Executive Healthcare Plan Application Form

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

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy**. A material fact is one which is likely to influence the assessment and acceptance of this application (e.g. a pre existing health condition or involvement in hazardous activities). If **You** are in any doubt whether a fact is material, it should be disclosed.

As the applicant, **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **You** on request within three months of completion. **You** should keep a record of all information (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

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

Executive Healthcare Solutions Limited
10th Floor, IPS Building
Kimathi Street
PO Box 51343, 00200- City Square
Nairobi, Kenya

T: (254 20) 221 9621/9826
F: (254 20) 222 9006
E: **info@executive-healthcare.com**

Aetna International
PO Box 6380
Dubai, UAE

T: + 971 4 433 0400
F: + 971 4 428 7100
E: **MEASales@aetna.com**

Section 1 – Applicant's Details (First Person)

Family Name – As per Passport				Title
First Name(s) – As per Passport				
Marital Status	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
Industry		Occupation		
Nationality		**Country of Residence**		
Residential Address		Correspondence Address		
Town/City		Town/City		
Country/State		Country/State		
ZIP/Postal Code		ZIP/Postal Code		
Home Telephone		Business Telephone		
Mobile		Fax		
Home E-mail		Business E-mail		

Please Retain a Copy for Your Records

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Section 2 – Dependant's Information (Please note children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full-time education and are fully dependant upon **You**. If **You** have any further **Dependants**, please provide details on a separate sheet.)

Dependant 1	Family Name		First Name(s)		
	Other Initials	Title	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Occupation		Nationality		
Dependant 2	Family Name		First Name(s)		
	Other Initials	Title	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Occupation		Nationality		
Dependant 3	Family Name		First Name(s)		
	Other Initials	Title	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Occupation		Nationality		
Dependant 4	Family Name		First Name(s)		
	Other Initials	Title	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Occupation		Nationality		
Dependant 5	Family Name		First Name(s)		
	Other Initials	Title	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant		Date of Birth (Day/Month/Year)		
	Occupation		Nationality		

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**. If **You** wish **Your** cover to start later, please indicate below. 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**	**Foundation**	**Lifestyle**
☐ Area 1 - Africa plus India, Pakistan, Bangladesh and Sri Lanka	☐	☐	☐
☐ Area 2 - Worldwide excluding USA	☐	☐	☐
☐ Area 3 - Worldwide*	Not Applicable	☐	☐

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

Product Options:	**Major Medical**	**Foundation**	**Lifestyle**
☐ Exclude Pregnancy Cover	Not Applicable	☐	☐
☐ Routine Management of Chronic Conditions*	Not Applicable	☐	Not Applicable
☐ Medical History Disregarded**	☐	☐	☐
☐ Wellness*	Not Applicable	☐	☐
☐ Routine Dental Treatment*	Not Applicable	☐	Not Applicable
☐ Vision Care***	Not Applicable	☐	☐

*For compulsory groups of three or more employees only
**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
• **Foundation**	☐ US$40	☐ US$80	☐ US$150	☐ US$250
	☐ US$400	☐ US$750	☐ US$1,500	☐ US$4,000
• **Lifestyle**	☐ US$40	☐ US$80	☐ US$150	☐ US$250

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 Cheque:** All Banker's Cheques 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 cheque.

☐ 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: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
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): ____________

continued

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Section 5 – Premium Payment (Continued)

If paying by monthly credit card please read and complete the Recurring Transaction Authority below.

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 UAE Dirhams 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.

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.)

Section 8 – Pre-existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**.

Section 9 – Medical Questionnaire (When completing **Section 9,** 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 reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.

	Yes	No
a. Have **You**, or anyone included in this application, ever been admitted to **Hospital** or other similar establishment?	☐	☐
b. Have **You**, or anyone included in this application, been prescribed with a course of any drugs or medication, or **Treatments** for a period in excess of seven days in the last two years?	☐	☐
c. Have **You**, or anyone included in 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 included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	☐	☐

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space.

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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**, and other healthcare institution (“Providers”), 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 Aetna affiliates; Providers, payors, other insurers, third party administrators, vendors, consultants, Executive Healthcare Solutions 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 understand and accept **Section 8** on Pre-existing Condition(s).

Aetna must be informed in writing if there are any persons living and/or working in the United Arab Emirates.

This Policy is not issued to a UAE resident.

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

Commencement of this Policy is subject to screening of members as per company’s Anti Money Laundering Policy.

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.

Applicant’s Signature	Date (Day/Month/Year)

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