
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Country of Residence		Occupation	Nationality	
Dependant 4	Family Name		First Name(s)		
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Country of Residence		Occupation	Nationality	
Dependant 5	Family Name		First Name(s)		
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (ins/cms)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Country of Residence		Occupation	Nationality	

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

Section 4 – Applicants Medical Questionnaire

Section 4.1 Pre-existing Condition(s)

First time applicants

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You**, or anyone included in this application have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**

Members applying for Continuous Transfer

For those applicants requesting Continuous Transfer from another similar policy to a Regional Healthcare Plan, the previous underwriting applied in respect of **Your** existing policy will apply. **We** reserve the right to apply additional terms.

Section 4.2 Please reply to the following questions by checking Yes or No.

Where **You** have checked Yes, please provide details.

	Yes	No
a. Have You , or anyone included in this application, been admitted to Hospital or other similar establishment in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are You , or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.

Section 4.3 Please give details of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application.

Medical Practitioner Name

Medical Practitioner Qualifications

Medical Practitioner Address

Additional Information

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

Section 5 – Your 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 Royal & Sun Alliance 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 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 Royal & SunAlliance and/or 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 Royal & SunAlliance and/or 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 Royal & SunAlliance and/or 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 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 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 Royal & SunAlliance and/or Aetna Global Benefits for the purpose of defrauding or attempting to defraud Aetna. 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 or any affiliated Aetna Entity.

I understand and accept **Section 5.1** on Pre-existing Condition(s).

Aetna must be informed in writing if there are any persons living and/or working and /or have residency visa issued in the Emirate of Abu Dhabi so that We can issue them with an Abu Dhabi compliant product.

Eligible applicants are UAE residents only.

Any change of occupation, hazardous pursuits and change of residential address or area should promptly be notified in writing to 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 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 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**, the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Royal & SunAlliance and in the event that funds so due from me to Royal & SunAlliance 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 Royal & SunAlliance 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 Royal & SunAlliance 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.

Additional Provisions for members applying for Continuous Transfer

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.

continued

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

GR-68582-8 RHPF (6-10)

Section 5 – Your Declaration (Continued)

Where **You** transfer to the Regional Healthcare plan from any other of **Our** existing plans or, whilst covered under the Regional healthcare plan, **You** apply for and receive any enhanced **Benefits** or coverage (such as inclusion of an option at any **Renewal Date/Review Date**), any enhanced **Benefits** coverage or maximum refundable amounts are restricted to new **Medical Conditions** which have not been previously suffered from, whether or not diagnosed, after the date of transfer.

Transfer from a group to an individual **Policy** is subject to written approval from **Us**. Terms of cover may be subject to variation.

Transfer of any similar private medical cover provided by any other insurer is subject to submission of a copy of the expiring **policy** 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 Signature	Date (Day/Month/Year)
Please Print Applicant Name	Title

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, having its registered address at 416, Oud Metha office, PO Box 6380, Dubai, UAE.

GR-68582-8 **RHPF** (6-10)