

SELECT YOUR GLOBAL PERSONAL HEALTH PLAN

Please select the type of Personal Health Plan you are applying for (Traditional Choice or Open Choice) and indicate the specific Plan Option.

Coverage Applied For:

- Traditional Choice Plan:** Plan Option _____
- Open Choice Plan:** Plan Option _____
- Annual Premium Amount \$ _____
- Semi-Annual Premium Amount \$ _____

Rates are based on the Attained Age of oldest applicant.
Attained Age is the age attained during 12 month coverage period.

PAYMENT TYPE:

- Check # _____ OR Money Order

All payments should be made in U.S. dollars and submitted with this completed application form. Please make U.S. check or U.S. money order payable to Aetna Life & Casualty (Bermuda) Ltd.

Coverage applied for:

- Primary Applicant
- Primary Applicant & Spouse
- Primary Applicant & Child(ren)
- Primary Applicant, Spouse & Child(ren)

Requested effective date of coverage _____
Mo/Day/Year

Must be first day of any month following submission of your application. For residents of the United States, Puerto Rico, the U.S. Virgin Islands or Bermuda, this should be the first day of the month following your departure from those locations. Coverage is not effective until approved in writing by Aetna Global Benefits.

ADDRESS for mailing of correspondence. (Please include country)

Email address _____

Phone number _____

Do you prefer to receive plan information
(Forms, Plan Booklet, etc.) in English OR Spanish?

MEDICAL HISTORY

Primary Applicant: Please provide medical history information for yourself and any dependents for whom you are requesting coverage:

Yes No *Within the past 10 years, have you and/or your dependents ever been diagnosed, prescribed medication for or treated for:*

- 1. Disease of eyes, ears, nose or throat?
- 2. Mental or nervous disease: dizziness, fainting, convulsions, headache, paralysis, stroke or other disease of the brain?
- 3. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis or other disease of the lungs?
- 4. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, high blood cholesterol, heart attack or other disease of the heart or blood vessels?
- 5. Jaundice, hepatitis, cirrhosis, intestinal bleeding, ulcer, colitis, diverticulitis, hernia, hemorrhoids or other disease of the stomach, intestines, liver, gall bladder or pancreas?
- 6. Sugar, albumin, blood or pus in urine; any disease of the kidneys, bladder, prostate, reproductive organs or breasts?
- 7. Diabetes, thyroid, pituitary, adrenal or other endocrine diseases?
- 8. Arthritis, gout, neuritis, sciatica or disease or injury of the muscles, bones or joints including the back and neck?
- 9. Deformity or amputation?
- 10. Acquired Immune Deficiency Syndrome or any AIDS-Related disorders?
- 11. Cancer, tumor, cyst; disease of skin or lymph glands?
- 12. Allergies, anemia or other disease of the blood?
- 13. Have you ever had any disorder of menstruation or complication of pregnancy?
- 14. Are any inpatient or outpatient medical/surgical procedures (including diagnostic testing) recommended or being contemplated?
- 15. To your knowledge, are you now pregnant?
- 16. Are you now under observation or treatment for a medical condition?
- 17. Do you use alcoholic beverages? If "Yes" give type, quantity and frequency.
- 18. Do you use prescription drugs? If "Yes" give type, dosage and frequency.
- 19. Have you ever received or been advised to have counseling for emotional or mental nervous condition?
- 20. Have you ever received or been advised to have counseling or treatment for alcohol or drug use?
- 21. Do you use tobacco products? If they include cigarettes, indicate: packs per day _____ # years smoked _____

Yes No *Other than the above, have you within the past 5 years:*

- 22. Had a check-up or consultation? If yes, please describe results.
- 23. Had an illness, injury or surgery?
- 24. Been an inpatient or outpatient at a hospital, clinic or other medical facility?
- 25. Had an electrocardiogram, x-ray or other diagnostic test?
- 26. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?

- 27. Do you and/or your dependents have a known physical impairment(s) or health condition(s) not already mentioned in the Medical History section?

For YES answers, give details in space provided. Identify question number(s) for which you are providing details. Indicate name of individual for whom treatment was rendered and provide any additional information such as diagnosis, duration of illness and/or treatment and names and addresses of attending physicians and medical facilities. Please attach additional pages as necessary.

FAMILY HISTORY: Include information about heart or kidney disease, high blood pressure, stroke, tuberculosis, diabetes, cancer, mental illness or suicide below. Please attach additional pages as necessary.

	Living		Deceased	
	Age	Health Status	Age	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

LIFE INSURANCE BENEFICIARY: Every Global Personal Health Plan includes a \$10,000 Term Life Benefit for the Primary Insured. Primary Insured: please complete the Beneficiary Information below.

Beneficiary Name(s) First, Middle Initial, Last	Beneficiary Relationship(s)
_____	_____
_____	_____

Additional Beneficiary Information

FOR SERVICING AGENT USE ONLY

Control Number _____ Suffix _____ Account _____ Plan _____ Claim Office Code 049

Selling Agent/Agency _____ Servicing Agent Signature _____ Date _____

Guideline Requirements: In addition to this Evidence of Insurability Statement, a medical exam performed by an Aetna-approved doctor is required if the applicant or spouse is age 60 or over. If the applicant or spouse has been seen by an Aetna-approved doctor within the last 90 days for a complete physical exam, including blood and urine tests, we will accept the results of that exam from this doctor. Aetna may request additional information upon receipt of this completed Application Form and related medical information.

