

(effective 1st July 2008)



Agent/Broker Name and Stamp

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. 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.

## 1. Details of Applicant (First Person)

Family Name:																									
First Name(s):																			Title:						
Marital Status:				M/F:		Date of Birth:	day	month	year	Height:	m/ft	Weight:	kg/lb												
Industry:																									
Occupation:																									
Nationality:																									
Country of Residence:																									
Passport No.													ID No.												

Residential Address:													Correspondence Address:												
Town/City:													Town/City:												
Country/State:													Country/State:												
Postcode:													Postcode:												

Home Telephone:													Business Telephone:												
Mobile:													Fax:												
Home Email:													Business Email:												

## 2. Dependant's Details

Please note children to be included under this plan must be under 18 Years of age, or 23 years old if they are in full-time education and are fully dependant upon You.

Dependant 1											
Family Name:											
First Name(s):											
Other Initials:	Title:		Sex: M/F		Height: m/ft		Weight: kg/lb				
Relationship to Applicant:					Date of Birth:		day	month	year		
Occupation:											
Nationality:											

Dependant 2											
Family Name:											
First Name(s):											
Other Initials:	Title:		Sex: M/F		Height: m/ft		Weight: kg/lb				
Relationship to Applicant:					Date of Birth:		day	month	year		
Occupation:											
Nationality:											

Dependant 3											
Family Name:											
First Name(s):											
Other Initials:	Title:		Sex: M/F		Height: m/ft		Weight: kg/lb				
Relationship to Applicant:					Date of Birth:		day	month	year		
Occupation:											
Nationality:											

Dependant 4											
Family Name:											
First Name(s):											
Other Initials:	Title:		Sex: M/F		Height: m/ft		Weight: kg/lb				
Relationship to Applicant:					Date of Birth:		day	month	year		
Occupation:											
Nationality:											

If You have any further Dependents please provide details on a separate sheet.

## 3. Commencement Date

Subject always to Section 9 of this application form, the Commencement Date of this Policy will be the date on which this application is accepted in writing by Us. If You wish Your cover to start later, please indicate below.

Please note the Commencement Date can be no more than 30 days from the date of completion of this application by You. Under no circumstances will Policies be backdated.

Commencement Date:	day	month	year
--------------------	-----	-------	------



## 8. Medical Questionnaire

Please reply to the following questions by ticking Yes or No. Where **You** have ticked Yes, please provide details.

	Yes	No
a) Have <b>You</b> , or anyone included in this application, been admitted to <b>Hospital</b> or other similar establishment in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have <b>You</b> , or anyone included in this application, been prescribed with a course of any drugs or medication, or <b>Treatments</b> for a period in excess of seven days in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have <b>You</b> , or anyone included in this application, any known or foreseeable need to consult with a <b>Medical Practitioner</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 <b>Hospital</b> or other similar establishment?	<input type="checkbox"/>	<input type="checkbox"/>
d) Are <b>You</b> , or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to provide any additional information, or use the page overleaf if this space is insufficient.

## 9. Declaration

I understand and accept Section 6 on Pre-existing Condition(s).

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, understood and agreed to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date**.

I confirm and agree that the personal information collected or held by Goodhealth, whether contained in this application form or otherwise obtained may be used by Goodhealth, or disclosed to or transferred to any organisation within the Aetna Group (of Companies), their suppliers and partners, worldwide for the purpose of 1) assessing this application and providing on-going insurance and customer service, 2) processing and giving effect to credit card payment, 3) providing marketing material in respect of insurance-related services of Goodhealth or it's associated companies and 4) processing claims or analysing the insurance.

I authorise any doctor, physician or **Specialist** who I have attended in any capacity to provide Goodhealth, or their representatives, with any and all information in respect of such attendance and any known medical history.

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 Goodhealth 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 Goodhealth 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 Goodhealth and in the event that funds so due from me to Goodhealth 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 Goodhealth 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 Goodhealth for a period in excess of 15 days from notification, my **Policy** will be cancelled void ab initio, without refund of premium.

Signature of applicant:

Date:

--	--	--



## Contact Details

### Goodhealth Worldwide (Asia Pacific) Limited

Suite 401-403

DCH Commercial Centre

25 Westlands Road

Quarry Bay

Hong Kong

T +852 3071 5022

F +852 2147 9960

E [AsiaPacSales@aetna.com](mailto:AsiaPacSales@aetna.com)

[www.goodhealthworldwide.com](http://www.goodhealthworldwide.com)