HEALTHSHIELD REQUEST FOR CHANGE (FOR PAYOR & TERMINATION)

AIA SINGAPORE PRIVATE LIMITED (Reg. No. 201106386R)

TO: POLICY SERVICES DEPARTMENT - HEALTHSHIELD SECTION *(Please tick as appropriate)*

Date: ☐☐☐ / ☐☐ / ☐☐ (MTH e.g. Jan, Feb / DD / YY)

Policy No: ☐☐☐☐☐☐☐☐☐☐

Name of Insured: _____ NRIC/FIN/Passport No: _____ Unit Name: _____

Name of Policyowner: _____ NRIC/FIN/Passport No: _____ Location: _____

FSC/IR Name: _____ FSC/IR Code: ☐☐☐☐☐ FSC/IR Tel No: _____

PART A: TERMINATION OF POLICY

* ☐ **I would like to terminate the above Healthshield / Healthshield Gold / Healthshield Gold Prestige / Healthshield Gold Public Service / Healthshield Gold Prestige Public Service policy(ies). I agreed that my Healthshield Gold Essential / Healthshield Gold Prestige Essential (if any) will be terminated at the same time.**

* **Important Notes:**

1. If the notice of the termination is submitted and received by the Company On OR BEFORE the 15th of the month, termination of the policy will be effected on the next working day; if the notice of termination is received by the Company AFTER the 15th of the month, termination of the policy will be effected on the following month.
2. Upon the termination of the Healthshield Gold / Healthshield Gold Prestige / Healthshield Gold Public Service / Healthshield Gold Prestige Public Service Plan (under the Integrated Private Medical Insurance Scheme, IPMIS), you will continue to be covered under the Basic Medishield plan by CPF Board. Kindly contact CPF Board should you wish to terminate your Basic Medishield plan.(Applicable only if full renewal premium has been paid under IPMIS)
3. Kindly note that upon termination of Healthshield policy, you are no longer covered by any medical insurance plan the Private Medical Insurance Scheme or the CPF Medishield/Medishield Plus Scheme. For future coverage, it is necessary to submit new application with the chosen insurer, under the new Integrated Private Medical Insurance Scheme (IPMIS).

\+ ☐ **I would like to terminate the above Healthshield Gold Essential/ Healthshield Gold Prestige Essential only.**

\+ **Important Notes:**

1. If the notice of the termination is submitted and received by the Company within fourteen (14) days from the Issue Date or up to the end of the free-look period of the Healthshield Gold/ Healthshield Gold Prestige/ Healthshield Gold Public Service/ Healthshield Gold Prestige Public Service policy(ies), whichever is later, we will refund the premiums paid for this policy without interest, less medical expenses incurred in considering your application.
2. If the notice of termination is submitted and received by the Company AFTER fourteen (14) days from the Issue Date, termination will be effective at the next policy anniversary of the Healthshield Gold/ Healthshield Gold Prestige/ Healthshield Gold Public Service/ Healthshield Gold Prestige Public Service policy(ies) or on the same date the Healthshield Gold/ Healthshield Gold Prestige/ Healthshield Gold Public Service/ Healthshield Gold Prestige Public Service policy(ies) is terminated, whichever is earlier.

PART B: CHANGE OF PERSONAL PARTICULARS OF INSURED / OWNER

☐ **I would like to change the following particulars for the above policy:**

- ◯ 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)
- ◯ Others: Please specify _____

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.

DECLARATION & AUTHORISATION BY POLICYOWNER (PAYOR/OWNER) FOR PART A & B

1. I hereby request that the policy stated above be changed in accordance with the above application stated in Part A or Part B.
2. I understand and agree that no application is valid until this 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 understand and agree that my 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 understand and agree that my 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 by the Company.
5. 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 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.

_____ _____

NAME/NRIC/FIN/PASSPORT/SIGNATURE OF WITNESS **SIGNATURE OF POLICYOWNER (PAYOR/OWNER)**

PT 0022150 (10/2008 06/2009 01/2012)

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PART C: CHANGE OF POLICYOWNER (PAYOR/OWNER)

Policy Number 1	Name of Insured 1	NRIC/FIN/Passport No of Insured 1
Policy Number 2	Name of Insured 2	NRIC/FIN/Passport No of Insured 2
Policy Number 3	Name of Insured 3	NRIC/FIN/Passport No of Insured 3
Policy Number 4	Name of Insured 4	NRIC/FIN/Passport No of Insured 4

☐ **I would like to change the Policyowner (Payor/Owner) of the above policy(ies) as follows:**

Name of Existing Payor/Owner ____________________ Name of New Payor/Owner ____________________

Relationship of New Payor/Owner to:

Insured 1: ____________________ Insured 3: ____________________

Insured 2: ____________________ Insured 4: ____________________

NRIC/Passport /FIN No of New Payor/Owner ____________________

CPF Account No of New Payor/Owner ____________________
(If different from NRIC/Passport/Fin No)

Date of Birth of New Payor/Owner M M / D D / Y Y

Gender of New Payor/Owner ○ M ○ F

Correspondence Address of New Payor/Owner

Blk/House Number # Unit Number -

Postal Code

Street Name / Building Name

DECLARATION & AUTHORISATION BY EXISTING POLICYOWNER (PAYOR/OWNER)

1. I understand and agree that future premium(s) under the policy(ies) stated above will be deducted from the new Payor/Owner's Medisave Account mentioned above.
2. I/We hereby authorise, agree and consent to AIA Singapore Private Limited (”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.

NAME / NRIC/FIN/PASSPORT / SIGNATURE OF WITNESS

SIGNATURE OF EXISTING POLICYOWNER (PAYOR/OWNER)

DECLARATION & AUTHORISATION BY NEW POLICYOWNER (PAYOR/OWNER)

1. I understand that future premium(s) under the policy(ies) stated above will be deducted from my Medisave Account.
2. I authorise CPF Board to deduct the premium(s) due for the Live(s) to be covered as named under the policy(ies) stated above from my Medisave Account in accordance with the provision of the CPF Act (Chapter 36), and the regulations made thereunder and as amended from time to time and subject to all terms and conditions as may imposed by CPF Board from time to time.
3. I authorise CPF Board to deduct the premium(s) due under the policy from my new Medisave Account should I be given a new Medisave Account upon obtaining Singapore Permanent Residence status.
4. I authorise CPF Board to disclose/seek information on a confidential basis to/from any insurer(s) such information relating to:
(a) payment of premium(s) due under the policy(ies) stated above, including deduction of premiums from my Medisave Account/new Medisave Account; and
(b) the making of refund(s) under the policy(ies) stated above, as CPF Board shall reasonably consider appropriate.
5. 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 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.

NAME / NRIC/FIN/PASSPORT / SIGNATURE OF WITNESS

SIGNATURE OF NEW POLICYOWNER (PAYOR/OWNER)

PT 0022150 (10/2008 06/2009 01/2012)