AIA SINGAPORE
Change of Insured for Platinum Legacy/Platinum Wealth Elite

Particulars of Insured and Policy Owner/Trustee/Assignee

Name of Insured

NRIC/Passport/FIN No.

Name of Policy Owner/Trustee/Assignee *(if different from Insured)*

NRIC/Passport/FIN/Entity Registration No

Name of Trustee *(if any)*

NRIC/Passport/FIN No.

Policy Number

1 DETAILS OF PROPOSED INSURED

Name (shown on NRIC/FIN/Passport):

Date of Birth: dd mm yyyy

Gender: ☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married
☐ Widowed / Divorced / Separated

Residency Status:
☐ Singapore Citizen ☐ Singapore PR
☐ Pass Holders ☐ Others

NRIC/FIN/Passport No.:

Country of Residence:

Current Residence Address -

Postal Code:

Occupation:

Company Name:

Exact Duties (please provide in details):

Contact Details

Home: ________ – ________ – ____________
Country Code Area Code Home Number

Mobile: ________ – ________ – ____________
Country Code Area Code Mobile Number

Office: ________ – ________ – ____________
Country Code Area Code Office Number

Email:

Nature of Business:

Citizenship:

Company Address:

Postal Code:

Place of Birth:

Foreign Permanent Residence Address - Please provide the full address in English.
Compulsory for non-Singaporeans (including Singapore PR). Please indicate "Nil or NA" if not applicable. Do not leave this blank.
For Passers-by, please submit copy of passport or foreign identification card that shows proof of this address.
If the address on the document(s) differs from this address, please explain the reason(s) in writing.

Postal Code:

Relationship of Owner to Proposed Insured:

☐ Spouse ☐ Parent

NOTE: APPLICABLE FOR NON-ENTITY APPLICATION

Annual Income ☐ US$ ☐ S$

☐ ≤ 30,000 ☐ 30,001 – 50,000 ☐ 50,001 – 100,000 ☐ 100,001 – 150,000 ☐ 150,001 – 300,000 ☐ > 300,000

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2 DETAILS OF POLITICALLY EXPOSED PERSON

Are you a Politically Exposed Person (PEP) or related to a PEP?
If Yes, please complete 2a to 2e.

☐ Yes ☐ No

a. What is the name of the Politically Exposed Person?

b. What is your relationship to the Politically Exposed Person?

c. What official position does the Politically Exposed Person hold?

d. In which country is/was the position held?

e. During what time period was the position held? Starting Year ______________Ending Year______________

* PEP means an individual who is or has been entrusted with prominent public functions in Singapore, a foreign country or an international organisation, which includes the roles held by a head of state, a head of government, government ministers, senior civil or public servants, senior judicial or military officials, senior executives of state owned corporations, senior political party officials, members of the legislature and senior management of international organisations.
By "related", we mean that you, the insured, beneficiary or beneficial owner are closely connected to a PEP either socially or professionally, or are a parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling and adopted sibling of a PEP.

3 DETAILS OF PREVIOUS, CONCURRENT INSURANCE APPLICATIONS AND PURSUITS OF PROPOSED INSURED

3.1 a. Are there any existing and/or concurrent applications?
☐ No ☐ Yes - Please complete Q3.1b and provide details of existing and/or concurrent applications in Q3.2.

b. Please provide the total amount of life insurance coverage that you intend to incept with all companies (including this application).
Currency: _________ Amount: _________

3.2 Please provide details of the Proposed Insured's total inforce and concurrent life insurance policies.
Your total coverage, including previous and concurrent applications within AIA and with other insurers, is an important and material fact which the Company uses to assess this policy.

	Policy 1	**Policy 2**	**Policy 3**	**Policy 4**	**Policy 5**
Insurance Company					
Country of Insurance Company	☐ Singapore ☐ Non-Singapore	☐ Singapore ☐ Non-Singapore	☐ Singapore ☐ Non-Singapore	☐ Singapore ☐ Non-Singapore	☐ Singapore ☐ Non-Singapore
Death (Sum Assured US$/S$)					
Total & Permanent Disability					
Disability Income					
Critical Illness					
Long Term Care					
Year Issued/Pending					

