1 January 2016

Aetna Pioneer[SM] Plan Application

Need help completing this application?
Please contact either your advisor or us directly. You can find our contact details on our website at www.aetnainternational.com

Europe
Moratorium

IMPORTANT - PLEASE READ – YOUR DUTY OF DISCLOSURE

The questions in this application and any other information we ask for are essential for us to underwrite and administer your plan. You must take reasonable care to accurately and fully answer any questions that we ask you.

You must also exercise reasonable care to make sure that all information or material facts that you supply to us are true and correct, whether or not we have asked you a question about such facts.

Material facts are those which we take into account in assessing whether to offer you insurance and, if so, at what premium and on what terms. If you have any doubt as to whether certain facts are material, please ask us or your insurance broker or intermediary if you have one.

Failure to exercise reasonable care may:

- entitle us to treat your plan as if it had never existed,
- result in different terms being applied to your plan, or
- result in a claim not being paid in full or at all.

Please do not assume that we will carry out any searches or contact any other person (including any medical practitioner) to check the answers to any of the questions we ask you or the information you provide on this application. It remains your responsibility to fill in the application and check that the information within it is accurate.

You should keep a record of all information that you have provided to us in respect of this insurance. If any of the details that you give on this application are different from the details that you gave when you received your quotation, your premium may be different.

Eligibility

The Aetna Pioneer plans and add-on plans are available to people of most nationalities, except citizens of the United States (US) who reside in the US and people who are governed by exchange controls or local licensing regulations. Please see your Benefits schedule and Handbook for full eligibility details.

Please fill in this application clearly in BLOCK CAPITALS.

If you have received a quotation from us, please write the quotation number and option number if you have one:

Quotation number	Option number

A. Your personal details (the planholder)

Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
Family name (surname)	First name(s)	
Where will you be living?[1]		
Nationality on passport		
Occupation	Date of birth (dd/mm/yyyy)	Gender: ☐ **M** ☐ **F**
Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)	

[1] The amount of insurance premium tax and any other relevant taxes you will have to pay will depend on where you will be living. Please speak to your advisor or contact us if you are unsure whether your premium will be affected. Please make sure that your plan meets the requirements of the country where you will be living.

Your correspondence address
We will send all correspondence to this address. You must tell us immediately about any changes to your contact or personal details. A change in circumstances may affect your cover.

Address	
Town	City
Postcode	Country
Phone	Mobile
E-mail	

B. Dependants to be covered

You do not need to fill in the height and weight sections for dependants aged 17 years or younger.

Dependant 1	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)	First name(s)	
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 2	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)	First name(s)	
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 3	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)	First name(s)	
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)
Dependant 4	Title ☐ **Mr** ☐ **Mrs** ☐ **Miss** ☐ **Ms**	Other	
	Family name (surname)	First name(s)	
	Date of birth (dd/mm/yyyy)	Gender ☐ **M** ☐ **F**	Where will they be living?[1]
	Nationality on passport	Occupation	
	Relationship to you	Height (cm) or Height (inches)	Weight (kg) or Weight (pounds)

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

C. Cover start date

The plan is a yearly contract. Your cover will begin on the date when we confirm acceptance of your application in writing. If you want your cover to start at a later date, please tell us below. This date can be no more than 30 days after the date you fill in this application.

We will not backdate cover under any circumstances.

When do you need your cover to begin in the country in which you will be living? (dd/mm/yyyy)

D. Your cover options

Plan levels

Please tell us the Aetna Pioneer plan level that you need. Please make sure that you have read the Plan summary and Benefits schedule before making your choice. You must make sure the plan meets your needs. Please contact us if you need copies of these documents.

If you and your dependants reside outside of the United States (US), and you wish or need to include cover in the US on your plan:

- You must choose Aetna Pioneer 5000 if you are non-US citizens
- You must choose Aetna Pioneer 5000+ if you are US citizens

If you and your dependants are non-US citizens residing in the US you must choose Aetna Pioneer 5000+.

If none of these apply to you, Aetna Pioneer 5000+ is not available.

To select your chosen plan level, please tick the appropriate box below.

