



International 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 hazardous activities). 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 (Middle East) LLC
 PO Box 6380
 Dubai, UAE

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 F: + 971 4 428 7100
 E: MEASales@aetna.com

Section 1 – Applicant’s Details (First Person)

Family Name – As per passport				Title		
First Name(s) – As per passport						
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 <input type="checkbox"/> UAE <input type="checkbox"/> Others (Specify)			
Residential Address						
Apartment or Villa No. _____						
Street _____						
Location _____						
PO Box _____						
Emirate _____						
Correspondence Address - If different from residential address						

Home Telephone			Business Telephone			
Mobile			Fax			
Home Email			Business Email			

Please Retain a Copy for Your Records

Policies issued in the United Arab Emirates (UAE) are issued by Royal & SunAlliance (RSA) and administered by Aetna Global Benefits (Middle East) LLC, an Aetna Company Aetna Global Benefits (Middle East) LLC. Registered address: 416, Oud Metha office, PO Box 6380, Dubai, UAE. Aetna

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

Dependant 1	Family Name – As per passport			First Name(s) – As per passport	
	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 <input type="checkbox"/> UAE <input type="checkbox"/> Others (Specify)	
	Residential Address				<input type="checkbox"/> Abu Dhabi <input type="checkbox"/> Other Emirate
Dependant 2	Family Name – As per passport			First Name(s) – As per passport	
	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 <input type="checkbox"/> UAE <input type="checkbox"/> Others (Specify)	
	Residential Address				<input type="checkbox"/> Abu Dhabi <input type="checkbox"/> Other Emirate
Dependant 3	Family Name – As per passport			First Name(s) – As per passport	
	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 <input type="checkbox"/> UAE <input type="checkbox"/> Others (Specify)	
	Residential Address				<input type="checkbox"/> Abu Dhabi <input type="checkbox"/> Other Emirate
Dependant 4	Family Name – As per passport			First Name(s) – As per passport	
	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 <input type="checkbox"/> UAE <input type="checkbox"/> Others (Specify)	
	Residential Address				<input type="checkbox"/> Abu Dhabi <input type="checkbox"/> Other Emirate

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Section 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

Section 4 – Options (The table below is for guidance only. Please refer to the full **Benefit Schedule** and **Policy Wording** for a detailed description of the **Benefits** of each plan option.)

A) Product (This plan enables You to choose various options to suit Your personal requirements. Please clearly check the option You have selected. Your Policy will be issued on this basis.)				
Benefits	Major Medical OPTION 001	Foundation OPTION 002	Lifestyle OPTION 003	Lifestyle Plus OPTION 004
Standard Excess	NIL	\$100	\$100	\$100
Maximum Benefit per Insured Person per Period of Cover	\$1,600,000	\$1,600,000	\$1,600,000	\$1,600,000
In-Patient and Day-Patient Treatment	Full Refund	Full Refund	Full Refund	Full Refund
Oncology, CT and MRI scans	Full Refund	Full Refund	Full Refund	Full Refund
Complications of Pregnancy	Full Refund	Full Refund	Full Refund	Full Refund
Parent Accommodation	Full Refund	Full Refund	Full Refund	Full Refund
Evacuation	Full Refund	Full Refund	Full Refund	Full Refund
Out-Patient Treatment	No Cover	Full Refund	Full Refund	Full Refund
Accidental Damage to Teeth	Full Refund	Full Refund	Full Refund	Full Refund
Daily Hospital Cash Benefit	Full Refund	Subject to Limits	Subject to Limits	Subject to Limits
AIDS/HIV	Full Refund	Subject to Limits	Subject to Limits	Subject to Limits
Extended Evacuation	Optional	Optional	Full Refund	Full Refund
Routine Management of Chronic Conditions	No Cover	No Cover	Subject to Limits	Subject to Limits
Routine Pregnancy and Childbirth	No Cover	No Cover	No Cover	Subject to Limits
Routine and restorative dental care	No Cover	No Cover	No Cover	Subject to Limits
Your Selection – please check Your choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALL limits and Excesses expressed in \$ shall in all instances mean US\$.				

B) Excess (Please select where You wish to change from the standard Excess applicable by checking the appropriate box.)				
Nil	Standard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$50	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$250	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
\$500	N/A	<input type="checkbox"/>	N/A	N/A
\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
\$2,000	N/A	<input type="checkbox"/>	N/A	N/A
\$5,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A

C) Additional (Please check Your choices.)				
USA Elective Treatment - [Option 005]	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct Settlement Network - [Option 008] <i>Only available with Nil Excess and annual payment. Available in certain countries. Please check with Your local sales centre.</i>	N/A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation - [Option 009]	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A

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Section 8 – Pre-existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**.

Section 9 – Medical Questionnaire

Please reply to the following questions by checking Yes or No. Where You have checked Yes, please provide details.

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Have You , or anyone included in this application, been admitted to Hospital or other similar establishment in the last five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have You , or anyone included in this application, been prescribed with a course of any drugs or medication, or Treatments for a period in excess of seven days in the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have You , or anyone included in 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are You , 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 a separate sheet of paper if there is insufficient space.

Section 10 – Broker Name/Stamp

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Section 11 – Declaration

My spouse, competent adult **Dependents**, 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 Royal & Sun Alliance) and/or 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 Royal & SunAlliance and/or Aetna Global Benefits, whether contained in this Application form or otherwise obtained, may be disclosed worldwide to Royal & SunAlliance and/or 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 Royal & SunAlliance and/or 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 **Dependents**, 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 Royal & SunAlliance and/or 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 Royal & SunAlliance and/or 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 Royal & SunAlliance and/or Aetna Global Benefits for the purpose of defrauding or attempting to defraud Royal & SunAlliance and/or 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 or any affiliated Aetna Entity.

I understand and accept **Section 8** on Pre-existing Condition(s).

Aetna must be informed in writing if there are any persons living and/or working and/or have residency visa issued in the Emirate of Abu Dhabi so that We can issue them with an Abu Dhabi compliant product.

This Policy is issued only to UAE residents.

Any change of occupation, hazardous pursuits and change of residential address or area should promptly be notified in writing to Aetna.

Commencement of this Policy is subject to screening of members as per company's Anti Money Laundering Policy.

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 '**Policy Wording**' and '**Benefit Schedule**' and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date**. I am satisfied that the product selected meets my requirements at this time.

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 Royal & SunAlliance 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 Royal & SunAlliance 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 Royal & SunAlliance and in the event that funds so due from me to Royal & SunAlliance 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 Royal & SunAlliance 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 Royal & SunAlliance and/ or Aetna Global Benefits for a period in excess of 15 days from notification, my **Policy** will be cancelled void as if I had no cover in place from the start, without refund of premium.

Applicant's Name and Signature

Date (Day/Month/Year)

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