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DETAILS OF INSURED DEPENDANT(S)

Name of Insured Dependand 1 (shown on NRIC/FIN/Passport):	
Date of Birth: dd mm yyyy	NRIC/FIN/Passport No.:
Place of Birth:	<i>For AIA HealthShield Gold Max application, please fill in NRIC/FIN No. only.</i>
Gender: <input type="radio"/> Male <input type="radio"/> Female	CPF Medisave Account (If different from NRIC No.):
Occupation:	Country of Residence:
Company Name:	Residency Status: <input type="radio"/> Singapore <input type="radio"/> Singapore PR
Exact Duties (please provide in details):	<input type="radio"/> Pass Holders <input type="radio"/> Others
Nature of Business:	<i>If the Proposed Insured / Applicant / Owner (Payor) is not Singaporean or Singapore PR, he/she must hold one of the following Valid Passes (Visa) to apply for AIA HealthShield Gold Max: S Pass, Employment Pass, Personalised Employment Pass, EntrePass, Student Pass, selected categories of Long Term Visit Pass, Dependent Pass or Work Permit.</i>
Relationship of Applicant/Owner to Insured Dependand 1: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Grandchild <input type="radio"/> Spouse <input type="radio"/> Sibling	<i>If not Singaporean</i> Citizenship 1:
	Citizenship 2:
	Citizenship 3:
Name of Insured Dependand 2 (shown on NRIC/FIN/Passport):	
Date of Birth: dd mm yyyy	NRIC/FIN/Passport No.:
Place of Birth:	<i>For AIA HealthShield Gold Max application, please fill in NRIC/FIN No. only.</i>
Gender: <input type="radio"/> Male <input type="radio"/> Female	CPF Medisave Account (If different from NRIC No.):
Occupation:	Country of Residence:
Company Name:	Residency Status: <input type="radio"/> Singapore <input type="radio"/> Singapore PR
Exact Duties (please provide in details):	<input type="radio"/> Pass Holders <input type="radio"/> Others
Nature of Business:	<i>If the Proposed Insured / Applicant / Owner (Payor) is not Singaporean or Singapore PR, he/she must hold one of the following Valid Passes (Visa) to apply for AIA HealthShield Gold Max: S Pass, Employment Pass, Personalised Employment Pass, EntrePass, Student Pass, selected categories of Long Term Visit Pass, Dependent Pass or Work Permit.</i>
Relationship of Applicant/Owner to Insured Dependand 2: <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Grandchild <input type="radio"/> Spouse <input type="radio"/> Sibling	<i>If not Singaporean</i> Citizenship 1:
	Citizenship 2:
	Citizenship 3:

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DETAILS OF PLAN APPLIED FOR

	Applicant/Owner	Insured Dependand 1	Insured Dependand 2
AIA HealthShield Gold	<input type="text" value="H"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Max A <input type="radio"/> Cancer Care Booster <input type="radio"/> Max B <input type="radio"/> Max B Lite <input type="radio"/> Max A <input type="radio"/> Max B Foreigner Foreigner <input type="radio"/> Standard Plan	<input type="text" value="H"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Max A <input type="radio"/> Cancer Care Booster <input type="radio"/> Max B <input type="radio"/> Max B Lite <input type="radio"/> Max A <input type="radio"/> Max B Foreigner Foreigner <input type="radio"/> Standard Plan	<input type="text" value="H"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="radio"/> Max A <input type="radio"/> Cancer Care Booster <input type="radio"/> Max B <input type="radio"/> Max B Lite <input type="radio"/> Max A <input type="radio"/> Max B Foreigner Foreigner <input type="radio"/> Standard Plan
AIA Max VitalHealth (Not applicable for Standard Plan)	<input type="radio"/> Yes For AIA HealthShield Gold Max A, please indicate: <input type="radio"/> AIA Max VitalHealth A <input type="radio"/> Emergency and Outpatient care Booster <input type="radio"/> AIA Max VitalHealth A Value <input type="radio"/> Emergency and Outpatient care Booster	<input type="radio"/> Yes For AIA HealthShield Gold Max A, please indicate: <input type="radio"/> AIA Max VitalHealth A <input type="radio"/> Emergency and Outpatient care Booster <input type="radio"/> AIA Max VitalHealth A Value <input type="radio"/> Emergency and Outpatient care Booster	<input type="radio"/> Yes For AIA HealthShield Gold Max A, please indicate: <input type="radio"/> AIA Max VitalHealth A <input type="radio"/> Emergency and Outpatient care Booster <input type="radio"/> AIA Max VitalHealth A Value <input type="radio"/> Emergency and Outpatient care Booster
Please complete AIA Vitality Application form	<input type="radio"/> +AIA Vitality	<input type="radio"/> +AIA Vitality	<input type="radio"/> +AIA Vitality

