Executive Healthcare Plan
Group Plans
Formation & Medical Declaration

Aetna International

Explanatory Notes: This form should be completed by the **group administrator** authorised to accept a quotation and set up a plan for the **plan sponsor**. Please use BLOCK CAPITALS and check boxes as appropriate and return this completed form to **us** or your agent.

Note 1: The group administrator name given should be the person who will be the company's regular contact for correspondence and administration purposes.

Note 2: The definition of those members of staff to be covered under the plan could for example be – "senior managers, all staff with more than one year's service," etc.

If defining more than two categories, please provide details on a separate sheet of paper.

Note 3: Where an employee's child **Dependants** are to be included under the group plan, all children must be unmarried and under the age of 18 years (or 26 years if in full-time education).

Note 4: The details shown in **Section 4** should match the group quotation terms proposed/accepted by Aetna.

Aetna reserves the right to amend or withdraw its offer of cover should there be any material change to the original risk.

Please return this completed form to one of the following offices:

Executive Healthcare Solutions Limited
6th Floor, 9 West
Ring Road Parklands
PO Box 14680, 00800, Westlands
Nairobi, Kenya

T: (254 20) 291 0000
F: (254 20) 291 0600
E: info@executive-healthcare.com

Aetna Global Benefits Limited
PO Box 6380
Dubai, UAE

T: + 971 4 438 7600
F: + 971 4 428 7100
E: MEASales@aetna.com

This form should be read in conjunction with the **sales** brochure, policy wording and quotation summary.

Words and phrases in bold font have specific meanings and are defined in the policy wording.

Aetna reserves the right to amend or withdraw its offer of **cover** should there be any material change to the original risk. Commencement of this **policy** is subject to review by **our underwriters** and screening of the **group** under the company's anti-money laundering **policy**.

For **groups** of less than 10 **employees**, **we** require a completed group member application form for each **employee**.

Section 1 – Plan Sponsor Details

Company Name and Registered Address (Kindly attach a copy of certificate of incorporation to this application.)	Postal Code
Name(s) of Any Subsidiary Company/ Companies To Be Included	
Type of Business	
Correspondence Address for all Documentation (if different from above)	Postal Code
Registered address	
Company type and Industry	

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Section 2 – Group Administrator's Details (see Note 1 above)

Group Administrator's Name		Job Title
Telephone	Fax	Email
Intermediary/Agent Name (if applicable)		

Section 3. Company (plan sponsor) shareholder details

Sl. No.	Name of the shareholder	% of shares held in the company	Nationality	Date of Birth/ Year of Incorporation	Current address
If the shareholder is a company provide details of the Ultimate Beneficial Owner (UBO):					

Section 4. Director details

Sl. No.	Names of all directors	Nationality	Date of Birth/ Year of Incorporation	Current residential address

If you are unable to complete the above information in the space given, please provide this on a separate page.

Section 5: The MOA and AOA of the Company should be enclosed with this Form.

Signature of the Client	Date

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Section 6 -- Politically exposed persons (PEPs)

A PEP is a natural person who has been entrusted with prominent functions in a foreign country, such as a head of state, member of the royal family, prime minister, senior politician, senior government official, judicial or military official, senior executive of a state-owned enterprise, prominent political figure, or person who has been entrusted with a prominent position at an international organisation.

Is the company or any of its shareholders, directors or managers a PEP? **Yes** ☐ **No** ☐

Is the company or any of its shareholders, directors or managers associated with a PEP? **Yes** ☐ **No** ☐

If you answered yes to either of the above questions, complete the information below:

Name of the PEP	**The PEP's connection to the company (e.g. shareholder, director, manager, etc.)**	**Nature of the PEP (e.g. Head of State, Prime Minister etc.)**	**Nationality of the PEP**	**Current Residential address of the PEP**

If you are unable to complete the above information in the space given, please provide this on a separate page

Section 7 – Confirmation of Cover and Eligibility Definitions

Please provide the definition of those members of staff to be covered in each category (e.g., senior managers, all staff with more than one year's service, etc.) and return the completed quotation summary for each plan you wish to purchase.

Category 1
Category 2
Category 3

Section 8 –Underwriting

(see Note 4 above)	**Previously Uninsured Group**	**Previously Insured Group**	**Additional New Members**
Two Year Moratorium (MORI)	☐	☐	☐
Continued Personal Medical Exclusions (CPME) with Employer Declaration of Medical Facts	N/A	☐	☐
Medical History Disregarded (MHD)	☐	☐	☐

Section 5 –Expiring Insurance Plan Details

Is the Group Currently Insured? ☐ Yes ☐ No	Name of Insurer	
Current Plan Name		Expiry Date (Day/Month/Year)
Expiring Underwriting Terms	Variations to Standard Terms	

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Section 9 – Additional Options (The Executive Healthcare Plan enables **You** to choose various Standard Plan Designs and Optional Modules to suit **Your** personal requirements. Please clearly check the Standard Plan Design you require; any Optional Modules **You** have selected and the **Excess You** require. **Your Policy** will be issued on this basis. If no boxes are checked in this section, it will be assumed that cover required is Area 1 Foundation Plan with standard US$ Nil Policy Excess.)

