

(effective 1st September 2008)



Please tick which of the following applies to You

Apply to join a new Goodhealth Group Policy

Apply to join an existing Goodhealth Group Policy

**Explanatory Notes**  
Please use **BLOCK CAPITALS** or tick boxes as appropriate

## 1. Your Information

Family Name:	<input type="text"/>	Title:	<input type="text"/>
First Name(s):	<input type="text"/>		
Date of Birth:	<input type="text"/> day <input type="text"/> month <input type="text"/> year	M/F:	<input type="checkbox"/> <input type="checkbox"/>
		Height:	<input type="text"/> m/ft
		Weight:	<input type="text"/> kg/lb
Residential Address:	<input type="text"/>		
	<input type="text"/>		
		Postcode:	<input type="text"/>
Nationality:	<input type="text"/>	Country of Residence:	<input type="text"/>
Occupation:	<input type="text"/>	Telephone:	<input type="text"/>
Email:	<input type="text"/>	Company Name (if applicable):	<input type="text"/>

**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, 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.

## 2. Dependant Information

**Dependant 1** Relationship to person named in section ONE above:

Family Name:	<input type="text"/>	Title:	<input type="text"/>
First Name(s):	<input type="text"/>		
Date of Birth:	<input type="text"/> day <input type="text"/> month <input type="text"/> year	M/F:	<input type="checkbox"/> <input type="checkbox"/>
		Height:	<input type="text"/> m/ft
		Weight:	<input type="text"/> kg/lb
Nationality:	<input type="text"/>	Country of Residence:	<input type="text"/>
Occupation:	<input type="text"/>		

**Dependant 2** Relationship to person named in section ONE above:

Family Name:	<input type="text"/>	Title:	<input type="text"/>
First Name(s):	<input type="text"/>		
Date of Birth:	<input type="text"/> day <input type="text"/> month <input type="text"/> year	M/F:	<input type="checkbox"/> <input type="checkbox"/>
		Height:	<input type="text"/> m/ft
		Weight:	<input type="text"/> kg/lb
Nationality:	<input type="text"/>	Country of Residence:	<input type="text"/>
Occupation:	<input type="text"/>		

**Dependant 3** Relationship to person named in section ONE above:

Family Name:	<input type="text"/>	Title:	<input type="text"/>
First Name(s):	<input type="text"/>		
Date of Birth:	<input type="text"/> day <input type="text"/> month <input type="text"/> year	M/F:	<input type="checkbox"/> <input type="checkbox"/>
		Height:	<input type="text"/> m/ft
		Weight:	<input type="text"/> kg/lb
Nationality:	<input type="text"/>	Country of Residence:	<input type="text"/>
Occupation:	<input type="text"/>		

## 2. Dependant Information (continued)

For more information about the various product options available, please refer to the plan schedule of Benefits.

Dependant 4	Relationship to person named in section ONE above: <input type="text"/>		
Family Name:	<input type="text"/>	Title:	<input type="text"/>
First Name(s):	<input type="text"/>		
Date of Birth:	<input type="text"/> day <input type="text"/> month <input type="text"/> year	M/F:	<input type="text"/>
		Height:	<input type="text"/> m/ft
		Weight:	<input type="text"/> kg/lb
Nationality:	<input type="text"/>	Country of Residence:	<input type="text"/>
Occupation:	<input type="text"/>		

## 3. Commencement Date

Subject always to Section 8 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:	<input type="text"/> day	<input type="text"/> month	<input type="text"/> year
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## 4. Cover Details

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 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 standard plan (Area 1 Foundation).

		Yes	No
Option 001	Exclude Pregnancy Cover	<input type="checkbox"/>	<input type="checkbox"/>
Option 002	Major Medical expenses ( <b>In-Patient</b> only cover) (Option 005 is 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 <b>Benefits</b> are excluded).	<input type="checkbox"/>	<input type="checkbox"/>
Option 003	<b>Policy Excess</b> The standard plan carries a US\$ Nil <b>Policy Excess</b> as standard. If none of the options below are ticked, this will apply.  US\$40 <input type="checkbox"/> US\$80 <input type="checkbox"/> US\$150 <input type="checkbox"/> US\$250 <input type="checkbox"/> US\$400 <input type="checkbox"/> US\$750 <input type="checkbox"/> US\$1,500 <input type="checkbox"/> US\$4,000 <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Option 004	<b>Elective Treatment</b> Worldwide excluding USA	<input type="checkbox"/>	<input type="checkbox"/>
Option 005	<b>Elective Treatment</b> Worldwide (Excess options are limited to US\$40, US\$80, US\$150)	<input type="checkbox"/>	<input type="checkbox"/>
Option 006	Medical History Disregarded *For compulsory <b>Groups</b> of ten or more employees only.	<input type="checkbox"/>	<input type="checkbox"/>
Option 007	<b>Chronic</b> Conditions**	<input type="checkbox"/>	<input type="checkbox"/>
Option 008	Routine Dental** **For compulsory <b>Groups</b> of three or more employees only.	<input type="checkbox"/>	<input type="checkbox"/>

## 5. Method of Payment

Bankers Draft:	<input type="checkbox"/>	Credit Card:	<input type="checkbox"/>	Bank Transfer:	<input type="checkbox"/>
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## 6. Payment Frequency

Annual:	<input type="checkbox"/>	Quarterly:	<input type="checkbox"/>
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## 7. Medical Questionnaire Please complete the following questions by ticking Yes or No

	Yes	No
a) Have <b>You</b> , or anyone included in this application, ever been admitted to <b>Hospital</b> or other similar establishment?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have <b>You</b> , or anyone to be included under this application, been prescribed with a course of any drugs or medication, or <b>Treatment</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 to be included under 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 to be included under this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>

**MEDICAL QUESTIONNAIRE**  
When completing SECTION SIX, 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** health insurance advisor or contact the Executive Healthcare Solutions office.

I note and agree that I am required to confirm all material facts in respect of myself and my **Dependants** (if applicable) that may influence **Underwriters** acceptance of my application as part of the **Group** Private Medical Insurance Plan, of which I am to be included.

A material fact is one that is likely to influence an insurer in the assessment and acceptance of **Your** application for insurance. This includes, but is not limited to, hazardous past-times/activities undertaken and details of any ongoing conditions which are likely to require **Treatment** or attention in the future or any other known peril.

Where a material fact is present and has been declared, it is only covered within the scope of the insurance where **You** have received written confirmation of such from **Us** in writing.

Non-declaration of a material fact will result in such condition/hazard/peril or similar being excluded from cover.

If **You** have answered **Yes** to any of the questions above, please provide further details in the box below or on separate sheet of paper if there insufficient space.

## 8. Declaration

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

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

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 void 'ab initio' without refund of premium and any **Benefits** shall be forfeited and recoverable by Goodhealth Worldwide.

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.

Signature of Employee/Applicant:

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>
<small>day</small>	<small>month</small>	<small>year</small>

[www.executive-healthcare.com](http://www.executive-healthcare.com)

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