☐ **Aetna Pioneer℠ 1750** ☐ **Aetna Pioneer℠ 2500** ☐ **Aetna Pioneer℠ 4000**
☐ **Aetna Pioneer℠ 5000** ☐ **Aetna Pioneer℠ 5000+**

Areas of cover

Choose your area of cover based on your country of residence, your home country if you need the option of returning to your home country for treatment, and any other country in which you may wish or need to receive treatment. See the 'Areas of cover guide' section of your Handbook for more information.

You and your dependants must have the same area of cover.

To select your chosen area of cover, please tick the appropriate box below.

Area of cover
☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7**

Medical evacuation options

You can add non-emergency medical evacuation to your plan, subject to a premium increase. See the 'Medical evacuation' section in your Benefits schedule for information on the cover this provides.

Do you wish to select this optional cover?
☐ **Yes** ☐ **No**

Dental cover options

If you have chosen Aetna Pioneer 4000, 5000 or 5000+, you can choose to add routine and major restorative dental treatment to your plan, subject to a premium increase. See the 'Dental treatment' and 'Deductibles' sections in your Benefits schedule for information on the cover this provides and the coinsurance that applies.

Do you wish to select this optional cover?
☐ **Yes** ☐ **No**

Aetna Pioneer℠ 4000	**Aetna Pioneer℠ 5000**	**Aetna Pioneer℠ 5000+**
adds USD 750, GBP 500 or EUR 600 limit	adds USD 1,500, GBP 1,000 or EUR 1,200 limit	adds USD 1,500, GBP 1,000 or EUR 1,200 limit

Deductibles and direct billing

Aetna Pioneer℠ 1750 plan

Direct billing is not available under the Aetna Pioneer 1750 plan.

You must pay a standard annual excess amount of USD 2,000, GBP 1,250 or EUR 1,600 for each member in each plan. See the 'Deductibles' section in your Benefits schedule for full details.

If you want to change the annual excess from the standard annual excess shown, please tick the appropriate box below.

Nil	☐ (premium increase applies)
USD 1,000, GBP 625 or Euro 800	☐ (premium increase applies)
USD 2,000, GBP 1,250 or Euro 1,600	Standard
USD 4,000, GBP 2,500 or Euro 3,200	☐ (premium discount applies)

Aetna Pioneer℠ 2500, 4000, 5000 and 5000+ plans

Adding outpatient direct billing to your plan will increase your premium. Please contact us if you need more information.

Would you like to add outpatient direct billing to your plan?
☐ **Yes** ☐ **No**

You must pay a standard outpatient coinsurance amount of 10% for each claim. See the 'Deductibles' section in your Benefits schedule for full details.

If you want to change the coinsurance from the standard coinsurance shown please tick the appropriate box below.

0%	☐ (premium increase applies)
10%	Standard
20%	☐ (premium discount applies)
30%	☐ (premium discount applies)

E. Add-on plans and benefits

Do you want to add any of the following?		
Aetna Maternity plan	☐ **Yes**	☐ **No**
Aetna Travel plan	☐ **Yes**	☐ **No**
Aetna Personal Accident plan	☐ **Yes**	☐ **No**

If yes, please make your choices below.

Aetna Maternity
The Aetna Maternity plan is available with Aetna Pioneer 2500, 4000, 5000 and 5000+. The Aetna Maternity plan is only available with the same area of cover as your Aetna Pioneer plan and for female members aged 18 to 44 at entry. Please see your Benefits schedule and Handbook for full eligibility details.

If you have chosen direct billing for the Aetna Pioneer plan this will also be available for the Aetna Maternity plan.

Please select the members to be covered under the Aetna Maternity plan

☐ **Planholder** ☐ **Dependant 1** ☐ **Dependant 2** ☐ **Dependant 3** ☐ **Dependant 4**

Please select the Aetna Maternity plan required.

	Area 1	Areas 2-7	
Aetna Pioneer℠ plan level	Aetna Maternity 200	Aetna Maternity 150	Aetna Maternity 75
Aetna Pioneer℠ 5000+	☐	**N/A**	**N/A**
Aetna Pioneer℠ 5000	☐	☐	☐
Aetna Pioneer℠ 4000	**N/A**	☐	☐
Aetna Pioneer℠ 2500	**N/A**	☐	☐

You must pay a standard outpatient coinsurance amount of 10% for each claim. See the 'Deductibles' section in your Benefits schedule for full details.