Existing HealthShield Gold Max Assured?	<input type="radio"/> Yes	<input type="radio"/> Yes	<input type="radio"/> Yes
AIA Hospital Income	<input type="text" value="P"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text" value="P"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text" value="P"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	<input type="radio"/> Plan 1 <input type="radio"/> Plan 2 <input type="radio"/> Plan 3	<input type="radio"/> Plan 1 <input type="radio"/> Plan 2 <input type="radio"/> Plan 3	<input type="radio"/> Plan 1 <input type="radio"/> Plan 2 <input type="radio"/> Plan 3

4 PREMIUM PAYMENT DETAILS

		Applicant/Owner	Insured Dependant 1	Insured Dependant 2
AIA HealthShield Gold	Mode	Annual	Annual	Annual
	Method	<input type="radio"/> My CPF Medisave Account^	<input type="radio"/> My CPF Medisave Account^ <input type="radio"/> Insured Dependant 1 CPF Medisave Account**	<input type="radio"/> My CPF Medisave Account^ <input type="radio"/> Insured Dependant 2 CPF Medisave Account**
AIA Healthshield Gold Max Foreigner	Mode+	<input type="radio"/> Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Monthly
	Method	<input type="radio"/> Cash/Cheque <input type="radio"/> My CPF Medisave Account^	<input type="radio"/> Cash/Cheque <input type="radio"/> My CPF Medisave Account^	<input type="radio"/> Cash/Cheque <input type="radio"/> My CPF Medisave Account^
AIA Max VitalHealth / Cancer Care Booster	Mode	<input type="radio"/> Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Monthly
AIA Hospital Income	Mode	<input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Monthly	<input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Monthly

+If you are also applying for AIA Max VitalHealth, the mode of payment will follow the basic plan.

^Refers to the Applicant/Owner's CPF Medisave Account

DECLARATION OF APPLICANT/OWNER

**For each of the following Insured Dependant(s) selected above (each a "Selected Insured Dependant"), please deduct the premium for him/her from his/her respective CPF Medisave Account. I (Applicant/Owner) confirm that each Selected Insured Dependant is my child/ward and is below 16 years of age.

I (Applicant /Owner) confirm that I have received the notification letter from the CPF Board confirming the successful creation of the CPF Medisave Account(s) for the Selected Insured Dependant(s). If there is insufficient funds in a Selected Insured Dependant's CPF Medisave Account, please deduct the premium for him/her from my CPF Medisave Account.

***Note:** Financial Services Consultants and Insurance Advisers are not allowed to collect cash payment on behalf of AIA. If you are paying your premium by cheque, please ensure your cheque is crossed and made payable to AIA Singapore Private Limited. Please refer to AIA website for the list of payment methods available.

5 GENERAL DETAILS, FAMILY HISTORY AND HEALTH DETAILS OF APPLICANT/OWNER AND INSURED DEPENDANTS

PART I. DETAILS OF PREVIOUS CONCURRENT INSURANCE APPLICATION AND PURSUITS OF APPLICANT/OWNER AND INSURED DEPENDANTS	Applicant/Owner		Insured Dependant 1		Insured Dependant 2	
	Yes	No	Yes	No	Yes	No
<p>1 Is this proposal to replace or intended to replace in full or in part any insurance policy or investment products with AIA Singapore or any other financial adviser or institution?</p> <p>If the answer is "yes" and you are replacing an existing integrated shield plan, please tick to confirm: I confirm that my Insurance Adviser has explained to my satisfaction the implications associated with this switch/replacement and, based on his/her recommendation, I agree to proceed with the switch/replacement of my existing Integrated Shield Plan. I am aware that each Life Assured can only have one Integrated Shield Plan. Once this policy commences, the existing Integrated Shield Plan covering the Life Assured will be automatically terminated. My Insurance Adviser has explained to me the implications associated with this switch/replacement. I am aware that the implications that may arise from a switch/replacement could outweigh any potential benefits such as: - The new plan may offer a lower level of benefit at a higher cost or same cost, or offer the same level of benefit at higher cost and, the new plan may be less suitable for me. - If I am switching to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may lose coverage for those conditions. - If I am replacing my existing plan by upgrading to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may not be given the enhanced benefits to those conditions.</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>	
	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>	



2	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? (If yes, please indicate Company and provide details).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	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? (If yes, please provide details).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Remarks: In connection with Insurance applied for, if any answer to question is "Yes", please give details below, quoting the relevant Applicant/Owner/Insured Dependant(s) and question number(s).

