



**PART 4: ADD / DELETE DEPENDANTS**

**ADD**

|                      |       |              |       |
|----------------------|-------|--------------|-------|
| 1. Name of dependant | _____ | Relationship | _____ |
| 2. Name of dependant | _____ | Relationship | _____ |
| 3. Name of dependant | _____ | Relationship | _____ |
| 4. Name of dependant | _____ | Relationship | _____ |

**Important Notes:**

For addition of dependant, kindly submit the following with this application:

- (a) A&H Health Declaration Form
- (b) Birth Certificate &/OR Identity Card
- (c) Product Summary

**DELETE**

|                      |       |              |       |
|----------------------|-------|--------------|-------|
| 1. Name of dependant | _____ | Relationship | _____ |
| 2. Name of dependant | _____ | Relationship | _____ |
| 3. Name of dependant | _____ | Relationship | _____ |
| 4. Name of dependant | _____ | Relationship | _____ |

**PART 5: CHANGE OF OCCUPATION**

**I would like to declare that my occupation has been changed for the above policy(ies) as follows:**

New Occupation \_\_\_\_\_ Since \_\_\_\_\_

Please state \_\_\_\_\_ Nature Of \_\_\_\_\_  
exact duties \_\_\_\_\_ Business \_\_\_\_\_

Company Name \_\_\_\_\_

Business Address \_\_\_\_\_

**PART 6: CHANGE OF PERSONAL PARTICULARS OF INSURED / OWNER**

**I would like to change the following particulars for the above policy(ies):**

Name New Name \_\_\_\_\_

NRIC/FIN/Passport Number New NRIC/FIN/Passport No. \_\_\_\_\_

Date Of Birth New Date Of Birth [ ] [ ] [ ] / [ ] [ ] / [ ] [ ] (MTH e.g. Jan, Feb / DD / YY)

**Important Notes:**

- 1. Kindly submit photocopy of NRIC/FIN/Passport and Deed Poll for change of Name.
- 2. Kindly submit photocopy of NRIC/FIN/Passport for change of NRIC/FIN/Passport Number, Date Of Birth.

**PART 7: CHANGE OF PAYOR FOR JUVENILE POLICY**

**I would like to change the Payor for the above policy(ies) as follows:**

New Payor's Name \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

NRIC/FIN/Passport No. \_\_\_\_\_ New Payor's Signature

Gender  Male  Female

Date of Birth [ ] [ ] [ ] / [ ] [ ] / [ ] [ ] [MTH (eg Jan, Feb etc) / DD / YY]

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Policy No(s):

**Declaration A:** We, the new and existing Payors would like to make the following declaration:

- (1) That the Payor/Owner/Beneficiary of this policy be changed from (Name of Existing Payor) \_\_\_\_\_ (\*mother/father of the Insured) to (Name of New Payor) \_\_\_\_\_ (\*insured/mother of the Insured/father of the Insured).
- (2) That, I (Name of Existing Payor) \_\_\_\_\_, hereby relinquish and transfer my right to exercise all privileges, rights and options provided under this policy to the said (Name of New Payor) \_\_\_\_\_ who is the new Payor/Owner/Beneficiary subject to the terms and conditions contained in the said policy.
- (3) That Payor Benefit on the previous Payor, (Name of Existing Payor) \_\_\_\_\_ be deleted.
- (4) That Payor Benefit is now requested on the new Payor, (Name of New Payor) \_\_\_\_\_.
- (5) That (Name of New Contingent Beneficiary) \_\_\_\_\_ be named as Contingent Beneficiary.

**Declaration B:** I, the new Payor would like to make the following declaration:

That (Name of deceased Payor) \_\_\_\_\_ had passed away on (Date) \_\_\_\_\_ as per attached Death Certificate Number \_\_\_\_\_. As I am the contingent beneficiary (\*mother/father of Insured) as stated in the application for assurance, I will be the new payor of the policy. As such, I append my Specimen Signature above for the purpose of identification and I shall pay the future premiums of this policy as and when they fall due. I also wish to appoint Estate as the new contingent beneficiary.

(\*Delete as appropriate)

## PART 8: TERMINATION OF POLICY

I would like to terminate the policy(ies). (Policy contract attached).

**Important Note:**

Terminating the existing accident and/ or health insurance policy for another policy could result in higher premiums or lesser benefits at the same cost.

## PART 9: OTHERS (Kindly indicate the changes below)



**DECLARATION & AUTHORISATION**

1. I/We hereby request that the policy(ies) stated in this form be changed in accordance with the above application.
2. I/We understand and agree that no application is valid until this change form is received by AIA Singapore Private Limited ("the Company") during the life time of the Insured and is finally accepted by the Company.
3. I/We 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 the Company.
4. I/We understand and agree that my/our application is subject to the terms and conditions as stated in the Policy Contract and is effective only when it has been officially accepted and notified to me/us by the Company.
5. For addition of benefit, change of plan, increase in sum assured, I/we have received a copy of (1) Product Summary, (2) "Your Guide to Health Insurance" (applicable only to accident and health insurance products), the contents of which have been explained to me/us to my/our satisfaction.
6. I/We 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 this contract of insurance is concerned.
7. I/We hereby authorise, agree and consent to the Company to use and/or disclose any information collected and/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy and/or any other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, and/or providing subsequent services to me/us and/or providing advice and/or information concerning products and/or services which the Company believes may be of interest to me/us and/or communicating with me/us for any purpose. I/We hereby specifically waive any right to bring a claim of any nature against the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure and/or any disclosure in the nature described above. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorisation shall be effective and valid as the original.

Executed in (place) \_\_\_\_\_ on Month (e.g. Jan, Feb)   / Day   / Year

\_\_\_\_\_  
SIGNATURE / NAME / NRIC/FIN/PASSPORT OF WITNESS

\_\_\_\_\_  
SIGNATURE OF INSURED

\_\_\_\_\_  
SIGNATURE / NAME / NRIC/FIN/PASSPORT OF WITNESS

\_\_\_\_\_  
SIGNATURE OF \*OWNER / TRUSTEE(S) / ASSIGNEE(S) IF ANY  
(\*Delete as appropriate)

\_\_\_\_\_  
SIGNATURE / NAME / NRIC/FIN/PASSPORT OF WITNESS

\_\_\_\_\_  
SIGNATURE OF \*OWNER / TRUSTEE(S) / ASSIGNEE(S) IF ANY  
(\*Delete as appropriate)

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