



Global Healthcare Plan Application Form

Aetna Global Benefits®

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.

Aetna Global Benefits
c/o Goodhealth Worldwide (Global) Limited
PO Box 30545
Tampa, Florida 33630
USA

TF: +1 800 914 2177 (inside USA only)
T: +1 813 775 0220
F: +1 860 262 9111
E: AmericasServices@aetna.com

Requested Commencement Date (Must be within 30 days of completion of this MM DD YY Application for Enrollment)	
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Agent Name (if applicable)	Agent Code
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Section 1 – Applicant Detail

Family Name				Title	
First Name(s)					
Marital Status	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)	
Industry		Occupation			
Nationality		Country of Residence			
Residential Address (may not be in Your country of citizenship)			Correspondence Address (if different than residential address)		
_____			_____		
_____			_____		
Town/City		Town/City			
Country/State		Country/State			
Zip/Postal Code		Zip/Postal Code			
Home Telephone		Business Telephone			
Mobile		Fax			
Home Email		Business Email			

Please Retain a Copy for Your Records

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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 the applicant. If **You** have any further **Dependants**, please provide details on a separate sheet.)

Dependant 1	Family Name			First Name(s)	
	Other Initials	Title	Gender <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
	Relationship to Applicant			Date of Birth (Day/Month/Year)	
	Occupation			Nationality	

Section 3 – Options

A) Benefits (This plan enables **You** to choose various product options to suit **Your** personal requirements. Please clearly check the **Benefits** options **You** have selected (Primary Plus or Primary Care) and the deductible option **You** require.)

Medical Insurance: Primary Plus Primary Care

B) Annual Deductible (Please select one of the following annual deductibles, this will be the deductible for all.)

US\$500* US\$1,000 US\$2,500 US\$5,000 US\$10,000

*Only available with the Primary Plus option

Section 4 – Premium Calculations Using the Global Healthcare Plan Premium Rates, please complete the premium calculator below. If **You** require assistance completing this section, please call the contact number listed at the top of this form.

Payment Mode	<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual
Applicant	US\$ Annual Premium _____	US\$ Semi-Annual Premium _____
Dependant 1	US\$ Annual Premium _____	US\$ Semi-Annual Premium _____
Dependant 2	US\$ Annual Premium _____	US\$ Semi-Annual Premium _____
Dependant 3	US\$ Annual Premium _____	US\$ Semi-Annual Premium _____
Total	US\$ Total Premium Due _____	US\$ Total Premium Due _____

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Section 7 – Medical Questionnaire

Please reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.		
Conditions	Yes	No
1. Neurologic conditions, dizziness, fainting, convulsions, paralysis, migraine, impaired vision or hearing or any disease of the brain.	<input type="checkbox"/>	<input type="checkbox"/>
2. Respiratory illness, shortness of breath, asthma, emphysema, sinusitis or any disease of the lungs.	<input type="checkbox"/>	<input type="checkbox"/>
3. Circulatory, chest pain, murmur, hypertension, arrhythmia, heart attack, high cholesterol or any disease of the heart or blood vessels.	<input type="checkbox"/>	<input type="checkbox"/>
4. Hepatitis, cirrhosis, ulcers, intestinal bleeding, or any disease of the stomach, intestines, liver, gall bladder or pancreas.	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis, gout, neuritis or any disease of the bones, muscles or joints including the back or neck.	<input type="checkbox"/>	<input type="checkbox"/>
6. Diseases of the eyes, ears, nose or throat.	<input type="checkbox"/>	<input type="checkbox"/>
7. Any disease of the kidneys, urinary system, prostate, reproductive organs or breasts.	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes, thyroid, pituitary, adrenal or other endocrine diseases.	<input type="checkbox"/>	<input type="checkbox"/>
9. Any deformity or amputation.	<input type="checkbox"/>	<input type="checkbox"/>
10. Cancer, tumor or cyst.	<input type="checkbox"/>	<input type="checkbox"/>
11. Acquired Immune Deficiency Syndrome or any AIDS-Related disorders.	<input type="checkbox"/>	<input type="checkbox"/>
12. Any disease of the skin or lymph glands.	<input type="checkbox"/>	<input type="checkbox"/>
13. Allergies, anaemia or any other disease of the blood.	<input type="checkbox"/>	<input type="checkbox"/>
14. Any disorder of menstruation or complication of pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>
Please also answer the following:		
a) Are You under observation or Treatment for any medical or dental condition or have any medical/surgical or dental procedures been recommended or are being contemplated?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are You currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
c) Do You use alcoholic beverages? If Yes give type, quantity, and frequency. _____	<input type="checkbox"/>	<input type="checkbox"/>
d) Do You use prescription drugs? If Yes, give type, dosage, and frequency. _____	<input type="checkbox"/>	<input type="checkbox"/>
e) Do You use tobacco products? If cigarettes, please indicate how many per day. _____	<input type="checkbox"/>	<input type="checkbox"/>
f) Did You have or are You currently using counselling for alcohol, drug, emotional or mental nervous conditions?	<input type="checkbox"/>	<input type="checkbox"/>
g) Did You have a surgical operation, consultation, diagnostic test or been advised to do so in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
h) Do You have any family history of heart or circulatory disorders, hypertension or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
i) Any other disease, injury or defect not mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
Additional Information: If You answered Yes to any of the questions in Section 7 , please provide details below or a separate sheet of paper if there is insufficient space of this Application for Enrollment. Please provide the precise question number(s), name of the person, diagnosis, dates and duration of illness/injury/ Treatment and the names and addresses of attending Physicians and Medical Facilities.		