If you want to change the coinsurance from the standard coinsurance shown please tick the appropriate box below.

0%	☐ **(premium increase applies)**
10%	**Standard**
20%	☐ **(premium discount applies)**
30%	☐ **(premium discount applies)**

Aetna Travel
The Aetna Travel plan is available with all Aetna Pioneer plans and provides worldwide cover. The maximum age at entry for the Aetna Travel plan is 79. Please see your Benefits schedule and your Handbook for full eligibility details.

To select the Aetna Travel plan please tick the appropriate boxes below:

Aetna Travel	☐ **No**	☐ **Yes, planholder only**	☐ **Yes, planholder and all dependants**

Aetna Personal Accident
The Aetna Personal Accident plan is available with all Aetna Pioneer plans and provides worldwide cover. All members covered under the Aetna Personal Accident plan will have the same level of cover as the planholder. You must be aged 18 to 79 when joining this plan. Please see your Benefits schedule and Handbook for full eligibility details.

The Aetna Personal Accident plan provides cover for managerial, clerical and administrative occupations only. If your occupation puts you at greater risk of a bodily injury caused by an accident, the planholder must tell us. We will tell them if we agree to cover you and let them know any extra premium that will apply.

Please note that the Aetna Personal Accident plan benefits are only payable in relation to an accident that occurs during the plan year.Please select the Aetna Personal Accident plan required and indicate if any dependants are to be covered.

Planholder	☐ **Aetna Personal Accident 85**	☐ **Aetna Personal Accident 170**
	☐ **Aetna Personal Accident 255**	☐ **Aetna Personal Accident 340**
	☐ **Aetna Personal Accident 425**	

☐ **Dependant 1** ☐ **Dependant 2** ☐ **Dependant 3** ☐ **Dependant 4**

If you have any more dependants to be covered, please give us details on a separate sheet of paper and send it to us with this application.

F. Plan currency and premiums

Paying your premiums

To enjoy the full benefit of the plan, you must make sure the premiums are paid on or before the premium due date. You must tell us about any changes to your payment details to make sure that we can continue to collect any premiums due.

You can find full payment details and information on unpaid and late payments in your Handbook.

Plan currency

Aetna Pioneer and add-on plans are available in a range of currencies. Benefit limits will be based on the plan currency chosen, and all premiums must be paid in the same currency as the plans. Any add-on plans that have been chosen must be in the same currency as your Aetna Pioneer plan.

To select your plan currency, please tick the appropriate box below.

☐ **USD** ☐ **GBP** ☐ **EUR**

Payment options

You can pay yearly, every three months or every month. We cannot accept payment by bank transfer, cheque or banker's draft if you are paying by instalments. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% more if you pay every month and 4% if you pay every three months).

To select how often you want to pay your premiums and your chosen payment method from the options available, please tick the appropriate box below.

	Card	Bank transfer	Cheque or banker's draft	Direct debit
Yearly	☐	☐	☐	☐
Every three months	☐	**N/A**	**N/A**	☐
Every month	☐	**N/A**	**N/A**	☐

Add-on plans and benefits

Aetna Maternity

If you have chosen an Aetna Maternity plan, you can also choose how often you want to pay the premiums for this plan, depending on the payment option chosen for your Aetna Pioneer plan. Due to administration costs, the total premiums you pay every month or every three months will be higher than if you pay the premiums every year (about 12% if you pay every month and 4% if you pay every three months).

To make your selection, please tick the appropriate box below.

☐ Yearly ☐ Same as Aetna Pioneer plan

Aetna Travel and Aetna Personal Accident

Aetna Travel and Aetna Personal Accident plan premiums can only be paid yearly.

Payment details

Card

We can accept card payments by Visa, MasterCard or American Express. To make a payment please fill in the Card authority we give to you. Please make sure that your card is valid for at least three months from the start date of your plan.

Direct debit

We can only accept direct debits from UK bank accounts for plans in GB pounds. To make a payment please fill in the Direct debit mandate we give to you.

