

7. Is the Business owned by one Individual? Yes No, **skip** to number 8.

Name	Relevant Experience (Yrs)	Relevant Qualifications	Residential Address
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____
			_____ _____

8. Principle Trading Address _____

9. State _____ 10. Country _____ 11. Zip/Postal Code _____

12. Telephone _____ 13. Fax _____ 14. Email Address _____

15. State Principle Line of Business _____ 16. Number of Years Trading _____ 17. Number of Staff _____ 18. Approximate Annual Principle _____

19. Are **Your** clients:
 Individuals Corporations Intermediaries

20. Are **You** regulated? Yes No
 If Yes, please name the regulator: _____

21. Please give **Your** registration: _____

22. Does **Your** business have professional indemnity insurance? Yes No
 a. If Yes, please name the Insurer: _____
 b. If Yes, please name the Aggregate Cover (US\$): _____

Please Retain a Copy for Your Records

Policies issued in Latin America and the Caribbean are issued and administered by Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits Administrators Inc., an Aetna Company. Registered address: 201 South Biscayne Boulevard, Miami, FL 33131, USA.

24. Has this or any trading entity connected with the above controllers or the controllers themselves:

a. Censured by any Regulatory or Government Body?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Declared Insolvent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Subject to any Civil Action?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Subject to Criminal Prosecution?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

25. Please give details of the insurance bank account to be used:

a. Name of **Your** Bank: _____

b. Bank Address: _____

c. The Account Name: _____

d. Bank Sort Code: _____

e. Bank Account Number: _____

B. Authorized Individual (Partner/Director)

I can confirm that the information provided in this form is correct to the best of my knowledge and I have made reasonable enquiries to ascertain that this is the case. I understand that **You** have requested this information to improve **Your** awareness and understanding of **Us** as a sub-agent distributing Aetna Global Benefits (AGB) products and that this information will be held confidentially

Signature		Date (Day/Month/Year)
Print Name	Title	

C. Managing General Agent Details

Name	Code
Signature	Date (Day/Month/Year)

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