Geographical Cover	**Product Selection**			
Core Products:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	Not Applicable	☐	☐

* (Excess options are limited to US$40, US$80, US$150)

Product Options:	**Major Medical**	**Major Medical Plus**	**Foundation**	**Lifestyle**
☐ Exclude Pregnancy Cover	Not Applicable	Not Applicable	☐	☐
☐ Medical History Disregarded*	☐	☐	☐	☐
☐ Wellness	Not Applicable	Not Applicable	☐	☐
☐ Routine Dental Treatment	Not Applicable	Not Applicable	☐	Standard
☐ Vision Care**	Not Applicable	Not Applicable	☐	☐

***** For compulsory groups of 10 or more employees only

** For compulsory groups of 5 or more employees only

Policy Excess:				
• **Major Medical**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Major Medical Plus**	☐ US$250	☐ US$750	☐ US$1,500	☐ US$4,000
• **Foundation**	☐ US$40	☐ US$80	☐ US$150	☐ US$250
• **Lifestyle**	☐ US$40	☐ US$80	☐ US$150	☐ US$250

Section 10 – Aetna Global Health Connections – Wellness Checkpoint® Health Risk Reporting

Plan sponsors with more than 100 **members** can benefit from tailored and personalised Wellness Checkpoint reporting tools. In addition, **plan sponsors** of this size may customise certain sections of the Wellness Checkpoint tool. Please advise if you would like to work with **us** to tailor your **group's** reports and application.

☐ We would like to develop a tailored Wellness Checkpoint application and reporting capabilities at this time.

☐ We would like to defer tailoring our Wellness Checkpoint application and reporting to a later date.
(If this option is selected, when shall **we** contact you again to follow up?) _____

☐ We are happy to receive standardised comparative reporting and the standard Wellness Checkpoint application.

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Section 11 – Premium Payment and Payment Frequency.
(Please check which payment method **you** require and complete all details relevant to that method.)

Please select the desired payment method and frequency. Note that, regardless of frequency, all contracts are annual. A bi-annual and quarterly payment frequency will carry an extra 5% loading and monthly payment frequency will carry an extra 8% loading. Please check as appropriate (if no indication is given an annual frequency will be assumed).

☐ Annual Payment ☐ Bi-Annual Payment ☐ Quarterly Payment ☐ Monthly Payment (Credit Card Only)

☐ a) **Banker's Draft:** All Banker's Drafts must be payable to "Aetna Global Benefits Limited". Please ensure that the name of the **group** (as declared in **Section 1** of this form) is clearly stated on the reverse of the draft.

☐ b) **Bank Transfer:** Please ensure that the name of the **group** is clearly stated on any bank transfer. **Our** bank details are available on request by contacting our local representative office. **We** cannot accept liability for any bank transfer which does not clearly identify the **group** and applicant.

☐ c) **Credit Card (US Dollars only):** ☐ VISA ☐ MasterCard

1. Credit Card Number: | | | | | | | | | | | | | | | |
2. Expiry Date (Day/Month/Year): _____
3. Cardholder's Name: _____
4. Cardholder's Statement Address: _____
5. Cardholder's Authorisation Signature: _____
6. Signature Date (Day/Month/Year): _____

For payment method C, please note that **your** premium will be collected upon receipt of this application which may be in advance of the **commencement date**. All transactions will be undertaken in US Dollars at the prevailing rate.

If the annual premium exceeds USD 16,500, **We** are required to carry out identity checks of the **policyholder** by collecting his/ her copy valid photo identity documents- passport, driving license, national identity card or any other photo identity document issued by Government. Kindly attach a copy of the same with this application.

Section 12 – Recurring Transaction Authority

Your authority to Aetna to claim amounts due from **your** VISA or MasterCard account and signature:

I authorise **you** to charge to my above chosen card an unspecified amount in respect of medical insurance premiums as and when they become due. I understand that Aetna will advise me of the amount to be paid and the dates on which payment is due and that Aetna may only change these after giving me prior notice. I understand that this authority in favour of Aetna will remain in force until such a time as I cancel it in writing/email instruction to Aetna.

