

(effective 1st September 2007)

GOODHEALTHSM
An Aetna Company

Agent/Broker Name and Stamp



SWISS-SURE
COMPANY LIMITED

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18 Wing Lok St.,
Central, Hong Kong
Tel:2543 8428 Fax:2541 8147
E-mail:info@swiss-sure.com.hk
www.swiss-sure.com

CIB Member of "The Hong Kong Confederation of Insurance Brokers"

Please read through the following before completing this application and complete in BLOCK CAPITALS.

All information supplied will be treated in strict confidence. **You** must disclose all material facts. Failure to do so may invalidate the **Policy**. A material fact is one which is likely to influence the assessment and acceptance of this application. If **You** are in any doubt whether a fact is material it should be disclosed.

As the applicant **You** should answer all the questions and sign the declaration on behalf of all persons included in this application. A copy of this application can be supplied to **You** on request within three months of completion. **You** should keep a record of all information (including copies of all letters) supplied to **Us** for the purpose of entering into this contract.

1. Details of Applicant (First Person)

Family Name:																									
First Name(s):																			Title:						
Marital Status:				M/F:		Date of Birth:	day	month	year	Height:	m/ft	Weight:	kg/lb												
Industry:																									
Occupation:																									
Nationality:																									
Country of Residence:																									

Residential Address:													Correspondence Address:												
Town/City:													Town/City:												
Country/State:													Country/State:												
Postcode:													Postcode:												

Home Telephone:													Business Telephone:												
Mobile:													Fax:												
Home Email:													Business Email:												

2. Dependant's Details

Please note children to be included under this plan must be under 18 years of age, or 23 years or under if they are in full time education and are fully dependant upon You.

Dependant 1												
Family Name:												
First Name(s):												
Other Initials:			Title:			Sex:	M/F		Height:	m/ft	Weight:	kg/lb
Relationship to Applicant:						Date of Birth:	day	month	year			
Occupation:												
Nationality:												

Dependant 2												
Family Name:												
First Name(s):												
Other Initials:			Title:			Sex:	M/F		Height:	m/ft	Weight:	kg/lb
Relationship to Applicant:						Date of Birth:	day	month	year			
Occupation:												
Nationality:												

Dependant 3												
Family Name:												
First Name(s):												
Other Initials:			Title:			Sex:	M/F		Height:	m/ft	Weight:	kg/lb
Relationship to Applicant:						Date of Birth:	day	month	year			
Occupation:												
Nationality:												

Dependant 4												
Family Name:												
First Name(s):												
Other Initials:			Title:			Sex:	M/F		Height:	m/ft	Weight:	kg/lb
Relationship to Applicant:						Date of Birth:	day	month	year			
Occupation:												
Nationality:												

If You have any further Dependents please provide details on a separate sheet.

3. Commencement Date

Subject always to Section 9 of this application form, the Commencement Date of this Policy will be the date on which this application is accepted in writing by Us. If You wish Your cover to start later, please indicate below.

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									
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4. Product Options

This plan enables **You** to choose various options to suit **Your** personal requirements. Please clearly tick the option **You** have selected. **Your Policy** will be issued on this basis.

The table below is for guidance only, please refer to the full **Benefit Schedule** and **Policy Wording** for a detailed description of the **Benefits** of each plan option.

Benefits	Major Medical OPTION 001	Foundation OPTION 002	Lifestyle OPTION 003	Lifestyle Plus OPTION 004
Standard Excess	NIL	\$100	\$100	\$100
Maximum Benefit per Insured Person per Period of Cover	\$1,600,000	\$1,600,000	\$1,600,000	\$1,600,000
In-Patient and Day-Patient care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Oncology, CT and MRI scans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Complications of Pregnancy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Parent Accommodation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Evacuation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Out-Patient care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Emergency Dental Treatment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Daily Hospital Cash Benefit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
AIDS/HIV	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Extended Evacuation	optional	optional	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Routine Management of Chronic Conditions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Routine Pregnancy and Childbirth	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Routine and restorative dental care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Your Selection – please tick Your choice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALL limits and Excesses expressed in \$ shall in all instances mean US\$. Full Refund Subject to Limits No Cover

Excess Options - Please select where **You** wish to change from the standard Excess applicable by ticking the appropriate box.

