International Healthcare Plan — Application Form

Aetna International

Please read through the following before completing this application and complete in BLOCK CAPITALS.

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 a hazardous activity). 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 **us** or **your** agent.

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Section 1 – Applicant's Details (First Person)

Family Name				Title
First Name(s)				
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		

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GR-68581-10 **AMEXE** (2-14)

Section 2 – Dependant's Detail (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	

Section 3 – Commencement Date (Subject always to **Section 9** 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 – Options (The table below is for guidance only. Please refer to the full **Benefit Schedule** and **Policy Wording** for a detailed description of the **benefits** of each plan option.)

A) Product (This plan enables **you** to choose various options to suit **your** personal requirements. Please clearly check the option **you** have selected. **Your policy** will be issued on this basis.)

Benefits	Major Medical	Lifestyle	Lifestyle Plus
Standard **excess**	NIL	£50 or €/$80	£50 or €/$80
Maximum Benefit per **insured person** per **period of cover**	£1,000,000 or €/$1,600,000	£1,000,000 or €/$1,600,000	£1,000,000 or €/$1,600,000
Inpatient and **day patient** Cover	Full Refund	Full Refund	Full Refund
Oncology	Full Refund	Full Refund	Full Refund
Evacuation and Repatriation to country of choice	Full Refund	Full Refund	Full Refund
Blood Care Foundation	Full Refund	Full Refund	Full Refund
Outpatient Care	Subject to Limits	Full Refund	Full Refund
Primary Care	Subject to Limits	Full Refund	Full Refund
Home Nursing	Subject to Limits	Subject to Limits	Subject to Limits
Routine Management of **Chronic** Conditions	No Cover	Subject to Limits	Subject to Limits
Routine Dental	No Cover	No Cover	Subject to Limits
Major Restorative Dental	No Cover	No Cover	Subject to Limits
Pregnancy and Childbirth	No Cover	No Cover	Subject to Limits
Routine and Restorative Dental Care	No Cover	No Cover	Subject to Limits
Your Selection – please check **your** choice	☐	☐	☐

Currency of **Policy** - Please check **your** choice ☐ £ ☐ € ☐ $ Please note the currency of **your policy** will determine the **benefit** limits and the **excess** of **your policy**.

B) Excess (Please select where **you** wish to change from the standard **excess** applicable by checking the appropriate box.)

Nil	Standard	☐	☐
£30/€50/$50	N/A	☐	☐
£100/€150/$150	N/A	☐	☐
£150/€250/$250	N/A	☐	☐
£180/€300/$300	N/A	☐	☐
£300/€500/$500	N/A	☐	☐
£625/€1,000/$1,000	☐	N/A	N/A
£3,000/€5,000/$5,000	☐	N/A	N/A

C) Additional (Please check **your** choices.)

USA Elective **Treatment**	☐	☐	☐

ALL limits and **Excesses** expressed in $ shall in all instances mean US$.

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Section 5 – Premium Payment (Please note **your** premium will be collected on receipt of this application, which may be in advance of the **commencement date**. If **you** opt for the monthly payment plan, **we** may in some circumstances debit two month's premium in **your** first month. This is dependant on what time of the month **your** billing takes place)

a. Card Type ☐ American Express ☐ MasterCard ☐ VISA

b. Credit Card Number: | | | | | | | | | | | | | | | | |

c. Cardholder's Name: _____

d. Expiry Date (Month/Year): _____

e. Cardholder's Statement Address: _____

_____

_____

f. Currency of Payment: ☐ Euro ☐ Sterling ☐ Dollar

g. Type of Payment: ☐ Annual ☐ Monthly (if monthly please complete Recurring Transaction Authority)

h. Cardholder's Authorisation Signature: _____

i. Signature Date (Day/Month/Year): _____

Section 6 – Recurring Transaction Authority

Your authority to Aetna Global Benefits to claim amounts due from **your** VISA, AMEX 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 Global Benefits will advise me of the amount to be paid and the dates on which payment is due and that Aetna Global Benefits may only change these after giving me prior notice. I understand that this authority in favour of Aetna Global Benefits will remain in force until such a time as I cancel it in writing/e-mail instruction to Aetna Global Benefits.

Cardholder's Authorisation Signature	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**.

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Section 9 – Medical Questionnaire

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, been admitted to a **hospital** or other similar establishment in the last five years?	☐	☐
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

I request Aetna Global Benefits arrange the American Express International Healthcare Plan. I understand that my personal details will be passed to or used by Aetna Global Benefits to arrange and service my **policy** and I give consent to use my personal and sensitive personal data solely for these purposes.

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 Global Benefits 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 Global Benefits, 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, 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 Global Benefits 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 Global Benefits with consent to process my personal or healthcare information; however, this may result in declination of coverage.

If **you** wish to have **your** name removed from any marketing programmes please telephone American Express on +44 1273 668300 or write to American Express Insurance Services Europe Limited, 52-03-007, Amex House, Edward Street, Brighton, BN88 1AH.

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 Global Benefit or other party. This authorisation shall remain valid for the term of this coverage and at each subsequent renewal or for so long as allowed by law. I understand that Aetna Global Benefits shall be responsible for any control security and processing of such data/information in compliance with applicable law.

I acknowledge that Aetna Global Benefits' participating providers are independant contractors and are not agents or employees of Aetna Global Benefits or any affiliated Aetna Entity.

I confirm that I have read and understood the general exclusions section of the **Policy** Booklet pages 24-26, in particular item 1 relating to pre-existing conditions. I declare that the answers given are to the best of my knowledge full, true and complete. I have declared all material facts which relate to this application. I declare that I have read, understood 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 declare that I have read and understand the documents ***'Policy Summary'***, ***'Policy Booklet'*** 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 Global Benefits 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 Global Benefits 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 Global Benefits and in the event that funds so due from me to Aetna Global Benefits 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 Global Benefits of the funds concerned in which even 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 Global Benefits for a period in excess of 15 days from notification my **Policy** will be cancelled void from commencement, without refund of premium.

In presenting the plan in this way, American Express is not recommending a particular product option; this should be chosen after careful consideration of the full plan **benefits** and personal circumstances of each individual.

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

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