1 May 2019

Pioneer Plan Application

Full Medical Underwriting (FMU)

Need help completing this application?
Please contact either your advisor or us. You can find our contact details on our website at www.bnidirect.com 0r www.aetnainternational.com

Completing this application
Please make sure you complete all sections. The questions should be considered carefully and answered as fully as possible. We will not be able to process your application if information is missing.

If we need more information from your doctor and they charge for this, you must pay the costs. Once we have all the information needed to consider your application we will either:

- agree to accept all of these declared medical conditions and may charge an increased premium,
- agree to accept some of these declared medical conditions and may charge an increased premium. The declared conditions we do not accept will be excluded and specified on your Certificate of insurance,
- exclude all of the declared medical conditions. These will be specified on your Certificate of insurance, or
- decline the application.

All other terms and conditions of the Handbook still apply.

Your Duty of Disclosure
The questions in this application and any other information we ask for are essential for us to underwrite and administer your plan. You must tell us about all material facts before we can accept an application or renew the plan. If you do not tell us all material facts or misrepresent any material facts, it may affect your rights or your dependants' rights under the plan. A material fact is information likely to influence us in assessing or accepting the insurance. If there is any doubt about whether a fact is material, for your own protection, you must tell us. Failure to answer all questions fully and honestly may invalidate your insurance. A copy of the completed application can be supplied on request, but you should keep a record of all information you supply to us, including copies of all letters.

We must receive all outstanding information before we can process your application. If you do not complete this application in full it will cause delays.

Please fill in this application clearly in BLOCK CAPITALS.

A. Your personal details (the planholder)

Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
Family name (surname)	First name(s)	
Where will you be living?[1]		
Nationality on passport		
Occupation	Date of birth (dd/mm/yyyy)	Gender: ☐ **M** ☐ **F**
Employer details (name and address)	Email address	
	Phone	
Source of funds for premium payments		
Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)	

[1] The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on where you will be living. Please speak to your advisor or contact us if you are unsure whether your premium will be affected. Please make sure that your plan meets the requirements of the country where you will be living.

Your correspondence address
We will send all correspondence to this address. You must tell us immediately about any changes to your contact or personal details. A change in circumstances may affect your cover.

Address	
Town	City
Postcode	Country
Phone	Mobile
Email	

B. Dependants to be covered

You do not need to fill in the height and weight sections for dependants aged 17 years or younger.

Dependant 1	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)		First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 2	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)		First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 3	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)		First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 4	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)		First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

C. Cover start date

The plan is a yearly contract. Your cover will begin when we have received your signed acceptance of the special terms offered by our underwriters. We will not backdate cover under any circumstances.

D. Your cover options

Plan levels

Please tell us the Pioneer plan level that you need. Please make sure that you have read the Benefits schedule before making your choice. You must make sure the plan meets your needs. Please contact us if you need a copy of this document.

If you and your dependants reside outside of the United States (US), and you wish or need to include cover in the US on your plan:

- You must choose Pioneer 5000 or 5000+ if you are non-US citizens
- You must choose Pioneer 5000+ if you are US citizens

If you and your dependants are non-US citizens residing in the US you must choose Pioneer 5000+.

If none of these apply to you, Pioneer 5000+ is not available.

To select your chosen plan level, please tick the appropriate box below.

☐ **Pioneer 1750** ☐ **Pioneer 2500** ☐ **Pioneer 4000**
☐ **Pioneer 5000** ☐ **Pioneer 5000+**

Areas of cover

Choose your area of cover based on your country of residence, your home country if you need the option of returning to your home country for treatment, and any other country in which you may wish or need to receive treatment. See the 'Areas of cover guide' section of your Handbook for more information.

You and your dependants must have the same area of cover.

To select your chosen area of cover, please tick the appropriate box below.

Area of cover
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6**

Medical evacuation options

You can add non-emergency medical evacuation to your plan, subject to a premium increase. See the 'Medical evacuation' section in your Benefits schedule for information on the cover this provides.

Do you wish to select this optional cover?
☐ **Yes** ☐ **No**

Dental cover options

If you have chosen Pioneer 4000, 5000 or 5000+, you can choose to add routine and major restorative dental treatment to your plan, subject to a premium increase. See the 'Dental treatment' section in your Benefits schedule for information on the cover this provides and the coinsurance that applies.