PART II. LIFESTYLE AND HEALTH DETAILS OF INSURED DEPENDANT(S) – JUVENILE BELOW AGE 16 YEARS (ATTAINED AGE)	Insured Dependant 1		Insured Dependant 2	
	Yes	No	Yes	No

1	a. Height (metres):	m	m
	b. Weight (kilograms):	kg	kg
	c. Was there any weight change in the past year? If yes, how much and state the reason.	<input type="radio"/>	<input type="radio"/>

d. Please indicate the following		
	Name and address of the Doctor	Date, reason and result of the last consultation
Insured Dependant 1		
Insured Dependant 2		

2.	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	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? If yes, please indicate relationship, age at onset, current age, illness/age at death (if deceased).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	Has the child ever had, or have been told or been treated for:				
	a. any respiratory disease, prolonged cough, bronchitis, asthma, heart problems, fits, epilepsy or disorder affecting the nervous system?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. any heart disorder, blood disorder, diabetes, endocrine disorder, liver disease or any gastrointestinal disorder, kidney problems, nephritis or abnormality of the genitourinary system?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	c. condition affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any cancer, growth, tumor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	a. In the past 5 years, has the child had any (other than for immunisation or vaccination) of the following tests done? Blood test, Biopsy, Chest X-ray, CT Scan, ECGs, Cholesterol, Liver Function Tests, PAP smear, Ultrasound, Urine or other tests not mentioned. If yes, please specify the type of test done, date, reason and results of the respective test.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	b. In the past 5 years, has the child had any (other than for immunisation or vaccination) illness, operation, medical advice, investigations or hospital treatment not mentioned above?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Remarks: In connection with Insurance applied for, if any answer to question is "Yes", please give details below, quoting the relevant Applicant/Owner/Insured Dependant(s) and question number(s).

PART III. LIFESTYLE AND HEALTH DETAILS OF APPLICANT/OWNER AND INSURED DEPENDANT(S) – ADULT AGE 16 YRS AND ABOVE (ATTAINED AGE)		Applicant/ Owner		Insured Dependant 1		Insured Dependant 2												
		Yes	No	Yes	No	Yes	No											
1.	a. Have you smoked any cigarettes in the past 12 months? b. If yes, please state how many cigarettes per day.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
		/day		/day		/day												
2.	Do you drink? If yes, please state how many glasses of alcohol do you consume every week, indicating - Beer(Cans/330ml), Wine(Glasses/100ml) and Spirits(Tots/30ml).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
3.	a. Height (metres): b. Weight (kilograms): c. Was there any weight change in the past year? If yes, how much and state the reason.	m		m		m												
		kg		kg		kg												
	d. Please indicate the following	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 40%;">Name and address of the Doctor</th> <th style="width: 40%;">Date, reason and result of the last consultation</th> </tr> </thead> <tbody> <tr> <td>Applicant/Owner</td> <td></td> <td></td> </tr> <tr> <td>Insured Dependant 1</td> <td></td> <td></td> </tr> <tr> <td>Insured Dependant 2</td> <td></td> <td></td> </tr> </tbody> </table>		Name and address of the Doctor	Date, reason and result of the last consultation	Applicant/Owner			Insured Dependant 1			Insured Dependant 2							
	Name and address of the Doctor	Date, reason and result of the last consultation																
Applicant/Owner																		
Insured Dependant 1																		
Insured Dependant 2																		
4.	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
5.	Have you ever had or been told to have or been treated for:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	a. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	b. diabetes, thyroid disorders or any other endocrine disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	c. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	g. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	i. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	j. cancer, tumours, cysts or growths of any kind?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
	l. any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
6.	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
7.	a. Have you ever had HIV test done? If yes, please state reason, date and results. b. In the last 3 months have had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions? If yes, please state reason, date and results.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
8.	a. In the past 5 years, have you had any (other than for immunisation or vaccination) of the following tests done? Blood test, Biopsy, Chest X-ray, CT Scan, ECGs, Cholesterol, Liver Function Tests, PAP smear, Ultrasound, Urine or other tests not mentioned. If yes, please specify the type of test done, date, reason and results of the respective test. b. In the past 5 years, have you had any (other than immunisation or vaccination) illness, operation, medical advice, hospital treatment not mentioned above?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											
9.	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? If yes, please indicate relationship, age at onset, current age and illness/age at death(if deceased).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>											