Please Retain a Copy for Your Records

Section 8 – 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 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.

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 Benefits 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 Global Benefits for the purpose of defrauding or attempting to defraud Aetna Global Benefits. Penalties may include imprisonment, fines, denial of coverage, rescission of **Benefits**, and legal damages.

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

Acceptance

- a. 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, 'Terms and Conditions' and '**Benefits Table**' and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 30 days from the **Commencement Date**. I am satisfied that the product selected meets my requirements at this time.
- b. I confirm that I have checked and found correct any answers or statements in this Application for Enrollment that are not in my own handwriting.
- c. I have declared any and all material facts which relate to my Application for Enrollment

Acknowledgement

I understand that, to the extent permitted by applicable law, false statements may result in denial of claims or my insurance coverage being void as of its **Commencement Date** with no **Benefits** payable.

Authorization

To all Physicians and other health professionals, **Hospitals** and other health care institutions, Insurers, medical and **Hospital** services and pre-paid health plans, employers and the Medical Information Bureau.

You are authorized to provide Goodhealth Worldwide (Global) Limited c/o Aetna Global Benefits and their representatives information concerning health care, advice, **Treatment** or supplies provided to me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for coverage. This authorization shall be valid for as long as requests for coverage are sought under the **Policy**.

I agree that an electronic copy of this authorization is as valid as the original.

Applicant's Signature	Date (Day/Month/Year)
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Section 9 – Joinder Agreement

The undersigned hereby agrees to the establishment of an Insurance Fund for purposes of implementing an Agreement (the “Agreement”) for the Aetna Global Benefits Health Plan Arrangement (the “Arrangement”). The undersigned hereby agrees to the designation of Butterfield Trust (Bermuda) Limited as Agent for said Insurance Fund and Agreement. This Joinder Agreement shall be attached to and form a part of said Agreement.

The undersigned, as an Enrolled Person under the Agreement of 19 December 2006 accepts and agrees to be bound by the terms of the Agreement, including any amendments thereto.

The undersigned further requests that the insurance coverage indicated in the Plan Option selected in the Aetna Global Benefits Health Plan Arrangement Application Form be provided for the undersigned Enrolled Person and any other

Enrolled Persons (as applicable) under the health insurance Policy or Policies issued by one of the **Underwriters** defined in the Agreement, acting through Goodhealth Worldwide (Global) Limited (“Goodhealth”) c/o Aetna Global Benefits to the Agent, and (subject to the applicable underwriting requirements of Aetna Global Benefits) that such coverage becomes effective as of the requested **Commencement Date** indicated in the Aetna Global Benefits Healthcare Plan Arrangement Application Form or as of the date of approval by Aetna Global Benefits of the undersigned for participation under the Agreement, whichever is later, and continue as long as the undersigned remains an Enrolled Person. The insurance **Benefits** provided shall be in accordance with the selected Plan Option and shall be subject to the terms of the health insurance **Policy** or **Policies** issued to the Agent.

Coverage under the Aetna Global Benefits Health Plan Arrangement is provided for a 12 month period. A minimum of 12 months of premium is required regardless of the payment option chosen (Semi-Annual or Annual). The undersigned agrees to make the required non-refundable contributions to the Insurance Fund for the insurance coverage requested for undersigned Enrolled Person and any other Enrolled Persons (as applicable). If the undersigned fails to make any required contribution when due, they shall then be liable directly to Aetna Global Benefits for such unpaid contributions of the period during which coverage is in force with respect to the undersigned Enrolled Person and any other Enrolled Persons (as applicable).

I understand that the insurance Policy delivered under the Arrangement is subject to the laws of Bermuda, the jurisdiction in which the Arrangement was established and in which the Agent is domiciled, and Aetna Global Benefits and the Agent are not responsible for Enrolled Person’s compliance with applicable local law

Print Name	Signature	Date (Day/Month/Year)
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