1 January 2019

# Aetna Summit[SM] Plan
# Group Member Declaration

## Medical History Disregarded (MHD)
5-9 employees

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 enable us to repudiate liability (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.

### A. Plan Sponsor details

| Company name |
|---|
| |

### B. Your personal details

| Title<br>☐ Mr ☐ Mrs ☐ Miss ☐ Ms | Other |
|---|---|
| Family name (surname) | First name(s) |
| Date of birth (dd/mm/yyyy) | Gender:<br>☐ M ☐ F |
| Country where you live | Nationality on passport |
| Occupation | |

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

## C. Dependants to be covered

| | | |
|---|---|---|
| **Dependant 1** | Title<br>☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** | Other |
| | Family name (surname) | First name(s) |
| | Date of birth (dd/mm/yyyy) | Gender<br>☐ **M** ☐ **F** |
| | Country where they live | Nationality on passport |
| | Relationship to you | Occupation |
| **Dependant 2** | Title<br>☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** | Other |
| | Family name (surname) | First name(s) |
| | Date of birth (dd/mm/yyyy) | Gender<br>☐ **M** ☐ **F** |
| | Country where they live | Nationality on passport |
| | Relationship to you | Occupation |
| **Dependant 3** | Title<br>☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** | Other |
| | Family name (surname) | First name(s) |
| | Date of birth (dd/mm/yyyy) | Gender<br>☐ **M** ☐ **F** |
| | Country where they live | Nationality on passport |
| | Relationship to you | Occupation |
| **Dependant 4** | Title<br>☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms** | Other |
| | Family name (surname) | First name(s) |
| | Date of birth (dd/mm/yyyy) | Gender<br>☐ **M** ☐ **F** |
| | Country where they live | Nationality on passport |
| | Relationship to you | Occupation |

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.

## D. Medical questionnaire

| | | |
|---|---|---|
| 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 replacement, psychiatric or mental illness? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |
| 4. If the plan includes maternity cover, are you or any of your dependants currently pregnant? | ☐ Yes | ☐ 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? | ☐ Yes | ☐ No |

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

## E. 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.

## F. Declaration

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 Aetna information about my dependants 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.

I consent to any personal data, including medical information, that you may collect about me and my dependants, being processed by Aetna.

I understand that should I or one of my dependants attend a hospital/clinic/medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Aetna has the right to recover the full amount of the ineligible claim from myself, the dependant/s or the planholder.

I declare that the information I have provided in this application is correct in all respects.

**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.**

| Name | Date (dd/mm/yyyy) |
|---|---|
| | |
| Signature | |
| | |

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

## G. Medical Details

| Name | Question number | Symptom and/or 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) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |



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