Do you wish to select this optional cover?
☐ **Yes** ☐ **No**

Pioneer 4000	**Pioneer 5000**	**Pioneer 5000+**
adds USD 750 limit	adds USD 1,500 limit	adds USD 1,500 limit

Deductibles and direct billing

Pioneer 1750 plan

Direct billing is not available under the Pioneer 1750 plan.

You must pay a standard annual excess amount of USD 2,000 for each member in each plan year. See your Benefits schedule for full details.

If you want to change the annual excess from the standard annual excess shown, please tick the appropriate box below.

Nil	☐ (premium increase applies)
USD 1,000	☐ (premium increase applies)
USD 2,000	Standard
USD 4,000	☐ (premium discount applies)
USD 8,000	☐ (premium discount applies)

Pioneer 2500, 4000, 5000 and 5000+ plans

Adding outpatient direct billing to your plan will increase your premium. *Our direct billing network is one of the largest in the world; in the event the relevant medical provider is not in our provider network (for example, pharmacies in the U.S.), we'll reimburse you for any eligible claims instead.* Please contact us if you need more information.

Would you like to add outpatient direct billing to your plan?
☐ **Yes** ☐ **No**

You must pay a standard outpatient coinsurance amount of 10% for each claim. See your Benefits schedule for full details.

If you want to change the coinsurance from the standard coinsurance shown, please tick the appropriate box below.

0%	☐ (premium increase applies)
10%	Standard
20%	☐ (premium discount applies)
30%	☐ (premium discount applies)

E. Medical questionnaire

Please answer all questions in this section.
For the purpose of this application, diseases and disorders include any abnormality, injury, disability, illness or sickness, whatever the cause.

For the purpose of this application, medication includes the use of any substance:

- whatever the means of delivery, and
- whether or not a prescription is needed,

including, but not limited to, vitamins, minerals and supplements, oral and injected medicines and drugs, suppositories, patches, creams, lotions, ointments, gels, drops, sprays and lozenges.

This does not include skin moisturisers, sun protection products, shampoo or mouthwash, unless used in relation to a symptom, disease or disorder.

If a medical professional has confirmed that you, or any of your dependants in this application, have a disease or disorder, we will treat this as a diagnosed medical condition, whether or not they have confirmed the diagnosis to you or your dependant in writing, and regardless of whether or not treatment, medication or a special diet was needed or received following the diagnosis. This includes diseases or disorders diagnosed as the result of routine health or wellness checks.

1. In the last five years, have you, or any of your dependants in this application:
   - needed or had any medical investigations, diagnostic tests or procedures for, or in relation to,
   - been diagnosed with,
   - needed or received any treatment, medication or a special diet for, or in relation to,
   - needed or had any follow-up consultations, tests or procedures for, or in relation to,

any one or more of the following:

	Planholder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1.1 Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.2 Cardiovascular diseases?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
1.3 Diabetes?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 1, please also fill in the additional Cancer, Cardiovascular diseases and disorders and Diabetes questionnaires as applicable.

2. Were you, or any of your dependants in this application, diagnosed with any one or more of the following more than five years ago?

	Planholder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
2.1 Cancer?*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.2 Cardiovascular diseases or disorders?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of question 2, please also fill in the additional Cancer and Cardiovascular diseases and disorders questionnaires as applicable.

* *Including, but not limited to, bowel cancer, brain tumours, leukaemia, melanoma, myeloma and sarcoma.*

** *Including, but not limited to, hypertension or high blood pressure, hypotension or low blood pressure, hypercholesterolaemia or high cholesterol, abdominal aortic aneurysm (AAA), angina, atrial fibrillation (AF), stroke including transient ischaemic attack (TIA) and cerebrovascular accident (CVA), and supra ventricular tachycardia (SVT).*

(Continued)

E. Medical questionnaire *(continued)*

3. In the last five years, have you, or any of your dependants in this application:
   - needed or had any medical investigations, diagnostic tests or procedures for, or in relation to,
   - been diagnosed with,
   - needed or received any treatment, medication or a special diet for, or in relation to,

needed or had any follow-up consultations, tests or procedures for, or in relation to any one or more of the following, that you have not already told us about in questions 1-2:

