



# International Healthcare Plan – Application for Agency Facilities

Aetna Global Benefits®

Please return this completed form to **Us** or **Your** agent.

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## A. Agency Facilities Detail

1a. Agency Trading Name		1b. Company Number
1c. Full Company Name		
2a. Company Address		Zip/Postal Code
Telephone	Fax	Email Address
2b. Registered Address (if different from above)		Zip/Postal Code
Telephone	Fax	Email Address
3. Occupational/Nature of Business		
4. Is <b>Your</b> agency:		
a) authorised and regulated by any regulatory authority? If Yes, please provide:		
i) date of registration (Day/Month/Year): _____		
ii) name of authorising body and registration number: _____		
If No, please state if: i) an application is pending: _____		
ii) an application has not been made: _____		
b) a member or registered with any official insurance institution? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please name institution. _____		
c) or has it been subject to any regulatory enforcement action? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
5. a) How many years has <b>Your</b> organisation been established? _____		
b) Please provide the full name and address of <b>Your</b> agency's ultimate holding company:		
_____		
_____		
_____		
c) Has <b>Your</b> agency enforced documented policies and procedures for all of it's activities? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
d) Is <b>Your</b> agency registered with it's regional data privacy registrar? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please state it's number: _____		
e) Is <b>Your</b> agency, it's contractors, sub agents or customers connected to a government agency?... <input type="checkbox"/> Yes <input type="checkbox"/> No		
f) Does <b>Your</b> agency have enforced procedures to prevent inducements being offered or received to generate business by it, it's staff or associates? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
g) How many employees including executive directors? _____		
h) How many individuals are actively selling international medical insurance in <b>Your</b> organisation? _____		

*continued*

### Please Retain a Copy for Your Records

Policies are issued and underwritten or reinsured in Europe by Aetna Health Insurance Company of Europe, Limited, Aetna Life & Casualty (Bermuda) Ltd. and issued and administered by Aetna Global Benefits (Europe) Limited, an Aetna Company and regulated by the Financial Services Authority. Registered address: 76 Shoe Lane, London EC4A 3JB. Registered in England & Wales. Registered No. 04548434.



**A. Agency Facilities Detail (Continued)**

8. Do **You** have professional indemnity cover? .....  Yes  No  
 If Yes, please send a copy of **Your** certificate, which should state:

a) With Whom: \_\_\_\_\_  
 b) Certificate Number: \_\_\_\_\_  
 c) Limit of Indemnity: \_\_\_\_\_  
 d) **Excess** Level, if any: \_\_\_\_\_

9. a) The annual written premium income for **Your** private medical insurance portfolio is in the range (check applicable premium):  
 i)  US\$ 0m - US\$ 0.5m  
 ii)  US\$ 0.5m - US\$ 1m  
 iii)  US\$ 1m - US\$ 5m  
 iv)  US\$ 5m - US\$ 10m  
 v)  US\$ 10m +

b) The approximate breakdown in percentage terms or **Your** international medical insurance portfolio is (write in applicable percentage):  
 i) \_\_\_\_\_% Individual Business  
 ii) \_\_\_\_\_% Company Paid Small Group Business  
 iii) \_\_\_\_\_% Company Paid Large Group Business  
 iv) \_\_\_\_\_% Optional Group Business  
 v) \_\_\_\_\_% Groups in "Trust"

10. Please give the name and address of three other Insurers with whom **You** have agency facilities in respect of private medical insurance (and from whom **We** will take references), the date from which they become effective and **Your** approximate premium income with each of them.

a) Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Date (Day/Month/Year): \_\_\_\_\_  
 Written Premium: \_\_\_\_\_

b) Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Date (Day/Month/Year): \_\_\_\_\_  
 Written Premium: \_\_\_\_\_

a) Name: \_\_\_\_\_ Address: \_\_\_\_\_  
 Date (Day/Month/Year): \_\_\_\_\_  
 Written Premium: \_\_\_\_\_

11. Have agency or collection facilities ever been refused or withdrawn? .....  Yes  No  
 If Yes, by whom and for what reason:  
 \_\_\_\_\_  
 \_\_\_\_\_

**B. Bank Details (Completion is optional\*)**

12. Bank Sort Code: \_\_\_\_\_ Bank Address: \_\_\_\_\_  
 Bank Account Number: \_\_\_\_\_  
 Bank Name: \_\_\_\_\_  
 Bank Telephone: \_\_\_\_\_ Bank Fax Number: \_\_\_\_\_

\* Aetna Global Benefits has facility to direct credit commissions payable to **Your** Bank Account.

13. If available, please supply a copy of **Your** corporate brochure explaining the nature and scope of **Your** operations.

**C. Declaration**

I/**We** apply for an appointment to represent Aetna Global Benefits as an Agent. I/**We** agree that, if this application is accepted, the appointment shall be governed by the terms of Aetna Global Benefits (including acceptance of the terms of it's agency agreement) in accordance with FSA regulations.

I/**We** understand that references will be sought for My/**Our** application and to My/**Our** best knowledge and belief the above details are true and accurate. Any attempt to mislead or supply false information to Aetna Global Benefits will result in the voiding of the application/agency.

Applicant's Signature	Position in Organisation	Date (Day/Month/Year)
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