

Application for Agency Facilities

(effective 1st May 2009)

GOODHEALTHSM
An Aetna Company

Goodhealth Worldwide (Global) Limited

c/o Aetna Global Benefits
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E AmericasServices@aetna.com

1 Agency Trading Name:

a) Full Company Name:

b) Company Number:

2a) Company Address:

Post Code:

Telephone:

Fax:

Email Address:

2b) Registered Address (if different from above):

Post Code:

Telephone:

Fax:

Email Address:

3 Occupation/Nature of Business:

Is your agency:

4 a) Authorized and regulated by any regulatory authority? If Yes, please provide:

i) date of registration:

day month year

ii) name of authorizing body and registration number:

If No, please state if:

i) an application is pending:

ii) an application has not been made:

b) A member or registered with any official insurance institution?

Yes No

If Yes, please name institution.

c) or has it been subject to any regulatory enforcement action?

Yes No

8 Do **You** have professional indemnity cover? Yes No
If Yes, please send a copy of **Your** certificate, which should state:

- a) With Whom:
- b) Certificate Number:
- c) Limit of Indemnity:
- d) Excess Level(if any):

9 The annual written premium income for **Your** private medical insurance portfolio is in the range:

- a) US\$ 0m - US\$ 0.5m
- b) US\$ 0.5m - US\$ 1m
- c) US\$ 1m - US\$ 5m
- d) US\$ 5m - US\$ 10m
- e) US\$ 10m +

The approximate breakdown in percentage terms of **Your** international medical insurance portfolio is:

- a) Individual Business %
- b) Company Paid Small Group Business %
- c) Company Paid Large Group Business %
- d) Optional Group Business %
- e) Groups in "Trust" %

10 Please give the name and address of three other **Insurers** with whom **You** have agency facilities in respect of private medical insurance (and from whom **We** will take references), the date from which they become effective and **Your** approximate premium income with each of them:

- i) Name: Address:
Date: day month year
Written Premium:
- ii) Name: Address:
Date: day month year
Written Premium:
- iii) Name: Address:
Date: day month year
Written Premium:

11 Have agency or collection facilities ever been refused or withdrawn? Yes No
If Yes, by whom and for what reason:

Bank Details (completion is optional*)

- 12 Bank Sort Code: Bank
- Bank Account Number: Address:
- Bank Name:
- Bank Telephone Number: Bank Fax Number:

* Goodhealth has facility to direct credit commissions payable to your Bank Account.

13 If available, please supply a copy of **Your** corporate brochure explaining the nature and scope of **Your** operations.

Declaration

14 I/We apply for an appointment to represent Goodhealth Worldwide as an Agent. I/We agree that, if this application is accepted, the appointment shall be governed by the terms of Goodhealth Worldwide (including acceptance of the terms of it's agency agreement). I/We understand that references will be sought for My/Our application and to My/Our best knowledge and belief the above details are true and accurate. Any attempt to mislead or supply false information to Goodhealth Worldwide will result in the voiding of the application/agency.

- Applicant's Signature: Position in organization:
- Date: day month year

www.goodhealthamericas.com