	Standard	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nil	Standard	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
\$50	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
\$250	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
\$500	N/A	<input type="checkbox"/>	N/A	N/A
\$1,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
\$2,000	N/A	<input type="checkbox"/>	N/A	N/A
\$5,000	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A

Additional Options - Please tick **Your** choices.

USA Elective Treatment - [005]	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Semi-Private Room Restriction - [006] <i>Only available to residents of Hong Kong.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
China Private Room Restriction - [007] <i>Only available to residents of mainland China.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Direct Settlement Network - [008] <i>Only available with standard Excess. Available in certain countries. Please check with Your local sales centre.</i>	N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Extended Evacuation - [009]	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
Medical History Disregarded - [010] <i>Only available to compulsory group schemes of 10 employees or more.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Extension to Lifestyle Plus - [011] <i>Only available to compulsory group schemes of five employees or more.</i>	N/A	N/A	N/A	<input type="checkbox"/>

5. Premium Payment

Tick which payment method and payment frequency **You** require and complete all details relevant to that method.

a) **Cheque Payment (annual only)**. All cheques must be payable to "Goodhealth Worldwide (Asia Pacific) Limited". Please ensure that the name of the applicant, (as declared in Section 1 of this form) is clearly stated on the reverse of the cheque. We will only accept US Dollar or Hong Kong Dollar cheques drawn on a Hong Kong Bank.

b) **Bank Transfer (annual only)**. Please ensure the name of the applicant (as declared in Section 1 of this form) is clearly stated on any transfer. Our bank details for bank transfer are available on request by contacting the Hong Kong office:
We cannot accept liability for any bank transfer which does not clearly identify the applicant.

c) **Credit Card (annual and monthly)**. VISA* MasterCard AMEX (annual only)
(Monthly payment options are for VISA and MasterCards only)

Credit Card Number:	<input type="text"/>	Expiry Date:	<input type="text"/>	<input type="text"/>
Cardholder's Name:	<input type="text"/>	month	year	<input type="text"/>
Cardholder's Statement Address:	<input type="text"/>			
Currency of Payment:	US\$ <input type="checkbox"/>	HK\$	<input type="checkbox"/>	
Cardholder's Authorisation Signature:	<input type="text"/>	Date:	day <input type="text"/>	month <input type="text"/>
			year	<input type="text"/>

*If paying by monthly credit card please complete the Recurring Transaction Authority.

For payment method by c, please note **Your** premium will be collected on receipt of this application, which may be in advance of the **Commencement Date**. If **You** opt for the monthly payment plan, **We** may in some circumstances, debit two month's premium in **Your** first month. This is dependent on what time of the month **Your** billing takes place.

6. Medical Practitioner Details

Please give the details, including name, address and qualifications of **Your** usual **Medical Practitioner**, and in respect of anyone else included in this application.

Please use a separate sheet if this space is insufficient.

7. Pre-existing Condition(s)

Benefits will not be available for any **Medical Condition** or **Related Condition** for which **You** have received medical **Treatment**, had symptoms of, or to the best of **Your** knowledge existed, or sought **Advice** prior to **Your Date of Entry**, until two consecutive years have elapsed, after the **Date of Entry**, during which no **Treatment** or **Advice** was given in respect of that **Medical Condition** or any **Related Medical Condition**.

8. Medical Questionnaire

Please reply to the following questions by ticking Yes or No. Where **You** have ticked Yes, please provide details.

	Yes	No
a) Have You , or anyone included in this application, been admitted to Hospital or other similar establishment in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
b) Have You , or anyone included in this application, been prescribed with a course of any drugs or medication, or Treatments for a period in excess of seven days in the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
c) Have You , or anyone included in 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?	<input type="checkbox"/>	<input type="checkbox"/>
d) Are You , or anyone included in this application, suffering from any disability, abnormality, recurrent illness, major illness or injury, not already noted above?	<input type="checkbox"/>	<input type="checkbox"/>

Please use this space to provide any additional information, or a separate sheet of paper if there is insufficient space:

9. Declaration

I understand and accept Section 7 on Pre-existing Condition(s).