PART III. LIFESTYLE AND HEALTH DETAILS OF APPLICANT/OWNER AND INSURED DEPENDANT(S) – ADULT AGE 16 YRS AND ABOVE (ATTAINED AGE)	Applicant/ Owner		Insured Dependant 1		Insured Dependant 2	
	Yes	No	Yes	No	Yes	No
10. FOR ADULT FEMALE ONLY						
a. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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 6 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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 (dd/mm/yyyy) and results of test (copy to be submitted if available)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Are you now pregnant? If yes, please indicate the expected delivery date (dd/mm/yyyy) and when was the last time (dd/mm/yyyy) you visited the doctor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Has there been any complication(s) relating to this and/or previous pregnancies? If yes, please specify the complication(s) (Gestational diabetes, Caesarian section, Eclampsia, Hypertension, Diabetes, Thrombosis, Miscarriage or others not mentioned).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Remarks: In connection with Insurance applied for, if any answer to question is “Yes”, please give details below, quoting the relevant Applicant/Owner/Insured Dependant(s) and question number(s)						

6 DECLARATION						
1. RESIDENCY – Please answer according to your Citizenship/Residency that you are holding.	Applicant/ Owner *		Insured Dependant 1		Insured Dependant 2	
	Yes	No	Yes	No	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A.2 Are you currently residing in Singapore?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. For student pass or long term visit pass holders						
C.1 Does your pass have a duration of less than 90 days?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C.2 Have you resided in Singapore continuously for less than 90 days during the 12 months preceding the date of application?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. If you do not belong to any of the above categories, please tick here	<input type="radio"/>		<input type="radio"/>		<input type="radio"/>	
* For Applicant/Owner application, both the Applicant/Owner and Insured Dependant(s) need to answer; where the Applicant/Owner is not an individual, only the Insured Dependant(s) needs to answer.						
I/We acknowledge and agree that the policy to be issued in relation to this application shall be deemed to be a Singapore policy.						
2. YOUR GUIDE TO LIFE/HEALTH INSURANCE - Tick as appropriate						
<input type="radio"/>	I have been informed and directed to view or download a copy of (1) “Your Guide to Life Insurance” and/or (2) “Your Guide to Health Insurance” (applicable only to accident and health business) from www.aia.com.sg , or www.lia.org.sg					
<input type="radio"/>	I have been informed and I request to be given a hardcopy of (1) “Your Guide to Life Insurance” and/or (2) “Your Guide to Health Insurance” (applicable only to accident and health business).					

1. I authorise the Central Provident Fund Board (the "CPF Board") to deduct premium(s) due for the Life/Lives to be Insured as named under this application (the "Life/Lives to be Insured") from my CPF Medisave Account (including any new CPF Medisave Account(s) which I may have arising from obtaining Singapore Permanent Resident status or otherwise) in accordance with the provisions of the Central Provident Fund Act 1953, the MediShield Life Scheme Act 2015 and the respective subsidiary legislation made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPF Board from time to time for the purposes of the Private Medical Insurance Scheme (or by such other name as it may be referred to from time to time) (PMIS).

I authorise the CPF Board to disclose information/seek information on a confidential basis to/from any Insurer(s) for the PMIS in respect of the insurance cover issued following this application. Such information includes but is not limited to:

- (i) payment and amount of premiums due, including the deduction of premiums from my CPF Medisave Account and my CPF Medisave Account balance;
- (ii) the making of refunds under the PMIS, as the CPF Board shall reasonably consider appropriate; and
- (iii) the amount of premium subsidies for the Life/Lives to be Insured and the amount of additional premium applicable to the Life/Lives to be Insured.

Applicable for Selected Insured Dependant(s):

I, on behalf of each Selected Insured Dependant, hereby authorise the CPF Board to deduct the premium due for him/her from his/her respective CPF Medisave Account (including any new CPF Medisave Account(s) which he/she may have arising from obtaining Singapore Permanent Resident status or otherwise) in accordance with the provisions of the Central Provident Fund Act 1953, the MediShield Life Scheme Act 2015 and the respective subsidiary legislation made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPF Board from time to time for the purposes of the PMIS.

