



# Global Healthcare Plan Continuous Transfer Form

Aetna Global Benefits®

Please return this completed Continuous Transfer Form together with **Your** current valid certificate (where applicable) of insurance to **Us** or your **Agent**.

Aetna Global Benefits  
c/o Goodhealth Worldwide (Global) Limited  
PO Box 30545  
Tampa, Florida 33614  
USA

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

Agent Name (if applicable)	Agent Code
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**Please mark all respective boxes which apply to You.**

<input type="checkbox"/> Apply to transfer from another insurer to Aetna Global Benefits individual coverage	<input type="checkbox"/> Apply to transfer from existing Aetna Global Benefits group coverage to Aetna Global Benefits individual coverage	<input type="checkbox"/> Apply to transfer from one Aetna Global Benefits deductible option to another within the same plan type	<input type="checkbox"/> Apply to transfer from one Aetna Global Benefits plan type to another	<input type="checkbox"/> Apply to transfer from another insurer to Aetna Global Benefits group coverage
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## Section 1 – Applicant’s Details

Last Name		Title	
First Name(s)			
Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
Residential Address		Correspondence Address (if different from address opposite)	
Zip/Postal Code		Zip/Postal Code	
Telephone		Telephone	
Email		Email	
Company Name (if applicable)		Company Name (if applicable)	

## Section 2 – Dependant(s) Details

<b>Dependant 1</b>	Relationship to person named in Section 1 above		Last Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)

*continued*

**Please Retain a Copy for Your Records**

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**Section 2 – Dependant(s) Details (Continued)**

<b>Dependant 2</b>	Relationship to person named in Section 1 above		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
<b>Dependant 3</b>	Relationship to person named in Section 1 above		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)
<b>Dependant 4</b>	Relationship to person named in Section 1 above		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (in/ft)	Weight (kgs/lbs)

**Section 3 – Cover Details – Please mark one box only.**

<b>Product options:</b>	<b>Deductible options:</b>
<input type="checkbox"/> Primary Care	<input type="checkbox"/> US \$1,000 <input type="checkbox"/> US \$2,500 <input type="checkbox"/> US \$5,000 <input type="checkbox"/> US \$10,000
<input type="checkbox"/> Primary Plus	<input type="checkbox"/> US \$500* <input type="checkbox"/> US \$1,000* <input type="checkbox"/> US \$2,500* <input type="checkbox"/> US \$5,000* <input type="checkbox"/> US \$10,000*
* Not available to any applicants or <b>Dependants</b> aged 65 or over at the time of Application for Enrollment (except where You are moving within the same Aetna Global Benefit's Plan type to a higher Deductible option, or from one Aetna Global Benefit's Plan type to another with the same or higher deductible option).	

**Section 4 – Medical Questionnaire – Please complete the following questions by marking Yes or No.**

This information is not required when moving within the same Aetna Global Benefits Plan type to a higher deductible option.		<b>Yes</b>	<b>No</b>
a.	Have <b>You</b> , or anyone to be included under this Application for Enrollment, been admitted to a <b>Hospital</b> or other similar establishment in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Have <b>You</b> , or anyone included in this Application for Enrollment, been prescribed with a course of any drugs or medication, or <b>Treatments</b> for a period in <b>Excess</b> of seven days in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Have <b>You</b> , or anyone to be included under this Application for Enrollment, any known or foreseeable need to consult with a physician or <b>Specialist</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Are <b>You</b> , or anyone to be included under this Application for Enrollment, suffering from any disability, abnormality, recurrent illness, major illness, or injury not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>
e.	Are <b>You</b> , or anyone included under this Application for Enrollment, currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If <b>You</b> have answered <b>Yes</b> to any of the questions above, please provide further details below or on a separate sheet of paper if there is insufficient space.			

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**Section 5 – Declaration**

My spouse, competent adult **Dependants**, and I (those who are applying for coverage under this Application) authorise any physician, healthcare professional, **Hospital**, other healthcare institution ("Providers"), and my employer 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 my employer, 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 to the best of my knowledge and belief, the information given in this Application for Enrollment is true and complete. I agree to accept and conform to the terms of coverage when issued, unless I cancel this coverage within 14 days of the **Commencement Date**.
- 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 for coverage.

**Section 6 – 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.

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

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