Corporate Solutions
3 Tampines Grande, AIA Tampines #07-00, Singapore 528799

AIA Premier International Medical Member Enrolment Form

WARNING : In accordance with Section 25(5) of the Insurance Act Cap.142, as may be amended from time to time, you are to fully and faithfully disclose in this Application Form all facts which you know, or ought to know, failing which you may receive nothing from the policy and/or the policy issued may be void.

POLICY INFORMATION

Policy Number	**Name of Company**

EMPLOYEE'S INFORMATION

Full Name (According to NRIC/Passport/FIN Number) – Please underline Surname

NRIC/Passport/FIN Number	**Nationality**

Residential Address

Gender	**Marital Status**			**Date of Birth (DD/MM/YYYY)**
☐ Male	☐ Single	☐ Married	☐ Separated	
☐ Female	☐ Divorced	☐ Widowed		

Height	cm	**Contact Number (Mobile)**
Weight	kg	

Email Address

Occupation

SPOUSE'S INFORMATION							
Full Name (According to NRIC/ Passport/FIN Number)	**NRIC/Passport /FIN Number**	**Nationality**	**Occupation**	**Gender**	**Date of Birth (DD/MM/YYYY)**	**Height (cm)**	**Weight (kg)**
				☐ Male ☐ Female			

CHILD(REN)'S INFORMATION							
Full Name (According to NRIC/ Passport/FIN Number)	**NRIC/Passport /FIN Number**	**Nationality**	**Occupation**	**Gender**	**Date of Birth (DD/MM/YYYY)**	**Height (cm)**	**Weight (kg)**
1st Child				☐ Male ☐ Female			
2nd Child				☐ Male ☐ Female			
3rd Child				☐ Male ☐ Female			

FAMILY HISTORY OF THE EMPLOYEE AND DEPENDANT(S) (IF APPLICABLE)

Have any of your natural parents or sibling(s) suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)?**

☐ **Yes** ☐ **No**

If Yes, please provide details below (for Cancer, please specify type of cancer)**

Name of Employee/ Dependant	Relationship (to insured)	Medical Condition (Diagnosis)	Age at time of Diagnosis	Age of Death (if Deceased)	Cause of Death (if Deceased)

MEDICAL QUESTIONNAIRE						
All 11 questions must be answered		**Complete ONLY IF to be insured**				
		Employee	**Spouse**	**1st Child**	**2nd Child**	**3rd Child**
1	Do you engage in any sports(s) or occupation of a dangerous or hazardous nature such as motor racing, scuba/skin diving, parachuting, military (excluding NS) or private flying other than as a fare paying passenger, etc.? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2	Has any of your application/reinstatement for life, critical illness, accident, disability income, medical insurance ever been declined, postponed, or accepted with special terms (eg: extra premium loading or exclusion imposed)? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3	a) Have you ever used addictive drugs, narcotics, glue sniffing or been treated for drug addiction? b) Have you ever had or been treated for alcoholism? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
4	Do you drink wine, beer or other alcoholic beverages? If yes, please furnish details : a) Type of alcohol : (Beer/Wine/Others, please specify) b) Frequency : (number of times per week) c) Quantity : (mls/units per week)	☐ Yes ☐ No _____ _____ _____	☐ Yes ☐ No _____ _____ _____	☐ Yes ☐ No _____ _____ _____	☐ Yes ☐ No _____ _____ _____	☐ Yes ☐ No _____ _____ _____
5	Have you ever smoked cigarettes in the last 12 months? If yes, please provide details : a) Number of sticks per day :	☐ Yes ☐ No _____per day	☐ Yes ☐ No _____per day	☐ Yes ☐ No _____per day	☐ Yes ☐ No _____per day	☐ Yes ☐ No _____per day
6	a) Have you received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS Related Complex or any other AIDS related condition? b) Have you ever had HIV testing done? If yes, please state the reason and its results. **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No
7	In the past 3 months, have you ever had any of the following symptoms for more than one week continuously: Fatigue, weight loss, enlarged node(s) or unusual skin lesion(s)? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL QUESTIONNAIRE