Bank transfers

Bank transfers must be in the currency of your plan. Please make sure that you give your full name and quotation or plan number as the reference for your bank transfer. Please send your payment to 'Aetna Insurance Company Limited' using the details below.

USD account		**GBP account**		**EUR account**	
Bank name:	Citibank	Bank name:	Citibank	Bank name:	Citibank
Bank location:	London	Bank location:	London	Bank location:	London
IBAN:	GB95CITI18500817808674	IBAN:	GB83CITI18500817733909	IBAN:	GB95CITI18500817733887
Account number:	17808674	Account number:	17733909	Account number:	17733887
SWIFT code:	CITIGB2L	SWIFT code:	CITIGB2L	SWIFT code:	CITIGB2L
Sort code:	**185008**	**Sort code:**	**185008**	**Sort code:**	**185008**

To ensure that the full amount of your payment is received by us, please mark your bank transfer: 'Pay Full Amount' or 'Bank Charges Debit Account'. This does not apply to Euro payments.

Cheque or banker's draft

Cheques and banker's drafts must be in the currency of your plan and payable to 'Aetna Insurance Company Limited'. Please make sure that your full name and quotation or plan number are clearly shown on the back of the cheque or banker's draft in case your payment becomes separated from this application.

G. Doctor's or medical practitioner's details

Please give the contact details of any family doctor or medical practitioner who has treated you or your dependants in the last two years. If you do not provide this information, it may delay the processing of your claims and your claims may be rejected.

Member's name	Member's name
Doctor's name	Doctor's name
Hospital, clinic or practice	Hospital, clinic or practice
Phone	Phone
Fax	Fax
E-mail	E-mail
Address	Address
Postcode	Postcode

Please provide details on a separate page if your family are seen by more doctors than listed above, and confirm which members of your family each doctor has treated.

H. Pre-existing medical conditions

Please read benefit exclusion E1 in your Handbook carefully before applying for this plan. Benefit exclusion E1 is also explained below.

You must sign this section to show that you understand and accept our 24-month moratorium. We will not process your application unless you have signed this section as well as the declaration section in this application.

It is important that you read, understand and accept all of the paragraphs in the following declaration for your Aetna Pioneer plan, and your Aetna Maternity plan if chosen.

This declaration applies to you and to any eligible dependants you have included in this application.

A medical condition that, within the 24-month period before the date your trip is booked, or your date of joining as shown on your Certificate of insurance, whichever is later, has one or more of the following characteristics:

- Clearly showed itself
- You had signs or symptoms of
- You asked for advice about
- You received treatment for
- To the best of your knowledge, you were aware you had

I confirm that I have read, understood and accept this moratorium underwriting clause about pre-existing medical conditions and that it applies to any eligible dependants included in this application.

Signature	Date (dd/mm/yyyy)

I. Data Protection

We are committed to protecting your personal data and privacy. Any personal information that we collect will be kept confidential and will be processed in accordance with the UK Data Protection Act 1998, medical confidentiality guidelines, other related legislation and our own strict internal policy.

We will use any personal data we collect to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Aetna entities or third parties acting on our behalf inside or outside the European Union where there may be less stringent data protection laws. However, wherever it is held and processed, your personal data will be protected by strict security measures which we and any third parties working on our behalf are subject to, and will only be used in accordance with our instructions.

Your information may also be used for the detection and prevention of fraud and for audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass your information to other Aetna entities and agents working on our behalf, insurance industry bodies, law enforcement and other legal agencies, governmental or judicial bodies, or to regulators.

In order to assess the terms of the contract of insurance, including specific medical exclusions, or to administer claims, we may collect medical information which the UK Data Protection Act defines as 'sensitive' information. Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organisation that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your agent or broker if you have requested the broker to assist you in handling your claims and you have authorised us to provide them with such medical information.

We will not disclose your medical information to any other individual without your explicit consent. If you want us to disclose your medical information to another individual or next of kin, you must tell us. In exceptional emergency situations, and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

All membership documents will be sent to the planholder.

To help us ensure that your personal information remains accurate and up to date, please inform us of any changes.

You have the right to see personal information about you held by us. There may be a charge for this.

