Application Form

Executive Healthcare Plan

(effective 1st September 2008)

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:

Residential Address:

Town/City:

Country/State:

PO Box:

Correspondence Address:

Town/City:

Country/State:

PO Box:

Home Telephone:

Mobile:

Home Email:

Business Telephone:

Fax:

Business Email:

2. Dependant's Details

Please note children to be included under this plan must be under 18 years of age or under 23 years of age 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 **Dependants** 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**.

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

4. Additional Options

The Executive Healthcare Plan enables **You** to choose various Optional Modules as amendments to the Standard Cover provided in order to suit **Your** personal requirements. Please clearly tick the Optional Modules which you have selected.

Your policy will be issued on this basis.

If no boxes are ticked in this section, it will be assumed that cover is required as per the standard plan (Area1, Foundation).

		Yes	No
Option 001	Exclude Pregnancy Cover		
Option 002	Major Medical Expenses (**In-Patient** and **Day-Patient** Cover) (Option 005, 007 and 008 are not available if this option is selected. **Excess** options are limited to US$250, US$750, US$1,500, US$ 4,000 and routine pregnancy and childbirth **Benefits** are excluded)		
Option 003	**Policy Excess** The Standard Plan carries a US$ Nil **Policy Excess** as standard. If none of the options below are ticked, this will automatically apply.		

US$40	US$80	US$150	US$250
US$400	US$750	US$1,500	US$4,000

		Yes	No
Option 004	**Elective Treatment** Worldwide ex. USA		
Option 005	**Elective Treatment** Worldwide		
	(**Excess** options are limited to US$40, US$80, US$150)		
Option 006	Medical History Disregarded* *For compulsory groups of ten or more employees only		
Option 007	Chronic Conditions**		
Option 008	Routine Dental** **For compulsory groups of three or more employees only		

5. Premium Payment

Please tick which payment method **You** require and complete all details relevant to that method.

Payment Frequency Please declare the frequency of payment required. Note that, regardless of frequency, all contracts are annual. A quarterly frequency basis will carry an extra 5% loading. Please tick as appropriate (if no indication is given an annual frequency will be assumed).

Annual Payment: ☐ Quarterly Payment: ☐

☐ a) Banker's Cheque All Banker's Cheques must be payable to "Goodhealth Worldwide Limited - DIFC".
Please ensure that the name of the **Policyholder** (as declared in section 1 of this form) is clearly stated on the reverse of the cheque.

☐ b) Bank Transfer Please ensure that the name of the **Policyholder** is clearly stated on any Bank Transfer.
Our Bank details are available on request by contacting our local representative office.
We cannot accept liabiltiy for any bank transfer which does not clearly identify the **Policyholder**.

☐ c) Credit Card (US Dollars only). ☐ VISA ☐ MasterCard

Card Number: Expiry Date: day month year

Cardholder's Name:

Cardholder's Statement Address:

Cardholder's Authorisation Signature: Date: day month year

For payment method c. please note that **Your** premium will be collected upon receipt of this application which may be in advance of the commencement date. All transactions will be undertaken in UAE Dirhams at the prevailing rate.

6. **Medical Practitioner** Details

Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner,** and in respect of anyone else included in this application.

Please use a separate sheet if this space is insufficient.

7. 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**.

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 **You**, or anyone included in this application, ever been admitted to **Hospital** or other similar establishment?		
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?		
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?		
d) Are **You**, or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?		

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space:

9. Declaration

I understand and accept Section 7 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. **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.

I declare that I have read, understood 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 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.

Records may be passed to other Goodhealth companies, its insurers and other parties connected to the fulfillment of the **Policy**.

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: day month year