I, on behalf of each Selected Insured Dependant, hereby authorise the CPF Board to disclose information/seek information on a confidential basis to/from any Insurer(s) for the PMIS in respect of the insurance cover issued for him/her following this application. Such information includes but is not limited to:

- (i) payment and amount of premiums due, including the deduction of premiums from his/her respective CPF Medisave Account and his/her respective CPF Medisave Account balance;
 - (ii) the making of refunds under the PMIS, as the CPF Board shall reasonably consider appropriate; and
 - (iii) the amount of premium subsidies for him/her and the amount of additional premium applicable to him/her.
2. I/We, the Life/Lives to be Insured named under this application, hereby consent to the transfer and disclosure, at any time and without notice to me/us, of any medical information on me/us, in AIA Singapore's or the CPF Board's possession, between AIA Singapore and the CPF Board for the purpose of assessing the insurability of me/us and/or the making of a claim under the PMIS.

I, on behalf of each Life/Lives to be Insured who is/are below 16 years of age, hereby consent to the transfer and disclosure, at any time and without notice to him/her/them, of any medical information on him/her/them, in AIA Singapore's or the CPF Board's possession, between AIA Singapore and the CPF Board for the purpose of assessing the insurability of him/her/them and/or the making of a claim under the PMIS.

3. Subject to the relevant laws and terms and conditions, I understand that:
- (i) Upon the commencement of this HealthShield Gold Max cover, any other existing Integrated Shield Plan (if any) under the PMIS in favour of the Life/Lives to be Insured shall automatically terminate; and
 - (ii) Upon the commencement of another Integrated Shield Plan in favour of the Life/Lives to be Insured, this HealthShield Gold Max Cover of the Life/Lives to be Insured shall automatically terminate.
4. I/We declare that my insurance adviser(s) has/have advised me/us that all Singapore Citizens and Permanent Residents will be covered by MediShield Life, regardless of my/our decision on an Integrated Shield Plan. An Integrated Shield Plan comprises two parts- a MediShield Life portion provided by the CPF Board and an additional private insurance coverage portion provided by the Insurance Company. As Integrated Shield Plan premiums are higher than MediShield Life premiums, there should be sufficient monies in my/our MediSave Account(s) or I/we should have enough cash to pay for MediShield Life premiums on an ongoing basis before I/we consider purchasing an Integrated Shield Plan.

I/We agree and declare on behalf of myself and any other person or persons, firm or corporation, who may have or claim any interest in any insurance on this application that:

1. I/We will take up the additional cover offered by AIA Max VitalHealth, which is a complementary and non Medisave-approved health insurance plan.
2. I/We will pay the premium for AIA Max VitalHealth in cash only. Such premiums are separate from that deducted by CPF for the AIA HealthShield Gold Max plan.
3. I/We have received a copy of (1) Financial Health Review (2) Product Summary (3) "Your Guide to Health Insurance", the contents of which have been explained to me/us to my/our satisfaction.
4. I/We understand that all Pre-Existing Conditions before the effective date of this Policy are not covered.
5. 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.
6. The statements and answers in this application together with any required questionnaire 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 Policy issued hereunder may be void and I/we will receive only a refund of the premiums (without interest) less any and all medical expenses incurred in AIA Singapore's consideration of my/our application.
7. I (the Applicant/Owner if other than Proposed Insured) am not an undischarged bankrupt and that no bankruptcy application (including any statutory demand) or order has been made against me within the last twelve months.
8. AIA Singapore shall assume no liability whatsoever, and that my/our Policy/Policies will only be effective after this application is accepted by AIA Singapore and the initial premium duly paid in full to and accepted by AIA Singapore during the Insured's lifetime and good health.
9. All my/our declarations made and my/our statements or answers in this application and in any required medical examination, questionnaire or amendments together with the relevant policy shall constitute the entire contract between the parties in so far as it may be relevant to the policy or policies I/we have requested.
10. I am/We are aware that the Policy Contract and all other documents are considered to be received by me/us within 7 days of posting to the address which I/we have instructed AIA Singapore to send correspondences to. I/We agree to inform AIA Singapore immediately of any change in my/our correspondence address.
11. By signing this application, I/we confirm that the Insurance Adviser(s) of AIA Singapore has solicited insurance business from me/us in the Republic of Singapore and that the signing of this application has taken place in the Republic of Singapore.



