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EXECUTIVE HEALTHCARE SOLUTIONS

Executive Healthcare Plan Continuous Transfer Form

Insured by:

aetna™

EXPLANATORY NOTES: Please read through the following before completing this application and complete in BLOCK CAPITALS or check boxes as appropriate.

TERMS AND CONDITIONS: **You** must complete this form in full and **You** should attach a copy of **Your** existing **Policy Schedule**, detailing any endorsements and the original **Commencement Date** of the expiring plan.

Continuous transfer can be offered where the **Benefits** of the plan for which **You** are applying are similar to those of **Your** current **Policy**. These terms and conditions must be read in conjunction with the **Policy Wording**.

All material facts (e.g. a pre-existing health condition or involvement in a hazardous activity), which may affect **Our** assessment and consideration of this application, should be declared.

If **You** are in doubt as to whether a fact is material, then it should be disclosed. Please use a separate sheet of paper if necessary.

Please return this completed **Continuous Transfer Form** together with **Your** current valid certificate of insurance (where applicable) 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**

Please check all respective boxes which apply to You.

☐ Apply to transfer from another insurer to an Aetna International group **Policy**

☐ Apply to transfer from another insurer to an Aetna International individual **Policy**

☐ Apply to transfer from an existing Aetna International **Policy** to a new Aetna International **Policy**

Section 1 –Applicant's Information

Family Name				Title
First Name(s)				
Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
Residential Address _____ _____ _____				ZIP/Postal Code **Country of Residence**
Occupation			Telephone	
Email			Company Name (if applicable)	
Employer details (Name and address)			Email address Phone	
Source of funds for premium payments				

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Section 2 – Dependant(s) Information

Dependant 1	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 2	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 3	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 4	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		
Dependant 5	Relationship to person named in **Section 1** above		Family Name		
	Title	First Name(s)			
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)	Nationality
	Country of Residence		Occupation		

Section 3 – Commencement Date (Subject always to **Section 10** of this application form, the **Commencement Date** of this **Policy** will be the date on which this application is accepted in writing by **Us**. Please note the **Commencement Date** can be no more than 30 days from the date of completion of this application by **You**. Under no circumstances will **Policies** be backdated.)

Commencement Date (Day/Month/Year)

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Section 4 – 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 ten or more employees only
** For compulsory groups of five 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

Aetna Travel
The Aetna Travel plan is available with this Executive Healthcare Plan and provides worldwide cover. The maximum age at entry for the Aetna Travel plan is 65. Please see your Benefits schedule and your Handbook for full eligibility details.

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

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

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

Aetna Personal Accident
The Aetna Personal Accident plan is available with this Executive Healthcare Plan and provides worldwide cover. All members covered under the Aetna Personal Accident plan will have the same level of cover as the planholder. You must be aged 18 to 65 when joining this plan. Please see your Benefits schedule and Handbook for full eligibility details.

The Aetna 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 Aetna Personal Accident plan benefits are only payable in relation to an accident that occurs during the plan year. Please select the Aetna Personal Accident plan required and indicate if any dependants are to be covered.

Planholder	☐ **Aetna Personal Accident 85**	☐ **Aetna Personal Accident 170**
	☐ **Aetna Personal Accident 255**	☐ **Aetna Personal Accident 340**
	☐ **Aetna 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)**	
☐ **Dependant 5 (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.

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Pre-existing medical conditions for add-on plans

You must read and sign this section if you have chosen Aetna Travel plans in section 4.

Please read this declaration carefully before applying for any Aetna Travel plans. These plans are subject to moratorium underwriting terms.

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 Aetna 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 **(Day/Month/Year)**

Section 5 – Premium Payment (Please check which payment method **You** require and complete all details relevant to that method.)

Payment Frequency: Please declare the frequency of payment required. 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 **Policyholder** (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 **Policyholder** 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 **Policyholder**.

If paying by credit card please read and complete **Section 6** of this Form - **Recurring Transaction Authority**.

If the annual premium exceeds US$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 6 – Recurring Transaction Authority

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

I authorise **You** to charge to my card submitted through www.aetnainternational.com/payonline an unspecified amount in respect of medical insurance premiums as and when they become due. I understand that Aetna International will advise me of the amount to be paid and the dates on which payment is due and that Aetna International may only change these after giving me prior notice. I understand that this authority in favour of Aetna International will remain in force until such a time as I cancel it in writing/e-mail instruction to Aetna International.

Cardholder's Authorisation Signature	Date (Day/Month/Year)
E-mail (where signing online)	

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Section 7 – Medical Practitioner Details (Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application. Please use a separate sheet if this space is insufficient.)

Section 8 – Medical Questionnaire (When completing **Section 8,** please ensure that **You** declare all material facts for both **Your** own and all **Dependants** to be included under this application. Failure to do so could result in a claim not being paid. Should **You** have any doubt as to what information is required, please speak to **Your** health insurance advisor or contact the Executive Healthcare Solutions office.)