3.3 Is any application for or reinstatement of your life, critical illness, accidental, medical, disability or health-related insurance policy pending or has it ever been declined, postponed, rated or modified in any way?
☐ No ☐ Yes – Please indicate company, benefit type, reason, year of submission

3.4 Are you now a member of a military force (except NS men), are you contemplating or have you, in the last 5 years engaged in any private flying or hazardous sports or races or flying other than as a fare paying passenger on a regular scheduled airline?
☐ No ☐ Yes – Please give details:

4 LIFESTYLE QUESTIONS

4.1 Have you ever smoked any forms of tobacco? ☐ No ☐ Yes	If currently smoking, please state: Type of tobacco: Cigarettes/Cigars/Pipe/ Others:__________________ No. of sticks per day: ________________________	If former smoker, please state: When was the last time you smoked: __________ Type of tobacco: Cigarettes/Cigars/Pipe/ Others:__________________ No. of sticks per day: ________________________

4.2 Do you drink alcohol? ☐ No ☐ Yes	How many glasses of alcohol do you consume every week?	Beer cans (330ml)	Wine glasses (100ml)	Spirits tots (30ml)

4.3 In the last 12 months, do you travel or live outside your country of residence for more than **a total of 14 days** in a year? If so, please provide the following information: ☐ No ☐ Yes

Countries/Cities	Duration of each trip	Frequency (p.a.)	Purpose of travel (Business, Residence, Emigration, others, please specify)

4.4 Do you anticipate the pattern or frequency of travel will change substantially over the next 24 months? If yes, please provide the following information: ☐ No ☐ Yes

Countries/Cities	Duration of each trip	Frequency (p.a.)	Purpose of travel

4.5 Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, cardiomyopathy, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? ☐ Yes ☐ No

If yes, please provide details below.

Family Member	Current Age	State of Health and Nature of Condition (If cancer, please include type)	Age at Onset	Cause of Death (if applicable)	Age of Death (if applicable)
Mother					
Father					
Brothers					
Sisters					

4.6 In the past 5 years, have you had any (other than for immunisation or vaccination)

a. of the following tests done? If yes, please give details as indicated below. ☐ Yes ☐ No

Test	Date	Reason	Results	Test	Date	Reason	Results
a. Blood Test				g. Mammogram			
b. Biopsy				h. PAP Smear			
c. Chest X-Ray				i. Ultrasound			
d. CT Scan / MRI				j. Urine			
e. ECGs				k. Others. Please specify ______________			
f. Heart Scan (CT angiogram)							

b. illness, operation, medical advice, investigations or hospital treatment not mentioned above? ☐ Yes ☐ No
If yes, please provide details:

FOR SINGAPOREAN AND SINGAPORE RESIDENTS: Where your total insurance coverage under all policies issued by insurers in Singapore (including this and concurrent insurance application), you are required to disclose the predictive genetic test results for Huntington's disease ONLY if your total coverage for death exceeds SGD2,000,000; or Total & Permanent Disability exceeds SGD2,000,000; or your Long Term Care monthly benefit exceeds SGD3,000. You will need to disclose your test results for Huntington's disease and/or breast cancer (BRCA I & II) ONLY if your total coverage for Critical Illness exceeds SGD500,000 or Monthly Disability income exceeds SGD10,000. If you choose to voluntarily disclose the results of any predictive genetic tests, the Company will only utilise the favourable test results in its assessment. FOR NON SINGAPORE RESIDENTS: You are required to disclose your genetic tests results. FOR ALL APPLICANTS: You are not required to disclose results if genetic tests are done for biomedical research.

5 DETAILS OF ALL FAMILY MEMBERS AND ANY INSURANCE (IN-FORCE OR APPLIED) ON EACH LIFE (FOR JUVENILE AND STUDENTS ONLY)

Relationship to Proposed Insured	Age	Insuring Company	Amount of Life Insurance Cover (US$/S$)
Father			
Mother			
Sibling(s)			
Sibling(s)			
Sibling(s)			
Payor if other than a family member (legal guardian)			

5.1 Do all brothers and sisters have similar existing cover or are currently being proposed for cover?
☐ Yes ☐ No – please state reason:

6 HEALTH DETAILS OF PROPOSED INSURED OF AGE 15 AND BELOW

6.1 a. Height (metres):

b. Weight (kilograms):

c. Was there any weight change in the past year? ☐ Yes ☐ No
If yes, how much and state the reason:

d. Name and Address of the Proposed Insured's Regular Doctor:

e. When did you last consult a doctor? Please provide reason, name of clinic (if differs from 6.1.d) and result of the last consultation:

6.2 Is the child contemplating a trip or had been outside Singapore for a total of more than 90 days in a year, other than for leisure or social purposes? ☐ Yes ☐ No

If yes, please give details.

