

1 May 2019

Pioneer Plan Application

Continuous Transfer Terms (CTT)

Need help completing this application?

Please contact either your advisor or us directly on +965 1 80 81 81

You must tell us about all material facts before we accept an application or renew the plan. A material fact is information likely to influence us in assessing and accepting the insurance. If you do not tell us all material facts or if you misrepresent any material facts, this may render the insurance voidable from inception (the start of the contract) and entitle us not to pay your claims. If there is any doubt about whether a fact is material, for your own protection, you must tell us.

If any of the details that you give on this application are different from the details that you gave when you received your quotation, your premium may be different.

Please fill in this application clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quotation number and option number if you have one:

Quotation number	Option number
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A. Your personal details (the planholder)

Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> 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	

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

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 <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Other	
	Family name (surname)		First name(s)	
	Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Other	
	Family name (surname)		First name(s)	
	Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Other	
	Family name (surname)		First name(s)	
	Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms		Other	
	Family name (surname)		First name(s)	
	Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> M <input type="checkbox"/> 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.

C. Cover start date

The plan is a yearly contract. Your cover will start on the expiry date of your existing plan. We will not backdate cover under any circumstances.

Date existing cover ends (dd/mm/yyyy)	Date existing medical insurance was first taken out with the current insurer (dd/mm/yyyy)
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A copy of the current certificate of insurance must be provided for each member applying for CTT terms.

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.

<input type="checkbox"/> Pioneer 1750	<input type="checkbox"/> Pioneer 2500	<input type="checkbox"/> Pioneer 4000
<input type="checkbox"/> Pioneer 5000	<input type="checkbox"/> 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
<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4

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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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. 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	<input type="checkbox"/> (premium increase applies)
USD 1,000	<input type="checkbox"/> (premium increase applies)
USD 2,000	Standard
USD 4,000	<input type="checkbox"/> (premium discount applies)
USD 8,000	<input type="checkbox"/> (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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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%	<input type="checkbox"/> (premium increase applies)
10%	Standard
20%	<input type="checkbox"/> (premium discount applies)
30%	<input type="checkbox"/> (premium discount applies)

Please read carefully the disclaimers at the end of the form.

Please retain a copy for your records.

E. Add-on plans and benefits

Do you want to add any of the following?		
Maternity plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Travel plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Accident plan	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

<input type="checkbox"/> Planholder	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
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Please select the Maternity plan required.

Pioneer plan level	Area 1	Areas 2-4	
	Maternity 200	Maternity 150	Maternity 75
Pioneer 5000+	<input type="checkbox"/>	N/A	N/A
Pioneer 5000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pioneer 4000	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Pioneer 2500	N/A	N/A	<input type="checkbox"/>

You must pay a standard outpatient 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%	<input type="checkbox"/> (premium increase applies)
10%	Standard
20%	<input type="checkbox"/> (premium discount applies)
30%	<input type="checkbox"/> (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 schedules 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 F of this application if you choose this add-on plan.

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

Travel	<input type="checkbox"/> No	<input type="checkbox"/> Yes, planholder only	<input type="checkbox"/> Yes, planholder and all dependants
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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	<input type="checkbox"/> Personal Accident 85	<input type="checkbox"/> Personal Accident 170
	<input type="checkbox"/> Personal Accident 255	<input type="checkbox"/> Personal Accident 340
	<input type="checkbox"/> Personal Accident 425	
<input type="checkbox"/> Dependant 1 (must be over 18 years)	<input type="checkbox"/> Dependant 2 (must be over 18 years)	
<input type="checkbox"/> Dependant 3 (must be over 18 years)	<input type="checkbox"/> Dependant 4 (must be over 18 years)	

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.

F. 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)

G. 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

Your premiums must be paid in USD.

Payment options

You can pay yearly, every three months or every month. We cannot accept payment by bank transfer, cheque or banker's draft if you are paying by instalments. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% more if you pay every month and 4% if you pay every three months).

To select how often you want to pay your premiums and your chosen payment method from the options available, please tick the appropriate box below.

	Card	Bank transfer	Cheque or banker's draft
Yearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Every three months	<input type="checkbox"/>	N/A	N/A
Every month	<input type="checkbox"/>	N/A	N/A

Add-on plans and benefits

Maternity

If you have chosen a Maternity plan, you can also choose how often you want to pay the premiums for this plan, depending on the payment option chosen for your Pioneer plan. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% if you pay every month and 4% if you pay every three months).

To make your selection, please tick the appropriate box below.

Yearly Same as Pioneer plan

Travel and Personal Accident

Travel and Personal Accident plan premiums can only be paid yearly.

Payment details

Card

We can accept card payments by Visa, MasterCard or American Express. To make a payment please fill in the Card authority we give to you. Please make sure that your card is valid for at least three months from the start date of your plan.

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 'Aetna Insurance Company Limited' using the details below.

USD account	
Bank name:	Citibank
Bank location:	London
IBAN:	GB95CITI18500817808674
Account number:	17808674
SWIFT code:	CITIGB2L
Sort code:	185008

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 'Aetna Insurance Company Limited'. 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.

H. Doctor's or medical practitioner's details

Please give the contact details of any family doctor or medical practitioner who has treated you or your dependants in the last two years. If you do not provide this information, it may 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.

I. Medical questionnaire

We assess your CTT application based on your answers to the following questions and the information on your current certificate of insurance. Your current certificate of insurance must show your current insurance arrangements. A copy of the current certificate of insurance must be provided for each member applying for CTT terms.

1. Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint disorder, psychiatric or mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the last 12 months have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If you are applying for the Maternity plan, is anyone to be covered on this plan currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the last 2 years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions 1-4 above?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answer yes to any of the above questions, please provide details in section M Medical details.

J. Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect 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, governmental 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.

All membership documents will be sent to the planholder.

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

We may, from time to time, provide you with marketing information about our products and services and those of any associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box.

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

K. 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does anyone to be covered under the plan have sole ownership of a legal entity or a legal arrangement established to the benefit of a PEP? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

Please read carefully the disclaimers at the end of the form.

Please retain a copy for your records.

L. 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 enrol in the future after the start date of the plan. I confirm that I have authority to give Warba Insurance Company and any administrator acting on its behalf 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 or on behalf of Warba Insurance Company.

I authorise the doctor named in section H 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 F, H, I and M (if applicable), 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, Warba Insurance Company and any administrator acting on its behalf have 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 Warba Insurance 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)
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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.

M. Broker details

Broker's or advisor's details if applicable

N. Medical details

Name	Question number	What is the name of the medical condition or symptom and when did it start? (dd/mm/yyyy)	What treatment, medication or special diet have you been given? Please include dates and specify names of drugs and dosage.	What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended?	Do you still have this medical condition or symptom?	What date did you last see any health care professional for this medical condition or symptom? (dd/mm/yyyy)

If you require more space, please give us details on a separate sheet of paper and send it to us with this application.

Aetna® is a trademark of Aetna Inc. and is protected throughout the world by trademark registrations and treaties.

Warba and Aetna do not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com.

If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Warba and Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Asset Control (OFAC) license. For more information on OFAC, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Notice to United Kingdom residents: In the UK, Aetna Insurance Company Limited (FRN 458505) has issued and approved this communication.

Notice to all: Please visit <http://www.aetnainternational.com/ai/en/about-us/legal/regional-entities> for more information, including a list of relevant entities permitted to carry on or administer insurance business in their respective jurisdictions.

Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

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