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I will inform Aetna Global Benefits (AGB) of any material changes to the information provided which take place between the time this form is completed and the time coverage becomes effective. I agree that this document shall form a part of my request for coverage and I acknowledge that I have been given a copy of this document as completed by me.

Acknowledgement: I understand that, to the extent permitted by applicable law, false statements may result in the denial of claims or in my insurance coverage being void as of its effective date with no benefits payable. I understand the conditions which are disclosed on this form may be subject to all conditions of my plan including any pre-existing condition limitations and dependent health conditions requirements. My signature indicates that I have reviewed all information and statements on this form for completeness and accuracy.

Authorization: To all physicians and other health professionals, hospitals and other health care institutions, insurers, medical or hospital services and prepaid health plans, employers and the Medical Information Bureau: You are authorized to provide AGB and their representatives information concerning health care, advice, treatment or supplies (including those related to mental illness and/or AIDS/ARC/HIV) provided me or any members of my family for whom coverage has been requested. This information will be used for the purpose of determining eligibility for coverage. This authorization will be valid for thirty (30) months from the date signed. I agree that a photographic copy of this authorization is as valid as the original.

Disclosure of Information to others, Your rights of Access & Correction and Fraud Notice:

Your Right of Access & Correction: In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding), and to request correction, amendment or deletion of recorded personal information in states which provide such rights and grant immunity to insurers providing such access. We will disclose details of any medical information you request to your (attending) physician.

Disclosure of Information to Others: All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. For example, Aetna Global Benefits may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may apply for coverage, or to whom a claim for benefits may be submitted. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Fraud Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against any insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud. In addition, the policy will be terminated back to the original effective date.

Primary Applicant Signature _____ Date _____ Spouse Signature _____ Date _____

Please note: This document is a request for coverage, not a guarantee of coverage. You will be notified regarding approval of coverage by your Aetna Global Benefits Representative.

FOR INSURER USE ONLY: Acknowledgement to Servicing Agent

Approved Effective _____

Not Approved For _____ Applicant letter is enclosed.

If Primary Applicant's benefits are not approved, dependent coverage will not be issued. Dependents may reapply for coverage under a new application.

By _____ Date _____

INDICATE ENROLLMENT CHANGES HERE

Change the Plan Effective Date

Old Effective Date _____ Change to New Effective Date _____

Change ID Number

Old ID Number _____ Change to New ID Number _____

Add Dependent

Name _____

Birthdate _____ or Marriage Date _____

Address _____

Other Change? Please explain _____

If you wish to change your level of benefits/plan option, please consult your Aetna Global Benefits Representative.

Primary Applicant's Signature _____

Date _____

The undersigned hereby agrees to the establishment of an Insurance Fund for purposes of implementing an Agreement (the "Agreement") for Aetna Global Benefits' Global Personal Health (the "Arrangement"). The undersigned hereby agrees to the designation of The Bank of Butterfield Executor & Trustee Co. Ltd. as Agent for said Insurance Fund and Agreement. This Joinder Agreement shall be attached to and form a part of said Agreement.

The undersigned, as a Member under the Agreement of 1st October 1999 accepts and agrees to be bound by the terms of said Agreement, including any amendments thereto.

The undersigned further requests that the insurance coverage indicated in the selected Plan Option be provided for the undersigned individual and dependents (as applicable) under the Health Insurance policy or policies issued by Aetna Life & Casualty (Bermuda) Limited ("Aetna Global Benefits") to the Agent, and (subject to the applicable underwriting requirements of Aetna Global Benefits) that such insurance coverage become effective as of the requested effective date indicated in the Global Personal Health Application Form or as of the date of approval by Aetna Global Benefits of the undersigned for participation under the Agreement, whichever is later, and continue as long as the undersigned remains a Member. The insurance benefits provided shall be in accordance with the selected Plan Option and shall be subject to the terms of the Health Insurance policy or policies issued to the Agent.

Coverage under Global Personal Health is provided for a 12 month period. A minimum of 12 months of premium is required regardless of the payment option chosen (Semi-Annual or Annual). The undersigned agrees to make the required non-refundable contributions to the Insurance Fund for the insurance coverage requested for undersigned individual and dependents (as applicable). If the undersigned fails to make any required contribution when due, they shall then be liable directly to Aetna Global Benefits for such unpaid contributions for the period during which coverage is in force with respect to undersigned individual and dependents (as applicable).

I understand that the insurance policy delivered under the Arrangement is subject to the laws of Bermuda, the jurisdiction in which the Arrangement was established and in which the Agent is domiciled, and Aetna Global Benefits and the Agent are not responsible for Participant's compliance with applicable local law.

Primary Applicant Name _____

Selling Agent /Agency (if applicable) _____

Amount of Advance Payment

Annual Premium Amount \$ _____

Semi-Annual Premium Amount \$ _____

Rates are based on the Attained Age of oldest applicant. Attained Age is the age attained during 12 month coverage period.

Primary Applicant Signature _____

Date Signed _____

Please send this signed original agreement, your completed Global Personal Health Application Form, and U.S. check or U.S. money order payment to your Aetna Global Benefits representative. Keep a copy of all materials for your records.

All payments should be made in U.S. dollars. Please make U.S. check or U.S. money order payable to: Aetna Life & Casualty (Bermuda) Ltd.

For Servicing Agent Use Only

Servicing Agent _____

Street _____ P. O. Box _____

City _____ State _____ Country _____

Zip/Postal Code _____