Cardholder's Authorisation Signature	Date (Day/Month/Year)
Email (where signing online)	

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Section 13 – General Terms and Conditions

1. This document forms part of the contract and must be read together with the **policy wording**, **policy schedules** and application Form(s), where applicable [see points below].
2. This Contract of Insurance will take effect on the **commencement date** as notified to you separately and shall continue for a period of 12 months or until the next **renewal date** or until the **policy** is cancelled for whatever reason, whichever is sooner.
   The Contract of Insurance is subject to Anti Money Laundering checks on proposed members and the Group.
3. **Group** Eligibility
   a) A **group** can only be made up of **employees** of the same company or members of an existing and registered affinity group.
   b) For a **group** that consists solely of members of the same family, it must be fully substantiated that such **members** are all working for the same employer.
   c) Where a husband and wife are both employed by the same company, they are deemed to be one **employee** plus eligible **Dependant** NOT two employees.
   d) The minimum size of a **group** at inception or renewal is three current **employees**. If the membership is below three at inception or at a subsequent **renewal date**, then the **group** cannot continue, and members can transfer to individual policies on CTT basis subject to underwriters acceptance.
4. The inception premium must be received within a maximum of 30 working days from the **commencement date** of the **policy**. No claims will be paid until this is received.
5. Renewal premiums must be received by **renewal date**. If full renewal premium and any applicable taxes or local levies are not received by **renewal date**, claims will be suspended, and cover will lapse. Aetna may, at their discretion, reinstate **cover** if full premium and any applicable taxes or local levies are subsequently received.
6. Cover is only provided for group members (and eligible **Dependants**) where declared and accepted by Aetna.
   a. New **group members** (and eligible **dependants**) can be added to the **policy** mid-term subject to the following:
      i. For **groups** with less than 10 **employees**, a group member application form must be completed by each and every **group member**.
   b. For **groups** with more than 10 **employees**, the **group administrator** may supply the information electronically, in a format approved by Aetna. If the **group administrator** is not able to supply the required eligibility and enrolment information ("Information"), a separate group member application form must be completed by each applicant. Regardless of format, any **employee** or **dependant** not enrolled within 30 days will be subject to individual underwriting. If the **group** chooses to enroll electronically, the **group** shall:
      i. Maintain a reasonably complete record of the enrolment and eligibility information ("Information"). The records may be filed and kept under any acceptable and commercially reasonable format and they shall meet reasonable standards of availability, authenticity, non-repudiation and integrity (the "Records"). The Records shall include any original forms, including member enrolment applications containing the signature of covered **members**, which provide consent for Aetna to process personal and health information. The Records should also contain sufficient documentation to support **cover** requests for students or handicapped **dependants** requesting **cover** through an eligible **employee** and beneficiary designations;
      ii. Produce the Records upon reasonable request;
      iii. Transmit the Information in the exact way that it is contained in the Records;
      iv. Obtain from its **employees** and their **dependants**, information including authorisations, reasonably necessary for Aetna to perform its obligations for the **group** and its **employees**;
      v. Use Aetna's enrolment and change forms in paper or electronic format, or they must incorporate the following points into the enrolment materials:
         a) Name(s) of the Aetna company offering the insurance **cover**;
         b) A statement that the terms of the insurance documents will govern the **member's** rights and responsibilities;
         c) An acknowledgement that participating **providers** are not agents or employees of Aetna and that **network** composition can change; and
         d) A written authorisation from the **employee** indicating that they authorise Aetna to process the personal/health information of their spouse, competent adult **dependants**, and themselves; they have discussed the terms of the authorisation with their spouse and competent adult **dependants** and have obtained their authorisation to release/process their personal/health information; that the information may be shared with affiliates, government authorities with appropriate jurisdiction third parties with whom Aetna contracts worldwide, and their employer, for activities related to the operation of the health plan and other insurance operations; and notification that the **employee** may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna or other party; opt out of any direct marketing campaigns; and decline to provide Aetna with consent to process personal or health care information; however, such failure to provide consent may result in declination of **cover**.
         e) NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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c. The **group** may receive certain **benefit** plan information and documentation (the "Material") electronically and may publish the material on its internal website. The **group** shall, with respect to the Material to be electronically published or provided:
   i. Give access and distribute the Material only to covered **members**;
   ii. Place the Material only on its internal website (if applicable), which shall be available and accessible to authorised company personnel; and
   iii. Place in the electronic memo or on the internal website (if applicable) a disclaimer stating: "This information/material is provided solely for general guidance about the terms of the **benefit** plan your employer has made available to you. In the event of any conflict between this information and terms and conditions of the **policy** and related **policy documentation** delivered to the employer, the **policy** and related **policy documentation** will govern."

d. The g**roup** agrees that in placing the Material on its internal website, it shall not make any change to the terms of the **policy**, plan forms, or related **policy documentation**, and shall promptly amend such information to correct errors or reflect changes in any plan term or form. The **group** further agrees to take appropriate steps to prevent improper access, changes or usage of the material by unauthorised personnel no matter the means distributed. Furthermore, the **group** agrees to mitigate, to the extent practicable, any harmful effect of an improper access, changes or usage of the material by unauthorised personnel.