12. I/We hereby authorise, agree and consent to
- any medical source, insurance office or organisation to release to AIA Singapore, any relevant information concerning me/us at any time irrespective of whether the proposal is accepted by AIA Singapore; and
 - AIA Singapore to release to any medical source or insurance office any relevant information concerning me/us at any time, irrespective of whether the proposal is accepted by AIA Singapore; and
 - AIA Singapore or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests to underwrite and evaluate my/our health status in relation to this application and any resulting claim; and
 - 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**”) to collect, use, disclose, store, retain and/or process (collectively, “**Use**”) all personal data and information (“**Personal Data**”) that had/had 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**”) which is available on AIA Singapore’s website, 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 whether or not my/our application is accepted by AIA Singapore. A photocopy of this authorisation shall be effective and valid as the original.

13. Deemed Delivered

I/We understand that the policy document and all other documents from AIA Singapore are considered delivered and received (i) if made available electronically via My AIA, upon receipt of the relevant SMS and/or email notification informing me that the document is accessible on My AIA; and (ii) if posted, 7 days after the date of posting to the last known address notified to AIA Singapore.

14. Electronic Receipt of Policy Documents and Correspondences

I/We acknowledge and accept that if I/we had opted to receive my/our Policy Document and/or correspondences relating to my/our Policy (“Correspondences”) electronically, my/our Policy Documents and/or Correspondences will be made available in my/our My AIA. My AIA is AIA Singapore’s secure customer internet portal available on AIA Singapore’s corporate website.

I/We understand and agree to be notified via email and/or SMS to retrieve my/our Policy Document and/or Correspondences in My AIA once my/our application has been officially approved by AIA Singapore and/or Correspondences are available for viewing. If I/we had opted to receive Policy Documents and Correspondences electronically, I/we acknowledge that the terms and conditions governing the upload, access and viewing of electronic documents in AIA Singapore’s customer portal, (a copy of which is available upon request) have been explained to me/us and I/we agree to be bound by them.

I/We understand that not all of the Correspondences are currently available via electronic statements.

I/We consent to AIA Singapore providing me/us with hard copies of Correspondences that are currently unavailable electronically. I also understand and accept that AIA Singapore may cease providing hardcopies when the electronic copies become available in future.

I/We agree and accept that AIA (Singapore) will not be responsible for any consequences arising from my/our failure to (i) provide AIA Singapore with a true, complete and accurate email address and mobile number and/or (ii) notify AIA Singapore of any change(s) to my/our email address and mobile number. I/We acknowledge and accept that my/our Policy Document and/or Correspondences will be delivered via post if my/our email address and mobile number are not provided in this proposal.

Document Delivery Preference

	Policy Contract (Hardcopy version is only available for applicant/Owner age 60 and above)	All other correspondences (Hardcopy version is only available for applicant/Owner age 60 and above)
Policy 1	<input type="radio"/> Receive my contract in electronic version <input type="radio"/> Receive my contract in hardcopy version	<input type="radio"/> Receive future correspondences electronically <input type="radio"/> Receive future correspondences in hardcopy
Policy 2	<input type="radio"/> Receive my contract in electronic version <input type="radio"/> Receive my contract in hardcopy version	<input type="radio"/> Receive future correspondences electronically <input type="radio"/> Receive future correspondences in hardcopy
Policy 3	<input type="radio"/> Receive my contract in electronic version <input type="radio"/> Receive my contract in hardcopy version	<input type="radio"/> Receive future correspondences electronically <input type="radio"/> Receive future correspondences in hardcopy
Policy 4	<input type="radio"/> Receive my contract in electronic version <input type="radio"/> Receive my contract in hardcopy version	<input type="radio"/> Receive future correspondences electronically <input type="radio"/> Receive future correspondences in hardcopy

Note: Only one option to be selected (either electronic OR hardcopy).

15. Marketing Consent

I want to know the latest promotions and customer benefits and consent to receiving marketing, advertising and promotional material from, and the conducting of consumer, marketing-related and other similar research and analysis by, AIA Persons¹ and to each of them collecting, using, disclosing, storing, retaining and processing all my personal data in accordance with the terms in this form and the AIA Personal Data Policy (Singapore). I also consent to AIA Persons disclosing my personal data to independent third parties and their representatives and for them to process my personal data, for such purposes.

