Continuous Transfer Form

Executive Healthcare Plan

(effective 1st September 2008)

GOODHEALTH℠
An Aetna Company

Please tick which of the following applies to You

Apply to transfer from another insurer to a Goodhealth Group Policy ☐	Apply to transfer from another insurer to a Goodhealth individual Policy ☐	Apply to transfer from an existing Goodhealth Policy to a new Goodhealth Policy ☐

1. Your Information

Family Name: Title:

First Name(s):

Date of Birth: day month year M/F: Height: m/ft Weight: kg/lb

Residential Address:

Postcode:

Nationality: Country of Residence:

Occupation: Telephone:

Email: Company Name (if applicable):

2. Dependant Information

Dependant 1 Relationship to person named in section ONE above:

Family Name: Title:

First Name(s):

Date of Birth: day month year M/F: Height: m/ft Weight: kg/lb

Nationality: Country of Residence:

Occupation:

Dependant 2 Relationship to person named in section ONE above:

Family Name: Title:

First Name(s):

Date of Birth: day month year M/F: Height: m/ft Weight: kg/lb

Nationality: Country of Residence:

Occupation:

Dependant 3 Relationship to person named in section ONE above:

Family Name: Title:

First Name(s):

Date of Birth: day month year M/F: Height: m/ft Weight: kg/lb

Nationality: Country of Residence:

Occupation:

Explanatory Notes

Please use BLOCK CAPITALS or tick boxes as appropriate

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 (continued)

Dependant 4 Relationship to person named in section ONE above:

Family Name: Title:

First Name(s):

Date of Birth: day month year M/F: Height: m/ft Weight: kg/lb

Nationality: Country of Residence:

Occupation:

3. Commencement Date

Subject always to Section 7 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. 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		
Option 002	Major Medical expenses (In-Patient 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$4,000 and routine pregnancy and childbirth Benefits are excluded).		
Option 003	Policy Excess The standard plan carries a US$ Nil Policy Excess as standard. If none of the options below are ticked, this will apply.		
	US$40 US$80 US$150 US$250		
	US$400 US$750 US$1,500 US$4,000		
Option 004	Elective Treatment Worldwide excluding 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.

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

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 Questionnaire

Please complete the following questions by ticking Yes or No

		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 to be included under this application, been prescribed with a course of any drugs or medication, or Treatment for a period in excess of seven days in the last two years?		
c)	Have You, or anyone to be included under 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 to be included under this application, suffering from any disability, abnormality, recurrent illness, major illness or injury not already noted above?		

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 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 Our 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.

7. Declaration

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

I declare 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 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.

Signature of Employee/Applicant:

Date: day month year

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