e. The **group** shall retain all information required by this form for a period of not less than seven (7) years.

f. The **group** agrees to indemnify, and hold Aetna harmless from any costs, expenses, claims or judgments, including counsel fees that Aetna incurs as a result of customer's failure to comply with the terms of this agreement.

g. Payment for additions must be received within 14 days of acceptance date. If these conditions are not met, all **cover** will be deemed null and void without further notice. For additions to plans that have opted for end of year adjustments, six monthly payments or quarterly payments, the funds must be received by due dates, otherwise all **cover** will be deemed null and void.

h. The **group members** and/or their eligible **dependants** can be deleted from the date of notification in writing by the **group administrator** for which a pro rata return of premium will be calculated. Notification may be given to Aetna by the **group administrator** of a future deletion(s) date(s) no more than 30 days in advance.

i. The **group** understands that Aetna may not be able to conduct business and/or pay claims in locations or with/to people or groups that are listed by the European Union, the United States of America and/or the United Nations as sanctioned countries or prohibited groups. Wherever **cover** provided by this insurance contract is in violation of applicable trade or economic sanctions, such **cover** shall be null and void.

j. Please note it is not possible to change categories mid-term unless an **employee** is promoted, and he/she clearly fit within the definition of an alternate but existing **employee** category. For example, a member of the "staff" category is promoted and joins the **policyholder's** management team and therefore is eligible for inclusion in an existing and defined category for managers and directors. This may incur premium adjustment(s).

7. Accountability for any misuse of individual membership cards issued by Aetna or the insurers to **employees** (and their eligible **dependants**) lies with the **group** administrator, on behalf of the group, who holds responsibility to gather and return such cards upon deletion of **employees** (and their eligible **dependants**) from cover.

   In the event of being unable to return the **Direct Settlement Network** card for deleted **group** members, the **group** administrator, on behalf of the group, acts as guarantor that any claims incurred against such members' cards after their individual deletion dates, will be borne by the **group**.

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Section 14 – Declaration

This document serves as a contract between the **group** and Aetna and must be read together with the **certificate of insurance**, any application forms, the policy wording and other **policy documentation**, as applicable.
The **plan sponsor** understands that premiums due under the **group** plan must be paid in full by the agreed due date to Aetna. In the event that premiums are not paid by the due date, **cover** may be terminated.
The **plan sponsor** declares that the transfer by the **group** of personal data to Aetna, including information relating to **members** insured under the **group** plan, will not result in violation of applicable privacy and data protection laws. Aetna will hold and process personal data, including personal sensitive data, provided by the **group** for the purpose of insurance administration and other activities related to this contract of insurance. This information may be passed worldwide to select third parties.

The **plan sponsor** declares that the information given to Aetna for the purposes of entering into this contract of insurance is true and complete and that no material facts have been withheld.

I confirm and agree that personal information and/or healthcare information collected or held by Aetna International, 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, Executive Healthcare Solutions – Kenya, MIC Global Risks (Tanzania) Limited, MIC Global Risks (Uganda) Limited, EHS Zambia Limited, EHS Limited 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/**we** hereby declare to the best of my/**our** knowledge that no **insured person** has received inpatient **treatment** of any kind within the last three months, and that no **insured member** or potential **insured member** has any on-going or planned **inpatient treatment** of any kind.

Furthermore, I/**we** declare that to the best of my/**our** knowledge, no **insured member** or potential **insured member** has any on-going or planned **treatment** in respect of cancer, heart, lung, orthopedic or psychiatric related conditions.

I/**we** accept that any personal exclusions/limitations relating to an **insured member's** or potential **insured member's** existing cover will be maintained by Aetna International.

For Data Protection Act purposes, Aetna will hold and process **plan sponsor's** personal data for insurance administration. The information may only be passed to selected third parties and re-insurers.

The **plan** sponsor consents to **our** processing sensitive data about **plan sponsor** and other **insured members** or potential **insured members** who may be included in the **policy**. The **plan sponsor** understands that all personal data supplied must be accurate and **plan sponsor** has the specific consent of those **insured members** or potential **insured members** to disclose their personal data. Telephone calls may be monitored and/or recorded.

The **plan sponsor** acknowledges that both parties under this insurance arrangement shall be responsible for complying with applicable anti-corruption and anti-money laundering laws and certifies that it has neither received nor been promised any improper benefit, payment or advantage in connection with this insurance arrangement.

Any change of occupation, hazardous pursuits and change of residential address or area should promptly be notified in writing to Aetna.

As **group administrator**, I declare that I am authorised to enter into this contract of insurance with Aetna Global Benefits Limited on behalf of the **plan sponsor**

Authorised Signatory Signature (**Group Administrator**)	Date (Day/Month/Year)
Please Print Authorised Signatory's Name	Position in Company
Company Stamp	

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