I declare that the answers given are to the best of my knowledge full, true and complete and have checked and found correct any answers and statements in this application that are not in my own handwriting.

I have declared all material facts which relate to this application.

I declare that I have read and understand the documents, '*Policy Wording*' and '*Benefit Schedule*' and agree to accept and conform to the terms of the **Policy**, unless I cancel this **Policy** within 15 days from the **Commencement Date**. I am satisfied that the product selected meets my requirements at this time.

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 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, or their representatives, with any and all information in respect of such attendance and any known medical history.

I agree that where **Medical Treatment** is received within the **Provider Network** by myself or any of my **Dependants** and it is substantiated that the **Treatment** or **Medical Condition** is not refundable within the terms and conditions of the **Policy**, that I, as the **Policyholder**, shall be fully responsible for reimbursement to Goodhealth within 14 days of receipt of notice of such non-refundability of all funds expended in connection with any claim for such **medical Treatment**.

I understand and confirm that where I have not made repayment of funds disbursed by Goodhealth in respect of such **medical Treatment** not covered by the **Policy**, the **Policy** shall be suspended until the date of my full settlement of all outstanding amounts due from me to Goodhealth and in the event that funds so due from me to Goodhealth have been outstanding and unpaid for a period in excess of 14 days exclusion 1 of the **Policy Wording** shall be re-applied to the **Policy** with effect from the date of full receipt by Goodhealth of the funds concerned in which event any suspension of the **Policy** pursuant to this subclause shall be lifted with effect from such full receipt date. In no event shall any claim for **Treatment** received during the period of suspension be made or met.

I further accept that where funds have been outstanding to Goodhealth for a period in excess of 15 days from notification, my **Policy** will be cancelled void ab initio, without refund of premium.

Signature of applicant:

Date:

day	month	year
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10. Recurring Transaction Authority

Please complete parts 1 to 5 to authorise Us to claim payments directly from Your VISA, AMEX or MasterCard account.

Please return the completed form to:
Goodhealth Worldwide (Asia Pacific) Limited
3204A, Tower 1
Admiralty Centre
18 Harcourt Road
Hong Kong

1. Name of Policyholder:	<input type="text"/>		
2. Name of Cardholder (as shown on card):	<input type="text"/>		
3. Full Address of Cardholder:	<input type="text"/>		
	<input type="text"/>		<input type="text"/>
	Postcode:	Telephone:	
4. Full VISA, AMEX or MasterCard Account Number:	<input type="text"/>	<input type="text"/>	Expiry Date: <input type="text"/>
5. Your authority to Goodhealth Worldwide to claim amounts due from Your VISA, AMEX or MasterCard account and signature:			
I authorise you to charge to my * <input type="text"/> unspecified amount in respect of medical insurance premiums as and when they become due.			
I understand that Goodhealth Worldwide will advise me of the amount to be paid and the dates on which payment is due and that Goodhealth Worldwide may only change these after giving me prior notice. I agree to settle my premium in advance of receiving my Policy documents and cover.			
I understand that this authority in favour of Goodhealth Worldwide will remain in force until such a time as I cancel it in writing/email instruction to Goodhealth Worldwide.			
Signature:	<input type="text"/>		Date: <input type="text"/>
			day month year
Email (where signing online)	<input type="text"/>		

* Please insert the relevant card name

Contact Details

Goodhealth Worldwide (Asia Pacific) Limited

3204A, Tower 1 TF +800 624 81000**
Admiralty Centre T +852 2104 7486
18 Harcourt Road F +852 2147 9960
Hong Kong E enquiries@goodhealth.com.hk

** Toll free number for Goodhealth Worldwide (Asia Pacific) Limited +800 624 81000 will operate from Australia, Hong Kong, Japan, New Zealand, Philippines, South Korea and Thailand.
If You are calling from another location please dial +852 2104 7486.



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