

(effective 1st September 2008)

GOODHEALTHSM
An Aetna Company

1. Group Details

Company Name:	<input type="text"/>		
Type of Business:	<input type="text"/>		
Address:	<input type="text"/>		
	<input type="text"/>	Postcode:	<input type="text"/>
Group Administrator <i>(note 1)</i> :	<input type="text"/>		
Job Title:	<input type="text"/>	Telephone:	<input type="text"/>
Fax:	<input type="text"/>	Email:	<input type="text"/>
Intermediary (if applicable):	<input type="text"/>		

2. Cover Details

Preferred commencement date:	<input type="text" value="day"/>	<input type="text" value="month"/>	<input type="text" value="year"/>
Currency of Plan:	US\$	<input type="checkbox"/>	
Definition of staff <i>(see note 2)</i> :	<input type="text"/>		
	<input type="text"/>		
To be insured <i>(see note 3)</i> :	Employees only	<input type="checkbox"/>	Employees and Dependants <input type="checkbox"/>

3. Underwriting

<i>(see note 4)</i>	Previously uninsured Group	Previously insured Group	Additional new members
Two Year Moratorium (MORI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continued Personal Medical Exclusions (CPME) with employer declaration of Medical facts	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Medical History Disregarded (MHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Explanatory Notes

Please use **BLOCK CAPITALS** or tick boxes as appropriate.

Note 1

The **Group Administrator** name given should be the person who will be the company's regular contact for correspondence and administration purposes.

Note 2

The definition of those members of staff to be covered under the plan could for example be – "senior managers, all staff with more than one year's service" etc. If defining more than two categories, please provide details on a separate sheet of paper.

Note 3

Where an employee's child **Dependants** are to be included under the **Group** plan, all children must be unmarried and under the age of 18 years (or 23 years if in full time education).

Children on reaching the age of 18 years (or 23 if in full time education) may remain in the **Group** as separate members, subject to the full adult subscription being paid.

Note 4

The details shown in section three should match the **Group** quotation terms proposed/accepted by Goodhealth Worldwide.

Goodhealth reserves the right to amend or withdraw its offer of cover should there be any material change to the original risk.

4. Expiring Insurance Plan Details

Is Group currently insured?: Yes No

Name of insurer:

Current plan name:

Expiry date: day month year

Expiring underwriting terms:

Variations to standard terms:

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 liability 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. General Terms and Conditions

- 1) This document forms part of the contract and must be read together with the **Policy Wording**, **Policy Schedules** and **Application Form(s)**, where applicable [see points 6 i) a) and 6 i) b) below].
- 2) This Contract of Insurance will take effect on the commencement date and shall continue for a period of 12 months or until the next **Renewal Date** or until the **Policy** is cancelled for whatever reason, whichever is sooner.
- 3) **Group Eligibility**
 - i) A **Group** can only be made up of employees of the same company or members of an existing and registered affinity **Group**.
 - ii) For a **Group** that consists solely of members of the same family it must be fully substantiated that such members are all working for the same employer.
 - iii) Where a husband and wife are both employed by the same company they are deemed to be one employee plus eligible **Dependant** NOT two employees.
 - iv) The minimum size of a **Group** at inception or renewal is three current employees or affinity members. If the membership is below three at inception or at a subsequent **Renewal Date** then the **Group** cannot continue.
- 4) The inception premium must be received within a maximum of 30 working days from the commencement date of the **Policy**. No claims will be paid until this is received.
- 5) Renewal premiums must be received by **Renewal Date**. If full renewal premium and any applicable taxes or local levies are not received by **Renewal Date** claims will be suspended and cover will lapse. Goodhealth may, at their discretion, reinstate cover if full premium and any applicable taxes or local levies are subsequently received.
- 6) Cover is only provided for **Group Members** (and eligible **Dependants**) where declared and accepted by Goodhealth.
 - i) New **Group Members** (and eligible **Dependants**) can be added to the **Policy** mid-term subject to the following:
 - a) For Affinity, Voluntary **Groups** and Compulsory Company Paid **Groups** with less than 20 employees a **Group Application Form** or Continuous Transfer Form must be completed by each and every **Group Member**.
 - b) For Compulsory Company Paid **Groups** with more than 20 employees where the **Group Administrator** can supply the following information in writing this will be deemed sufficient: full proposed **Group Members** name; proposed **Group Members** date of birth; proposed **Group Members** nationality; proposed **Group Members** residential country; proposed **Group Members** occupation; known **Medical Conditions**; and confirmation of which **Group Policy** the applicant is to be added to. If the **Group Administrator** is not able to supply this information a separate **Group Application Form** or a Continuous Transfer Form must be completed by the applicant.
 - ii) Payment for additions must be received within 14 days of acceptance date. If these conditions are not met all cover will be deemed null and void without further notice. For additions to plans that have opted for end of year adjustments, six monthly payments or quarterly payments the funds must be received by due dates otherwise all cover will be deemed null and void.
 - iii) **Group members** and/or their eligible **Dependants** can be deleted from the date of notification in writing by the **Group Administrator** for which a pro rata return of premium will be calculated. Notification may be given to Goodhealth by the **Group Administrator** of a future deletion(s) date(s) no more than 30 days in advance.

7. Declaration

I declare that I am authorised by the Company to enter into this Contract of Insurance with Goodhealth.

I declare that I have understood and accepted the General Terms and Conditions in Section 7 of this Group Formation Form.

I understand that subscriptions due under the Group plan must be paid in full by the agreed due date to Goodhealth.

In the event that premiums are not paid by the due date, I understand that cover will be automatically cancelled.

I declare that the transfer by the Company of personal data to Goodhealth, including information relating to employees insured under the Group plan will not result in violating the Data Protection Law - 2007.

I declare that the information given to Goodhealth for the purpose of entering into this Contract of Insurance is true and complete and that no material facts have been withheld.

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 its associated companies and 4) processing claims or analysing the insurance.

Signature of Applicant:

Date: day month year

Please Print Name:

Position:

www.executive-healthcare.com

Executive Healthcare Solutions Limited

10th Floor, IPS Building
Kimathi Street
PO Box 51343, 00200-City Square
Nairobi, Kenya

T (254 20) 2219621/826
F (254 20) 222 9006
E info@executive-healthcare.com
W www.executive-healthcare.com