	Planholder		Dependant 1		Dependant 2		Dependant 3		Dependant 4	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
3.1 Diseases or disorders of the brain, nervous system or nerves? *Including, but not limited to, encephalitis, epilepsy, migraines, multiple sclerosis (MS), myalgic encephalomyelitis (ME), sciatica and trapped nerves.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.2 Diseases or disorders of the mouth, tongue, jaw, teeth or gums? *Including, but not limited to, abscesses, gingivitis, impacted teeth, temporomandibular joint (TMJ) and tongue-tie.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.3 Diseases or disorders of one or both eyes or ears, the nose or throat? *Including, but not limited to, adenoids, blindness, cataracts, deafness, detached retina, deviated septum, glaucoma, glue ear, iritis, keratoconus, macular degeneration, otitis, sinusitis, tinnitus and tonsillitis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.4 Diseases or disorders of one or both lungs, the trachea, bronchial tree or diaphragm? *Including, but not limited to, asthma, chest infections, chronic obstructive pulmonary disease (COPD), emphysema and tuberculosis (TB).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.5 Diseases or disorders of the oesophagus, stomach or duodenum? *Including, but not limited to, Barrett's oesophagus, duodenal ulcers, gastric ulcers, gastritis, gastro-oesophageal reflux disease (GORD) and oesophagitis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.6 Diseases or disorders of the bowel, small intestine, appendix, large intestine, rectum or anus? *Including, but not limited to, anal fissures, colonic polyps, Crohn's disease, diverticulitis, haemorrhoids or piles, irritable bowel syndrome (IBS), pilonidal sinus and ulcerative colitis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.7 Diseases or disorders of the liver, pancreas, spleen or gall bladder? *Including, but not limited to, enlarged spleen, gallstones, hepatitis and pancreatitis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.8 Diseases or disorders of one or both kidneys, the bladder or urinary tract? *Including, but not limited to, cystitis, kidney stones, pyelonephritis, urinary incontinence, urinary retention and urinary tract infections (UTI).*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.9 Diseases or disorders of the male reproductive system, genitals or prostate? *Including, but not limited to, balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility or infertility, phimosis and prostatitis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(Continued)

E. Medical questionnaire *(continued)*

3.10 Diseases or disorders of the female reproductive system, genitals or breasts? *Including, but not limited to, abnormal menstrual cycle or periods, abnormal PAP or smear test results, abnormal vaginal bleeding, endometriosis, fertility or infertility, fibroids, polycystic ovaries and uterine polyps.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.11 Diseases or disorders of the bones, body tissues, muscles, joints, cartilage, ligaments or tendons? *Including, but not limited to, back pain, cellulitis, fractured or broken bones, ganglions, gout, hallux valgus or bunions, joint pain, joint replacements, neck pain, osteoarthritis, plantar fasciitis, repetitive strain injuries (RSI), rheumatoid arthritis, slipped discs, sprains, tendonitis and tennis elbow.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.12 Diseases or disorders of the fingernails, toenails, hair or skin, including moles and birthmarks? *Including, but not limited to, alopecia, eczema, ingrowing toenails, moles that have changed in appearance, port-wine stains, psoriasis and venous ulcers.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.13 Diseases or disorders of the blood or veins? *Including, but not limited to, anaemia, deep vein thrombosis (DVT), factor V Leiden, haemochromatosis, haemophilia and other blood clotting diseases or disorders, thalassaemia and varicose veins.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.14 Diseases or disorders of glands, including hormone imbalance? *Including, but not limited to, Addison's disease, hyperhidrosis or excessive sweating, hyperthyroidism, hypothyroidism and parathyroiditis.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.15 Hernias, lumps, cysts or benign tumours that you have not already told us about in questions 3.1-3.15?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.16 HIV or AIDS, auto-immune conditions or allergies that you have not already told us about in questions 3.1-3.16? *Including, but not limited to, food allergies, insect allergies, lupus, myasthenia gravis and prescription drug allergies.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.17 Psychiatric, psychological or behavioural disorders? *Including, but not limited to, anxiety, attention deficit hyperactivity disorder (ADHD), depression, eating disorders and stress.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Do you, or any of your dependants in this application, have any one or more chronic, long-term or recurrent diseases or disorders that we have not asked you about in questions 1-3?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. In the last two years, have you, or any of your dependants in this application, had any abnormal test results that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Have you, or any of your dependants in this application, ever had any joint replacements that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

(Continued)

E. Medical questionnaire *(continued)*

7. Have you, or any of your dependants in this application, ever had any cosmetic treatment that you have not already told us about in questions 1-4?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. In the last two years, have you, or any of your dependants in this application, sought medical advice for any one or more symptoms***, but not had a disease or disorder diagnosed as a result of the advice?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. In the last two years, have you, or any of your dependants in this application, had one or more symptoms*** but not sought medical advice?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

*** Including, but not limited to, abdominal pain, back pain, change in bowel habit, chest pain, dizziness, fainting, fatigue, joint pain, neck pain, persistent cough, rectal bleeding, recurrent headaches, shortness of breath and weight loss or gain.