Please write to:

Data Protection Officer
25 Templer Avenue
IQ Farnborough
Farnborough
Hampshire
GU14 6FE
United Kingdom

We may, from time to time, provide you with marketing information about Aetna, our products and services and those of any associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box. ☐

You can find our full terms and conditions and details of our privacy policy at http://www.aetnainternational.com/ai/en/about-us/legal.

J. Declaration

I am applying to be covered under the Aetna Pioneer plan and any add-on plans I have chosen together with the dependants listed in this application. I have read, understood and agree to keep to the terms and conditions shown in the Handbook, along with all eligible dependants included in this application or any dependants I enrol in the future after the start date of the plan. I confirm that I have authority to give Aetna information about my family members referred to in this application. I confirm that I have exercised reasonable care to ensure that the following are true, accurate and complete:

1. The statements of fact set out in this application
2. The answers to the questions set out in this application
3. Any other material facts or information I may have provided you with prior to taking out this plan

I confirm that if I have failed to answer any question set out in this application or have left any question blank, that is because there is no material information to supply in answer to that question. Where I have left the answer to any question requiring a 'yes/no' answer blank, I confirm that my answer to such question is 'no'.

I declare that, unless you hear from me to the contrary, none of the answers to the questions set out in this application have changed between the date of signature and the date the insurance cover starts.

I confirm that where the plan to which I am subscribing provides cover for more than one person, family member or dependant, I have checked with each of them that any information relating to them which I may have provided you with is true, accurate and complete. I further confirm that I have passed a copy of this application on to every person who is intended to benefit from the plan and asked them to check it also.

By agreeing to the terms and conditions I consent to any personal data, including medical information, that you may collect about myself and my family members and dependants, being processed by Aetna.

I authorise the doctor named in section G or any other medical establishment, including any other health professional who has treated me and any of my dependants included under this plan, to give you any information you may need in connection with any claim made under these plans.

I understand that you are not obliged to conduct any searches or to make any enquiries of any medical practitioners (or any other persons) to check the accuracy of the statements of fact set out in this application, and that it remains my responsibility to take reasonable care to ensure that the statements, material facts and other information I provide to you are true, accurate and complete.

I understand that if I do not provide the information asked for in sections G and H, and I or any of my dependants included under these plans make a claim, which you view as being treatment for a pre-existing medical or related medical condition, the claim may be rejected.

I understand that should I or one of my dependants attend a hospital, clinic or medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Aetna has the right to recover the full amount of the ineligible claim from me or one of my dependants.

After reading all the terms and conditions and documents you have given me, I am satisfied that the products I have chosen meet my needs at this time.

For your own benefit and protection, you should read the terms and conditions shown in the Handbook carefully before signing this declaration. If you do not understand any point, please ask for more information.

Signature	Date (dd/mm/yyyy)

Cancellation

If you feel a plan does not meet your needs, you may cancel it. You must tell us in writing within 15 days of receiving the Benefits schedule, Certificate of insurance and Handbook, or the date of joining, whichever is later. You must return the Certificate of insurance when you cancel the plan. If the Aetna Pioneer plan is cancelled all Member ID Cards must also be returned. The Member ID Cards for any female members on the Aetna Maternity plan must be returned if the add-on plan is cancelled. See the 'Cooling-off period' section in the Handbook for full details.

K. Broker details

Broker's or advisor's details if applicable

Aetna does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to www.AetnaInternational.com.

If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Asset Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Notice to United Kingdom residents: In the UK, Aetna Insurance Company Limited (FRN 458505) has issued and approved this communication.

Notice to all: Please visit http://www.aetnainternational.com/ai/en/about-us/legal/regional-entities for more information, including a list of relevant entities permitted to carry on or administer insurance business in their respective jurisdictions.

Important: This is a non-US insurance product that does not comply with the US Patient Protection and Affordable Care Act (PPACA). This product may not qualify as minimum essential coverage (MEC), and therefore may not satisfy the requirements, if applicable to you and your dependants, of the Individual Shared Responsibility Provision (individual mandate) of PPACA. Failure to maintain MEC can result in US tax exposure. You may wish to consult with your legal, tax or other professional advisor for further information. This is only applicable to certain eligible US taxpayers.

Please read carefully the disclaimers at the end of the form.

Please retain a copy for your records.