Please complete the following questions by checking Yes or No.	**Yes**	**No**
a) Have **You**, or anyone included in this application, ever been admitted to a **Hospital** or other similar establishment?	☐	☐
b) Have **You**, or anyone to be included under this application, been prescribed with a course of any drugs or medication, or **Treatment** for a period in excess of seven days in the last two years?	☐	☐
c) Have **You**, or anyone to be included under this application, any known or foreseeable need to consult with a **Medical Practitioner** or any other health care professional and/or to be required to be prescribed any drugs or medication and/or to be admitted to a **Hospital** or other similar establishment?	☐	☐
d) Are **You**, or anyone to be included under this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?	☐	☐

If **You** have answered Yes to any of the questions above, please provide further details below or on a separate sheet of paper if there is insufficient space.

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Section 9 - Politically Exposed Person (PEP) or Government Affiliation Declaration

Are you associated or affiliated with PEP or Government entity or agency? See below for important guidance[1]

☐ Yes ☐ No

If yes, please provide further details.

1 The answer is "Yes" if you are an official, employee, member, or representative of a government, government department or agency, political party, public international organization, or any other entity that is wholly- or partially-owned or controlled by a government.

Government Definition: Any ownership (whole or part) or control of the Plan Sponsor by: (a) a government entity, department or agency (local, state, provincial, national or federal level) or (b) any official, employee, member, or representative of a government, government department or agency, political party, public international organization, or any other entity that is wholly- or partially-owned or controlled by a government; or (c) any close family member of a person described in (b).

A PEP is a natural person who has been entrusted with prominent public functions, 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 Government/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 Government/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 Government/PEP? ☐ Yes ☐ No

If the answer is 'yes' to any of the above questions, complete the information below:

Name of Government/ PEP	Member connected with the Government/PEP	Member's connection to Government/ PEP (e.g. father or business partner)	Nature of Government/ PEP (e.g. Head of State, Prime Minister etc)	Nationality of Government/ PEP	Current Residential address of Government/PEP

Please use additional sheet if required.

Attach the self-attested and dated copy of the passport of the Policyholder and for the PEP along with the application form.

Please Retain a Copy for Your Records

Section 10 – Declaration

My spouse, competent adult **Dependants**, and I (those who are applying for coverage under this Application) authorise any physician, healthcare professional, **Hospital**, other healthcare institution ("Providers"), and my employer to disclose, to the extent allowed by applicable law, to Aetna International or an affiliated entity ("Aetna"), information concerning the medical history, services, supplies, or **Treatment** provided to anyone listed on this Application, including those services involving dental, substance abuse and HIV/AIDS ("healthcare information").

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 understand that Aetna International may rely on such information to: 1) underwrite this application for coverage, make eligibility, risk rating, **Policy** issuance and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provisions of **Benefits**; 3) administer coverage; and 4) conduct other insurance operations, like marketing and publicity, according to applicable laws and regulations.

I have discussed the terms of this authorisation with my spouse and competent adult **Dependants**, and I have obtained their consent to the release of their healthcare information pursuant to this authorisation. I understand that I may decline to provide Aetna International with consent to process my personal or healthcare information; however, this may result in declination of coverage.

I understand that I may review and offer corrections to my personal or healthcare information, to the extent allowed by law, receive a copy of this authorisation upon request, and that a photocopy is as valid as the original; and I may revoke this authorisation at any time, to the extent it has not been relied upon by Aetna International or other party. I also have the right to opt out of any direct marketing campaigns.

This authorisation shall remain valid for the term of this coverage or for so long as allowed by law.

I understand it is unlawful for me or my **Dependants** to knowingly provide false, incomplete or misleading facts or information to Aetna International for the purpose of defrauding or attempting to defraud Aetna International. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

I acknowledge that Aetna International's participating providers are independent contractors and are not agents or employees of Aetna International or any affiliated Aetna Entity.

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

I have declared all material facts which relate to this application.

I declare that I have read and understand the documents '***Policy Wording***' and '***Benefit Schedule***' and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date**. I am satisfied that the product selected meets my requirements at this time.

I agree that where **Medical Treatment** is received within the **Provider Network** by myself or any of my **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy**, that I, as the **Policyholder**, shall be fully responsible for reimbursement to Aetna International within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such medical **Treatment**.

I understand and confirm that where I have not made repayment of funds disbursed by Aetna International in respect of such medical **Treatment** not covered by the **Policy**, the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Aetna International and in the event that funds so due from me to Aetna International have been outstanding and unpaid for a period in excess of 14 days, exclusion 1 of the **Policy Wording** shall be re-applied to the **Policy** with effect from the date of full receipt by Aetna International of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met.

I further accept that where funds have been outstanding to Aetna International for a period in excess of 15 days from notification, my **Policy** will be cancelled as if I had no cover in place from the start, without refund of premium.

I understand that if any statement made above or, if accepted for cover, if any subsequent claims made are found to be fraudulent or unfounded my cover will be cancelled as if I had no cover in place from the start, without refund of premium and any **Benefits** shall be forfeited and recoverable by Aetna International.

Employee/Applicant's Signature	Date (Day/Month/Year)

Please Retain a Copy for Your Records