



Executive Healthcare Plan Continuous Transfer Form

Aetna International

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.		
<input type="checkbox"/> Apply to transfer from another insurer to an Aetna International group Policy	<input type="checkbox"/> Apply to transfer from another insurer to an Aetna International individual Policy	<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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					

Please Retain a Copy for Your Records

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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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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			
	Major Medical	Major Medical Plus	Foundation	Lifestyle
Core Products:				
<input type="checkbox"/> Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Area 2 - Worldwide excluding USA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Area 3 - Worldwide*	Not Applicable	Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>

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

Product Options:	Major Medical	Major Medical Plus	Foundation	Lifestyle
<input type="checkbox"/> Exclude Pregnancy Cover	Not Applicable	Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Medical History Disregarded*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wellness	Not Applicable	Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Routine Dental Treatment	Not Applicable	Not Applicable	<input type="checkbox"/>	Standard
<input type="checkbox"/> Vision Care**	Not Applicable	Not Applicable	<input type="checkbox"/>	<input type="checkbox"/>

* For compulsory groups of ten or more employees only

** For compulsory groups of five or more employees only

	Policy Excess:			
• Major Medical	<input type="checkbox"/> US\$250	<input type="checkbox"/> US\$750	<input type="checkbox"/> US\$1,500	<input type="checkbox"/> US\$4,000
• Major Medical Plus	<input type="checkbox"/> US\$250	<input type="checkbox"/> US\$750	<input type="checkbox"/> US\$1,500	<input type="checkbox"/> US\$4,000
• Foundation	<input type="checkbox"/> US\$40	<input type="checkbox"/> US\$80	<input type="checkbox"/> US\$150	<input type="checkbox"/> US\$250
• Lifestyle	<input type="checkbox"/> US\$40	<input type="checkbox"/> US\$80	<input type="checkbox"/> US\$150	<input type="checkbox"/> 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 79. 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	<input type="checkbox"/> No	<input type="checkbox"/> Yes, planholder only	<input type="checkbox"/> Yes, planholder and all dependants
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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 79 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	<input type="checkbox"/> Aetna Personal Accident 85	<input type="checkbox"/> Aetna Personal Accident 170
	<input type="checkbox"/> Aetna Personal Accident 255	<input type="checkbox"/> Aetna Personal Accident 340
	<input type="checkbox"/> Aetna 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)	
<input type="checkbox"/> 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)
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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**”. 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**.

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

1. Credit Card Number:

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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 carryout 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.

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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 above chosen card 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)

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.)

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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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

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 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 a 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.

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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)

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