Direct debit mandate

Instruction to your bank or building society to pay by direct debit

Originator's Identification:

We offer direct debit as an alternative form of payment to all planholders who take out a plan in GB pounds and currently hold a UK bank or building society account. If you would like to take advantage of this facility for your regular payments, please fill in the form below.

We must receive the original of this form in order to set up your direct debit payments as banks will not accept copies.

Please fill in this form in BLOCK CAPITALS and send it to:

Aetna Insurance Company Limited,
25 Templer Avenue, IQ Farnborough, Farnborough,
Hampshire, GU14 6FE, United Kingdom.

Quotation number and option number if you have one	and/or Plan number	Reference number (for Aetna's use only)

Name and full postal address of your bank or building society	Name(s) of account holder(s)
To: **The Manager** Bank or building society name: _____ Address: _____ _____ _____ Postcode: _____	

If you are not the planholder, describe your relationship to the planholder

Bank or building society account number	Branch sort code

Instruction to your bank or building society

Please pay Aetna Insurance Company Limited direct debits from the account detailed in this instruction subject to the safeguards assured by the Direct Debit Guarantee.

I understand that this instruction may remain with Aetna Insurance Company Limited and, if so, details will be passed electronically to my bank or building society.

Signature(s)	Date (dd/mm/yyyy)

Banks and building societies may not accept direct debit instructions for some types of accounts.

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The Direct Debit Guarantee

This Guarantee should be detached and retained by the Payer.

- This Guarantee is offered by all banks and building societies that take part in the direct debit scheme. The efficiency and security of the scheme is monitored and protected by your own bank or building society.
- If the amounts to be paid or the payment dates change Aetna Insurance Company Limited will notify you 10 working days in advance of your account being debited or as otherwise agreed. If you request Aetna Insurance Company Limited to collect payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made by Aetna Insurance Company Limited or your bank or building society you are guaranteed a full and immediate refund from your branch of the amount paid.
- If you receive a refund you are not entitled to, you must pay it back when Aetna Insurance Company Limited asks you to.
- You can cancel a direct debit at any time by writing to your bank or building society. Please also send a copy of your letter to us.

Card authority
We are committed to safeguarding your personal data. Your payment details will be processed securely in accordance with our strict safety procedures and relevant legislation. We can accept card payments by Visa, MasterCard or American Express. There are three ways to pay by card:

1. Fill in the Card authority below in full and fax the application to: +44(0) 1252 745 928.
2. Fill in the Card authority below in full and post.
3. Call us to make a payment by telephone. You do not need to fill in this form.

Please do not send your card details to us by email. E-mail and internet messages cannot be guaranteed to be completely secure and can be intercepted, lost or stolen**.** We will not process card payments sent by email**.**

To Aetna Insurance Company Limited Please fill in in BLOCK CAPITALS**.**

Quotation number and option number if you have one		and/or Plan number
Name(s) (as shown on your card)		
If you are not the planholder, describe your relationship to the planholder		
My card billing address is		Postcode
Please tick the appropriate box ☐ **Visa** ☐ **MasterCard** ☐ **American Express**		My card number is
Issue date	Expiry date	Card security code

For your safety and security and to facilitate the processing of your payment, we require that you enter your card's verification number (card security code). The verification number is the last three digits of the number printed on the signature strip on the back of your card.

Your card details will be held and processed in accordance with strict data security regulations and guidelines which we adhere to. Once your payments have been initiated this number will be destroyed by us.

Please charge the above card (please tick)

☐ **Yearly** ☐ **Every three months** ☐ **Every month**

☐ **USD ($)** ☐ **GBP (£)** ☐ **EUR (€)**

I hereby authorise the Card Account specified above to be debited with the current premium due, and all subsequent renewal premiums and other charges due as notified by Aetna Insurance Company Limited until I give notice in writing that I wish to withdraw my authorisation. I understand that Aetna Insurance Company Limited will give at least 4 weeks' notice of renewal, and that the premiums may vary each year. I understand that Aetna Insurance Company Limited cannot be held liable if my plan lapses as a result of the card being declined and I have not provided or responded to requests for alternative methods of payment.

Cardholder's signature(s)	Date (dd/mm/yyyy)