Administered by:

Aetna Global Benefits

Insured by:

شركة العين الأهلية للتأمين (ش م ع)
Al Ain Ahlia Insurance Co. (PSC)

1 May 2018

Summit Plan
Group Member Application

Continuous Transfer Terms (CTT)

The plan is a yearly contract. Your cover will start on the expiry date of your existing plan. We cannot 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)

A copy of the current certificate of insurance must be provided for each member applying for CTT terms.

Please complete this application clearly in BLOCK CAPITALS and tick the boxes where needed.

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. Continuous Transfer Terms (CTT)

If members transfer from another insurer we may offer, subject to completion of this application and acceptance by us, to continue the same underwriting terms including any special exclusions which previously applied to them. Members will not be subject to any new personal underwriting terms. Cover will still be governed by the benefits, terms and conditions of the plan with us except for benefit exclusion E1 in the Handbook. CTT terms may not be available to new entrants onto a group CTT plan. Each new member will be assessed separately and we may offer moratorium terms if the CTT criteria applicable to the rest of the plan are not met.

B. Your personal details

Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
Family name (surname)	First name(s)	
Address		
Town	City	
Postcode	Country	
Phone	Mobile	
Country where you live	Nationality on passport	
Occupation	Date of birth (dd/mm/yyyy)	Gender: ☐ **M** ☐ **F**

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 ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other
	Family name (surname)	First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**
	Country where they live	Nationality on passport
	Relationship to you	Occupation
Dependant 2	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other
	Family name (surname)	First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**
	Country where they live	Nationality on passport
	Relationship to you	Occupation
Dependant 3	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other
	Family name (surname)	First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**
	Country where they live	Nationality on passport
	Relationship to you	Occupation
Dependant 4	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other
	Family name (surname)	First name(s)
	Date of birth (dd/mm/yyyy)	Gender ☐ **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. Doctor's or medical practitioner's details in your home country

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

E. Doctor's or medical practitioner's details in the country where you live

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

F. 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.

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 I Medical details.

G. 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.

H. Declaration

I am applying to be covered under the Summit plan or plans together with the dependants listed in this application.

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 Al Ain Ahlia Insurance Company or its relevant agents 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.

By agreeing to the Summit terms and conditions, I consent to any personal data, including medical information, that you may collect about me and my dependants, being processed by Al Ain Ahlia Insurance Company.

I authorise and request the doctors named in sections D and E 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 or the insurer's medical co-ordinator any information they may need in connection with any claim made under this plan.

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

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, Al Ain Ahlia Insurance Company 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.

I understand and agree that, unless the agreed premium, the completed application and the details of all scheme members have been received from the planholder, no claims for treatment will be authorised for payment by the insurer.

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	

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I. 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)

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