	Planholder		**Dependant 1**		**Dependant 2**		**Dependant 3**		**Dependant 4**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
10. In the last two years, have you, or any of your dependants in this application, regularly used any medication that you have not already told us about in questions 1-9?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Are you or any of your dependents currently pregnant?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. In the last 5 years, has anyone applying to be covered had any complications during pregnancy or childbirth? *Including, but not limited to, caesarean sections, ectopic pregnancies, pre-eclampsia, gestational hypertension and gestational diabetes – please complete the additional cardio-vascular diseases and diabetes questionnaire.*	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If the answer is 'Yes' for any part of questions 3-12, please also fill in the Additional medical information questionnaire as applicable.

Additional medical information

Name of applicant	Question number	What is the name of the disease or disorder (including joint replacements and cosmetic treatment), symptom(s) or complication(s) and when did it start? (dd/mm/yyyy)	If you have ticked 'Yes' to question number 5, what abnormal test results have you had and when were they done? (dd/mm/yyyy)	What treatment, medication or special diet have you been given? Please specify names of drugs and dosage required.	What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended ? Please give details including dates where necessary.	Do you still have this disease or disorder (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests?	What date did you last see any health care professional for this disease or disorder, (including joint replacements and cosmetic treatment), symptom(s), complication(s) or abnormal tests? (dd/mm/yyyy)	If you answered 'Yes' to question 10, what medication are you regularly using and why do you take it?

F. Full Medical Underwriting declaration

You must ensure that all information provided is full and accurate. If full and accurate information is not provided we may not be able to cover a claim and we may cancel your plan. Please tell us about any change in the information given in this application which occurs between the date of signing and the date the cover commences. If you are unsure whether we need to know about a condition, you should tell us about it.

I declare that to the best of my knowledge and belief:

The information in this application and any additional information supplied is full, true and correct. Where I have supplied medical information for any dependants to be included in this application, I confirm that I have checked with them that the information is correct and that I have their consent to provide this information on their behalf. I understand that no cover will apply for treatment of any medical condition or related medical condition which exists or has existed before the start date of the plan unless agreed and accepted by the insurer.

I also understand that Bahrain National Life Assurance or its administrator will advise me of any medical conditions which are exclude from cover or for which a loading will be applied because of information I have provided to them. I consent to Bahrain National Life Assurance or its administrator contacting my doctor should further medical information be required to support my application. I also consent to Bahrain National Life Assurance or its administrator dealing with my broker, if one is appointed, and that they have authority to see medical information that I have declared in this application.

Planholder signature	Date (dd/mm/yyyy)
Dependant 1 signature (if 18+)	Date (dd/mm/yyyy)
Dependant 2 signature (if 18+)	Date (dd/mm/yyyy)
Dependant 3 signature (if 18+)	Date (dd/mm/yyyy)
Dependant 4 signature (if 18+)	Date (dd/mm/yyyy)

Please read carefully the disclaimers at the end of the form.
Please retain a copy for your records.

G. Doctor's or medical practitioner's details

Please give the contact details of your family doctor or medical practitioner who last treated you or your family in the last two years. If you do not provide this information, it may result in a delay the processing of your claims and your claims may be rejected.

Member's name	Member's name
Doctor's name	Doctor's name
Hospital, clinic or practice	Hospital, clinic or practice
Phone	Phone
Fax	Fax
Email	Email
Address	Address
Postcode	Postcode

Please provide details on a separate page if your family are seen by more doctors than listed above, and confirm which members of your family each doctor has treated.

H. Add-on plans and benefits

Do you want to add any of the following?

Maternity plan ☐ **Yes** ☐ **No**
Travel plan ☐ **Yes** ☐ **No**
Personal Accident plan ☐ **Yes** ☐ **No**

If yes, please make your choices below.

Maternity

The Maternity plan is available with Pioneer 2500, 4000, 5000 and 5000+. The Maternity plan is only available with the same area of cover as your Pioneer plan and for female members aged 18 to 44 at entry. Please see your Benefits schedule and Handbook for full eligibility details.

If you have chosen direct billing for the Pioneer plan this will also be available for the Maternity plan.

Please select the members to be covered under the Maternity plan.