All 11 questions must be answered		Complete ONLY IF to be insured				
		Employee	Spouse	1st Child	2nd Child	3rd Child
8	In the past 5 years, have you ever undergone or been advised to undergo any medical investigation(s) carried out on the recommendation of a doctor such as X-ray, Ultrasound, Heart scan, CT scan, Biopsy, Endoscopy, Gastroscopy, Colonoscopy, Surgical operation, etc.? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9	Have you EVER had or been told you had or been treated for:					
	a) Asthma, coughing with blood, pneumonia, tuberculosis, bronchitis, breathing discomfort or breathlessness and/or any other lung disease/disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	b) Rheumatic fever, high blood pressure, heart murmur, heart attack, coronary artery disease, mitral valve prolapse, or other heart valve disorder, irregular or fast heart rate, chest discomfort or chest pain, and/or any disease or disorder of the heart or blood vessels?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	c) Renal/bladder stone(s), albumin/protein in urine, blood or sugar in urine, urine infection or any other disorder of the kidney(s), bladder, urinary or genital organs?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	d) Epilepsy, fits, stroke, paralysis, dementia, Parkinson's disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, anxiety, depression, or any other nervous or mental disorder(s) or disease of the brain?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	e) Diabetes, thyroid disorder(s), or any other endocrine disorder(s)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	f) Gastritis, ulcer, blood in stools, fistula, hernia, irritable bowel syndrome, or any other disease/ disorder of the stomach or bowel?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	g) Hepatitis B carrier or any form of hepatitis, jaundice, liver disorder or gall bladder disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	h) Ear discharge, nose bleeding, double vision, impaired sight, hearing or speech, or any other disorder of the ear(s), eye(s), nose, or throat?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	i) Slipped disc, back pain, gout, any form of arthritis, joint pain or deformity, and/or any disease/disorder of the muscles, spine, limbs or joints or severe injury?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	j) Anaemia, any other disorders of the blood, or advised to abstrain from donating or received blood transfusion?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	k) Cancer, tumour(s), cyst(s) or growth(s) of any kind?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	l) Congenital anomalies, physical disability or any other illness, disorder, operations, hospital admission, accident or injury not mentioned above? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MEDICAL QUESTIONNAIRE						
For Female Applicants only (including children age 12 years and above)		**Complete ONLY IF to be insured**				
		Employee	**Spouse**	**1st Child**	**2nd Child**	**3rd Child**
10	a) Have you ever been to any doctor for a Pap Smear (cervical smear)? If yes, please state result :	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	(i) Result : (Normal/Abnormal)	_____	_____	_____	_____	_____
	b) Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within 6 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	c) Have you ever been found to have or are you aware of any breast cyst(s)/lump(s)/ nodule(s) or any other disease or disorder of the breast(s)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	d) Have you ever suffered from irregular, painful or unusually heavy menstruation, fibroid(s), cyst(s) or any other disorder involving the female organ(s)? **If yes, please furnish details in the box on page 6**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11	a) Were there any complication(s) noted during any of your pregnancy such as gestational diabetes, hypertension etc.? If yes, please provide details.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	(i) Details :	_____	_____	_____	_____	_____
	b) Are you currently pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	If yes, please state weeks of pregnancy :	_____	_____	_____	_____	_____

If any of the answers is "Yes", please give full details in the space provided below		
Qn. No.	Name of Employee/Dependant	Please provide date of consultation, details of diagnosis/exact condition, result, name and address of doctor seen

DECLARATION AND AUTHORISATION

1) I hereby declare and confirm that I have read and understood the contents of "Your Guide to Health Insurance" (applicable only to accident and health business), "Your Guide to Life Insurance" and "Product Summary". (Applicable if coverage is on voluntary basis).

2) I/We understand that all Pre-Existing Conditions before the effective date of this Policy are not covered.

3) No statement, information or agreement made by/to or given by/to the person soliciting/taking this application or any other persons, shall be binding on AIA Singapore Private Limited ("AIA Singapore"), unless presented to me/us in writing and approved by an officer specified in the policy.

4) The statements and answers in this application together with any required questionnaires or amendments ("the information") are full, complete, true and correct and that no information or material has been withheld. I/We understand that AIA Singapore, believing the Information to be such, will rely and act on the Information accordingly. I/We further agree that the Information shall form the basis of the contract between the parties hereto. I/We understand that if any of the Information is not full or complete or true or correct, the coverage issued or claims incurred hereunder may be void and nothing may be received from the group policy(ies).

5) I/We hereby authorise, agree and consent to:

   a) persons and organisations, whether within or outside Singapore, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/ organisations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to AIA Singapore Private Limited ("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"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);

   b) the AIA Persons sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;

   c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);

   d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "Using"/"Use") the Personal Data for the Purpose; and

   e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) 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 any Personal Data for the Purpose.

   Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws:
   (i) to collect their Personal Data;
   (ii) to disclose their Personal Data to the AIA Persons; and
   (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause.

   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. In this Clause, "Purpose" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore. 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.

6) I/We understand and agree that should a Relevant Person be found at any time to be a Prohibited Person, AIA Singapore is entitled, at its absolute discretion and without any liability to me/us, to (i) decline, block, suspend or cancel this application or any request, instruction, or transaction including any payment, transfer or receipt of money; (ii) decline to provide cover or to pay any claim or benefit under the Policy; and (iii) immediately terminate or void the Policy. AIA Singapore's decision in exercising this right shall be final. This right may only be waived in writing; no delay or failure in exercising this right shall be deemed as a waiver of the same. "Relevant Person" includes (a) persons and entities who are the policy holders, insured persons, beneficiaries, trustees, payees, or assigns; (b) their beneficial owners or affiliates; (c) (in the case of an entity) their directors, partners, or direct / indirect shareholders or persons having executive authority, or (d) natural persons appointed to act on their behalf. "Prohibited Person" includes a person or entity that is subject to any sanction, prohibition or restriction administered by any regulatory authorities in any country or jurisdiction, such that the provision of such cover, payment of such claim or provision of such benefit may in AIA Singapore's opinion expose it to any, or any risk of, sanction, prohibition or restriction. As an ongoing obligation, I/we will immediately inform AIA Singapore if there are any changes to the identities, status, constitution, establishment, particulars and identification documents of these Relevant Persons. I/we will indemnify AIA Singapore and hold it harmless from and against any and all related losses, damages, costs and/or expenses suffered and/or incurred, including but not limited to legal costs.

7) I/We further agree that this form may be signed and delivered by facsimile, electronic mail or other electronic means, including via a website or electronic portal designated by AIA Singapore. A copy of such form received via any of the above means may be stored electronically or using other means by or under the authority of AIA Singapore and such copy shall have the same legal effect and validity as if it were the original.

WARNING : If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Services Consultant(s)/ Insurance Representative(s) but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal. Additionally and without prejudice to the parties' rights and obligations whether under law or otherwise, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

Declared in Singapore on: D D M M Y Y Y Y

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Name & Signature of Employee

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Name & Signature of Spouse (if Applicable)