International Healthcare Plan – Continuous Transfer Form

Aetna Global Benefits®

EXPLANATORY NOTES: Please use BLOCK CAPITALS or check boxes as appropriate.

TERMS AND CONDITIONS: **You** must complete this form in full and **You** should attach a copy of **Your** existing **Policy Schedule**, detailing any endorsements and the original **Commencement Date** of the expiring plan.

Continuous transfer can be offered where the **Benefits** of the plan for which **You** are applying are similar to those of **Your** current **Policy**. These terms and conditions must be read in conjunction with the **Policy Wording**.

All material facts (e.g. pre-existing health conditions or involvement in hazardous activities), which may affect **Our** assessment and consideration of this application, should be declared.

If **You** are in doubt as to whether a fact is material, then it should be disclosed. Please use a separate sheet of paper if necessary.

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

Aetna Global Benefits (Asia Pacific) Limited
Suite 401-403
DCH Commercial Centre
25 Westlands Road
Quarry Bay
Hong Kong

T: +852-2860-8031
F: +852-2147-9960
E: **PSSAsiaPac@aetna.com**

Please check all respective boxes which apply to You.

- ☐ Apply to transfer from another insurer to an Aetna Global Benefits group **Policy**
- ☐ Apply to transfer from another insurer to an Aetna Global Benefits individual **Policy**
- ☐ Apply to transfer from an existing Aetna Global Benefits group **Policy** to an Aetna Global Benefits individual **Policy**

Section 1 – Employee's/Applicant's Information

Family Name			Title
First Name(s)			
Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
Residential Address			
Zip/Postal Code	Telephone	Email	
Correspondence Address			
Zip/Postal Code	Nationality (Country of Passport)	Passport Number/ ID Card Number	
Company Name (if applicable)			

Section 2 – Dependant(s) Information

Dependant 1	Relationship to person named in Section 1		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Nationality (Country of Passport)		Passport Number/ ID Card Number	

continued

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Section 2 – Dependant(s) Information (Continued)

Dependant 2	Relationship to person named in Section 1		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Nationality (Country of Passport)		Passport Number/ ID Card Number	
Dependant 3	Relationship to person named in Section 1		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Nationality (Country of Passport)		Passport Number/ ID Card Number	
Dependant 4	Relationship to person named in Section 1		Family Name	
	Title	First Name(s)		
	Date of Birth (Day/Month/Year)	Gender ☐ M ☐ F	Height (in/ft)	Weight (kgs/lbs)
	Nationality (Country of Passport)		Passport Number/ ID Card Number	

Section 3 – Cover Details (For more information about the various product options available, please refer to the plan schedule of **Benefits**.)

Please check all respective boxes which apply to You.

Product Option:		**Excess Option:**	**Additional Option:**		
☐ Major Medical	☐ Lifestyle	☐ ______________	☐ 005	☐ 008	☐ 011
☐ Foundation	☐ Lifestyle Plus	☐ US$	☐ 006	☐ 009	
			☐ 007	☐ 010	

Section 4 – Medical Questionnaire (When completing Section 4, please ensure that **You** declare all material facts for both **Your** own and all **Dependants** to be included under this application. Failure to do so could result in a claim not being paid. Should **You** have any doubt as to what information is required, please speak to **Your** broker or contact the Aetna Global Benefits (Asia Pacific) Limited office.)

Please complete the following questions by checking Yes or No.

	Yes	**No**
a. Have **You**, or anyone to be included under this application, been admitted to a **Hospital** or other similar establishment in the past five years?	☐	☐
b. Have **You**, or anyone to be included under 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?	☐	☐
c. Are **You**, or anyone to be included under this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?	☐	☐

If **You** have answered Yes 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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Policies issued in Hong Kong are issued by GAN Assurances IARD and administered by Aetna Global Benefits (Asia Pacific) Limited, an Aetna Company. Registered address: Suite 401-403, DCH Commercial Centre, 25 Westlands Road, Quarry Bay, Hong Kong. Insurance Agency Registered No. 02905813.

Section 5 – Declaration

Applicable to members applying for transfer to an Aetna Global Benefits individual policy only:

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 event 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 as if I had no cover in place from the start, without refund of premium.

Applicable to all members applying for transfer to an Aetna Global Benefits group or individual policy:

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

I acknowledge that Aetna’s participating providers are independent contractors and are not agents or employees of Aetna or any affiliated Aetna Entity.

I declare that the answers to the above questions are, to the best of my belief, full, complete, accurate, and true.

I understand that if any statement made above or, if accepted for cover, if any subsequent claims made are found to be fraudulent or unfounded my cover will be cancelled as if I had no cover in place from the start without refund of premium and any **Benefits** shall be forfeited and recoverable by Aetna Global Benefits

Employee/Applicant’s Signature	Date (Day/Month/Year)

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