☐ **Planholder** ☐ **Dependant 1** ☐ **Dependant 2** ☐ **Dependant 3** ☐ **Dependant 4**

Please select the Maternity plan required.

	Area 1	Areas 2-6	
Pioneer plan level	Maternity 200	Maternity 150	Maternity 75
Pioneer 5000+	☐	**N/A**	**N/A**
Pioneer 5000	☐	☐	☐
Pioneer 4000	**N/A**	☐	☐
Pioneer 2500	**N/A**	**N/A**	☐

You must pay a standard coinsurance amount of 10% for each claim. See the 'Deductibles' section in your Benefits schedule for full details.

If you want to change the coinsurance from the standard coinsurance shown please tick the appropriate box below.

0%	☐ **(premium increase applies)**
10%	**Standard**
20%	☐ **(premium discount applies)**
30%	☐ **(premium discount applies)**

Travel
The Travel plan is available with all Pioneer plans and provides worldwide cover. The maximum age at entry for the Travel plan is 79. Please see your Benefits schedule and your Handbook for full eligibility details.

The Travel plan is only available with moratorium underwriting terms. Please read and sign the declaration in section I of this application if you choose this add-on plan.

To select the Travel plan please tick the appropriate box below:

Travel	☐ **No**	☐ **Yes, planholder only**	☐ **Yes, planholder and all dependants**

Personal Accident
The Personal Accident plan is available with all Pioneer plans and provides worldwide cover. All members covered under the Personal Accident plan will have the same level of cover as the planholder. You must be aged 18 to 79 when joining this plan. Please see your Benefits schedule and Handbook for full eligibility details.

The Personal Accident plan provides cover for managerial, clerical and administrative occupations only. If your occupation puts you at greater risk of a bodily injury caused by an accident, the planholder must tell us. We will tell them if we agree to cover you and let them know any extra premium that will apply.

Please note that the Personal Accident plan benefits are only payable in relation to an accident that occurs during the plan year.

Please select the Personal Accident plan required and indicate if any dependants are to be covered.

Planholder	☐ **Personal Accident 85**	☐ **Personal Accident 170**
	☐ **Personal Accident 255**	☐ **Personal Accident 340**
	☐ **Personal Accident 425**	
☐ **Dependant 1 (must be over 18 years)**		☐ **Dependant 2 (must be over 18 years)**
☐ **Dependant 3 (must be over 18 years)**		☐ **Dependant 4 (must be over 18 years)**

I. Pre-existing medical conditions for add-on plans

You must read and sign this section if you have chosen any Travel add-on plans in section H.
Please read this declaration carefully before applying for any Travel plans. These plans are subject to moratorium underwriting terms as explained in the Handbook. Please refer to the 'Underwriting terms' section in the Aetna Travel plan Benefits Schedule.
You must sign this section to show that you understand and accept our 24-month moratorium. We will not process your application unless you have signed this section as well as the declaration section on this application.
It is important that you read, understand and accept all of the paragraphs in the following declaration for your plan.
This declaration applies to you and to any eligible dependants you have included in the application.
The Travel plan does not cover claims for, arising from or connected to a medical condition that, within the 24-month period before the date your trip is booked, or your date of joining as shown on your Certificate of insurance, whichever is later, has one or more of the following characteristics:

- Clearly showed itself
- You had signs or symptoms of
- You asked for advice about
- You received treatment for
- To the best of your knowledge, you were aware you had

I confirm that I have read, understood and accept this moratorium underwriting clause about pre-existing medical conditions and that it applies to any eligible dependants included in the application.

Signature	Date (dd/mm/yyyy)

J. Plan currency and premiums

Paying your premiums

To enjoy the full benefit of the plan, you must make sure the premiums are paid on or before the premium due date. You must tell us about any changes to your payment details to make sure that we can continue to collect any premiums due.
You can find full payment details and information on unpaid and late payments in your Handbook.

Currency
The premiums must be paid in USD and all premiums can only be paid yearly.

Payment options
To select your chosen payment method from the options available, please tick the appropriate box below.

	Card	Bank transfer	Cheque or banker's draft
Yearly	☐	☐	☐

Add-on plans and benefits
Travel and Personal Accident plan premiums can only be paid yearly.

Payment details

Card
Please contact Bahrain National Life Assurance Company BSC on +973 17 587 333 or email bnlmedical@bnhgroup.com for details on how to pay.