Country & Cities visited	Frequency per year	Duration per trip
		mth(s)

6.3 Has the child received medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition, been told the child has any of these; or that the child had HIV testing done OR in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions? ☐ Yes ☐ No

6.4 To the best of your knowledge and belief, has any member of the child's immediate family ever had tuberculosis, diabetes, cancer, cardiomyopathy, polycystic disease, mental disease or any AIDS related condition? ☐ Yes ☐ No

Relationship	Age at Onset	Current Age	Illness/Age at Death (if deceased)

6.5 Has the child ever had, or have been told or been treated for:

a. any respiratory disease, prolonged cough, bronchitis, asthma, fits, epilepsy or disorder affecting the nervous system? ☐ Yes ☐ No

b. any heart disorder, blood disorder, diabetes, endocrine disorder, liver disease or any gastrointestinal disorder, kidney problems, nephritis or abnormality of the genitourinary system? ☐ Yes ☐ No

c. condition affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any cancer, growth, tumor? ☐ Yes ☐ No

7 HEALTH DETAILS OF PROPOSED INSURED

7.1 a. Height (metres):

b. Weight (kilograms):

c. Was there any weight change in the past year? ☐ Yes ☐ No
If yes, how much and state the reason:

d. Name and Address of the Proposed Insured's Regular Doctor:

e. When did you last consult a doctor? Please provide reason, name of clinic (if differs from 7.1.d) and result of the last consultation:

7.2 Have you ever used any habit forming drugs or narcotics or been treated for drug habits or consumed alcohol excessively or been treated for alcoholism? ☐ Yes ☐ No

7.3 Have you ever had or been told to have or been treated for:

a. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders? ☐ Yes ☐ No

b. diabetes, thyroid disorders or any other endocrine disorders? ☐ Yes ☐ No

c. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat? ☐ Yes ☐ No

d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/ discomfort or any other lung disorders? ☐ Yes ☐ No

e. raised cholesterol, high blood pressure, heart attack, heart murmur, cardiomyopathy, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels? ☐ Yes ☐ No

f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders? ☐ Yes ☐ No

g. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder? ☐ Yes ☐ No

h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs? ☐ Yes ☐ No

i. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury? ☐ Yes ☐ No

j. cancer, tumours, cysts or growths of any kind? ☐ Yes ☐ No

k. anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason? ☐ Yes ☐ No

l. any other illness, disorder, operation, physical disability or accident not mentioned above? ☐ Yes ☐ No

7.4 Are you awaiting or intending to have any medical consultations, investigations or treatment; or experiencing any symptoms that might cause you to seek medical treatment in the near future? ☐ Yes ☐ No

7.5 Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition? ☐ Yes ☐ No

7.6 a. Have you ever had HIV testing done? ☐ Yes ☐ No

If yes, please state reason, date and results:

b. In the last 3 months have you had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions? ☐ Yes ☐ No

If yes, please state reason, date and results:

7.7 FEMALE ONLY

a. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts? ☐ Yes ☐ No

b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs? ☐ Yes ☐ No

c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months? ☐ Yes ☐ No

d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available). ☐ Yes ☐ No

e. Are you now pregnant? If yes, please indicate: ☐ Yes ☐ No

i) Expected delivery date: dd mm yyyy

ii) When was the last time you visited the doctor: dd mm yyyy

iii) Has there been any complication(s) relating to this and/or previous pregnancies? Please tick:

☐ No complication ☐ Gestational diabetes ☐ Caesarian section ☐ Eclampsia ☐ Hypertension
☐ Diabetes ☐ Thrombosis ☐ Miscarriage ☐ Others (please specify):

8 REMARKS

REMARKS In connection with insurance applied for, if any answer to question 6 and 7 is "Yes", give details below, quoting the relevant question number(s).