Bank transfers
Bank transfers must be in the currency of your plan. Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer. Please send your payment to 'Bahrain National Life Assurance Co. BSC. (C)' using the details below.

USD account	
Bank name:	National Bank of Bahrain
Bank address:	PO Box 106
	Manama
	Bahrain
IBAN:	BH10 NBOB 0000 0048 0108 04
Account number:	4801 0804
SWIFT code:	NBOBBHBM

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'Pay Full Amount' or 'Bank Charges Debit Account'.

Cheque or banker's draft
Cheques and banker's drafts must be in the currency of your plan and payable to 'Bahrain National Life Assurance Co. BSC. (C)'. Please make sure that your full name and quotation or plan number are clearly shown on the back of the cheque or banker's draft in case your payment becomes separated from this application.

K. Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with relevant legislation and our own strict internal policy.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, government or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

To help us ensure that your personal information remains accurate and up to date, please inform us of any changes.

You can find our full terms and conditions and details of our privacy policy at http://www.aetnainternational.com/ai/en/about-us/legal.

L. Politically exposed persons (PEPs)

A PEP is a natural person who has been entrusted with prominent functions in a foreign country, such as head of state, member of the royal family, prime minister, senior politician, senior government official, judicial or military official, senior executive of state-owned enterprises, prominent political figures, or persons who have been entrusted with prominent positions at international organizations.

Are you (the planholder), your spouse, your child, your child's spouse or your parents a PEP? ☐ Yes ☐ No					
Does anyone to be covered under the plan share joint ownership of a Legal Entity, a legal arrangement or any close work relationship with a PEP? ☐ Yes ☐ No					
Does anyone to be a covered under the plan have sole ownership of a legal entity or a legal arrangement established to the benefit of a PEP? ☐ Yes ☐ No					
If the answer is 'yes' to any of the above questions, complete the information below:					
Name of PEP	**Member connected with the PEP**	**Member's connection to PEP (e.g. father or business partner)**	**Nature of PEP (e.g. Head of State, Prime Minister etc)**	**Nationality of PEP**	**Current Residential address of PEP**

Please use additional sheet if required.

Attach the self-attested and dated copy of Passport with Visa Page of the policyholder along with the application form

M. Declaration

I am applying to be covered under the Pioneer plan and any add-on plans I have chosen together with the dependants listed in this application. Any reference to the insurer includes, where applicable, any third party administrators acting on the insurer's behalf.

I have read, understood and agree to keep to the terms and conditions shown in the Handbook, along with all eligible dependants included in this application or any dependants I enroll in the future after the start date of the plan. I confirm that I have authority to give Bahrain National Life Assurance information about my family members referred to in this application and where necessary that I have checked with them that the information I have provided is correct. I confirm that to the best of my knowledge, the information I have provided on this application is complete and accurate and that it contains all the information required for the underwriting option I have selected.

By agreeing to the terms and conditions I consent to any personal data, including medical information, that you may collect about myself and my family members and dependants, being processed by Bahrain National Life Assurance.

I authorise the doctor named in section G or any other medical establishment, including any other health professional who has treated me and any of my dependants included under this plan, to give you any information you may need in connection with any claim made under these plans.

I understand that if I do not provide the information asked for in sections E, G and I, and I or any of my dependants included under these plans make a claim, which you view as being treatment for a pre-existing medical or related medical condition, the claim may be rejected.

I understand that should I or one of my dependants attend a hospital, clinic or medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Bahrain National Life Assurance Company has the right to recover the full amount of the ineligible claim from me or one of my dependants.

I understand and agree that this declaration and the information in this application will form the basis of the contract between me, my dependants and Bahrain National Life Assurance Company. After reading all the terms and conditions and documents you have given me, I am satisfied that the products I have chosen meet my needs at this time.

For your own benefit and protection, you should read the terms and conditions shown in the Handbook carefully before signing this declaration. If you do not understand any point, please ask for more information.

Signature	Date (dd/mm/yyyy)

Cancellation

If you feel a plan does not meet your needs, you may cancel it. You must tell us in writing within 15 days of receiving the Benefits schedule, Certificate of insurance and Handbook, or the date of joining, whichever is later. You must return the Certificate of insurance when you cancel the plan. If the Pioneer plan is cancelled all Member ID Cards must also be returned. The Member ID Cards for any female members on the Maternity plan must be returned if the add-on plan is cancelled. See the 'Cooling-off period' section in the Handbook for full details.

N. Broker details

Broker's or advisor's details if applicable