9 DECLARATION

1. **RESIDENCY** – Please answer according to your Citizenship/Residency that you are holding.	Proposed Insured	
	Yes	**No**
A. For Singapore Citizen A.1 Have you resided outside of Singapore continuously for at least 5 years preceding the date of Application? A.2 Are you currently residing in Singapore?	☐ ☐	☐ ☐
B. For Singapore Permanent Resident & employment pass, work permit, dependant pass or other work pass holders Have you resided in Singapore for a total of less than 183 days in the 12 months preceding the date of Application?	☐	☐
C. For student pass or long term visit pass holders C.1 Does your pass have a duration of less than 90 days? C.2 Have you resided in Singapore continuously for less than 90 days during the 12 months preceding the date of Application?	☐ ☐	☐ ☐
D. If you do not belong to any of the above categories, please tick here	☐	

10 DECLARATION AND AUTHORISATION

1. I hereby request that the policy(ies) stated in this form be changed in accordance with the above application.

2. I understand and agree that no application is valid until this Change Form is received by AIA Singapore Private Limited ("AIA Singapore") during the life time of the Insured and is finally accepted by AIA Singapore.

3. I understand and agree that application shall not be considered as effected by reason of any money paid or settlement made in payment of, or on account of any premium, until this form has been duly approved by the authorised Officer of AIA Singapore.

4. I/We understand and agree that the coverage for new life insured will only take effect after the application is approved by AIA Singapore. Once the coverage for new life insured commences, coverage on original life insured will be automatically terminated. If the application is rejected, coverage on original life insured will remain.

5. I/We have received a copy of Policy Illustration - Change of Insured, the contents of which have been explained to me/us to my/our satisfaction.

6. I confirm that the above answers, given by me, are full, complete and true and agree that they form part of any policy issued, reinstated or amended, where these answers are, or may be, relied upon by AIA Singapore.

7. I understand and agree that the application of the Contracts (Rights of Third Parties) Act (Cap.53B) and any subsequent revision or replacement thereof is expressly excluded insofar as my policy is concerned.

8. I/We hereby authorise, agree and consent to AIA Singapore, its associated persons/organisations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "AIA Persons") to collect, use, disclose, store, retain and/or process (collectively, "Use") all personal data and information ("Personal Data") that had/has been provided to AIA Persons and/or that AIA Persons possess about me/us (whether from me/us or a third party), in the manner and for the purposes described in the AIA Personal Data Policy ("PD Policy"), including but not limited to, processing of this Application/form and/or to provide subsequent advice or services to me/us in relation to this Application/Policy/form/AIA Vitality Programme and/or any other existing or future policy/policies/ programmes that I/we may hold/participate with AIA Singapore. Without prejudice to the foregoing, I/we agree to comply with the terms of the PD Policy, including where such PD Policy is amended from time to time by AIA Singapore in accordance with its terms. Where Personal Data of another person is disclosed by me/us, I/we represent and warrant that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws: (i) to collect such Personal Data; (ii) to disclose such Personal Data to the AIA Persons; and (iii) for the AIA Persons to Use such Personal Data in the manner and for the purposes described in the PD Policy. I/We hereby specifically waive (on our own behalf and on behalf of each such other person, and I/we represent and warrant that such other person has granted me/us authority to so waive) any right to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of Personal Data in the nature of or for any of the purposes described above or in the PD Policy. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application/form is accepted by AIA Singapore. A photocopy of this authorisation shall be valid and effective as the original.

Warning: If a material fact is not disclosed in this application form, any application may not be valid. If you are in doubt as whether a fact is material, you are advised to disclose it. This includes any information that you may have provived to the Financial Service Consultant/Insurance representative but was not included in this application, Please check to ensure you are fully satisfied with the information declared in this application. Additionally and without prejudice to the parties[1] right and abligations whether under law or otherwise, following the submission of your application, you must continue to diclose any and all material facts that may arise or which have changed from the information you had provided.

Signature of New Insured

Date

Signature of Policyowner*/Trustee/Assignee

Date

* Contact No. :

If different from Insured

Signature of Trustee (*if any*)

Date

* Contact No. :

*** We will call you at this number if we need any clarifications regarding your request. This contact number will not be updated into our records. If you wish to update your contact details, please complete the Update of Address & Contact Details form.**

FSC/IR'S Name	FSC/IR's Code	FSC/IR's Unit Name	Mobile No.

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