Contact me by²:

- Post
- Electronic transmission to or through my email addresses and social media accounts
- Voice call
- Text message (e.g. SMS/MMS)

I understand that the consent provided by me in this form is in addition to and does not supersede any consent given previously for the above purposes.

I may withdraw one or more consents that I have given, at any time via AIA Customer Care Hotline at 1800-248-8000, My AIA SG or by completing and submitting the relevant forms.

¹ "AIA Persons" refers to AIA Singapore Private Limited, its associated persons/organisations, its and their third party service providers and its and their representatives, whether within or outside Singapore.

² According to the postal and email addresses and all telephone numbers (of which I confirm that I am the user and/or subscriber) in AIA Persons' records.

16. Payment methods used by AIA

I/We confirm and agree to the following:

- a) I/We are the legal and beneficial owner of the Singapore bank account that is linked to my/our Singapore NRIC/FIN in the use of PayNow.
- b) I/we agree and irrevocably authorise AIA Singapore to pay me/us all policy proceeds ("**Payment**") by making such Payment using PayNow to transfer to my/our bank account linked to my/our NRIC/FIN for the use of PayNow, and I/we accept all Payments made in such manner, save and except that Payment using PayNow will be made only if the amount does not exceed S\$200,000 (or such other permitted limit at the prevailing time);
- c) notwithstanding paragraph (b) above, where AIA Singapore in its sole and absolute discretion deems that it is not practicable for AIA Singapore to use PayNow, or that there is another preferable method of making Payment, AIA Singapore may make Payment using any other method as it deems fit in its sole and absolute discretion;
- d) all refunds of premiums or other payments will be effected by AIA Singapore to the source of the monies paid to AIA Singapore; however, if AIA Singapore is unable to ascertain or identify the origins of the payment to AIA Singapore, AIA Singapore may make such refunds to me/us using PayNow or such other methods as it deems appropriate in its sole and absolute discretion.
- e) Notwithstanding the above, I/we agree that payment will be made by cheque(s) if the insurance policy applied for is for business purposes and/or where the Applicant/Policyholder is not an individual.
- f) AIA Group is not responsible for verifying the authenticity, completeness and accuracy of my/our instructions and the contents of this application. Notwithstanding the foregoing, I/we authorize AIA Group to conduct any verifications on my/our accounts maintained with any persons or entities at its discretion, but such authorisation shall not be construed as creating any obligation on the part of the AIA Group to conduct such verification;
- g) AIA Group shall be discharged from all liabilities under and in connection with the Payment and I/we shall not hold AIA Group responsible or liable for any and all losses that I/we may incur in connection with the Payment using PayNow or other means to the accounts with details provided by me/us, including where I/we have provided incomplete, erroneous or inaccurate details of my/our account(s) or personal particulars ("**Inaccurate Information**");
- h) I/We shall indemnify and keep indemnified, the AIA Group, from and against and hold the AIA Group harmless in respect of any and all demands, claims, liabilities, losses, costs and expenses whatsoever (including all legal and other costs, charges and expenses, fines, penalties, levies and charges on a full indemnity basis) that may be incurred by such persons due to or in connection with the Payment using PayNow (including but not limited to the event where Inaccurate Information has been provided by me);
- i) AIA Group has the right to effect the Payment through any means for any reasons whatsoever, including the issuance of a cheque where another method to effect Payment is unsuccessful, and such payment shall constitute full and final discharge of any and all of AIA Singapore's obligations and liabilities to me/us in respect of the Payment.

In these terms and conditions, "**AIA Group**" means AIA Singapore, its related parties and service providers and its and their respective directors, employees, representatives, intermediaries, and agents.



17. 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.

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 Insurance Adviser 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, following the submission of your proposal, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

WARNING: Anyone who pays for, or is insured under AIA HealthShield Gold Max is not eligible for Additional Premium Support (APS) from the Government. *

If you are currently receiving APS to pay for your MediShield Life and/or CareShield Life premiums, and you choose to be insured under this AIA HealthShield Gold Max, you will stop receiving APS. This applies even if you are not the person paying for this AIA HealthShield Gold Max.

In addition, if you choose to be insured under this AIA HealthShield Gold Max, the person paying for AIA HealthShield Gold Max will stop receiving APS, if he or she is currently receiving APS.

* APS is for families who need assistance with MediShield Life and/or CareShield Life premiums, even after receiving premium subsidies and making use of MediSave to pay for these premiums.

PLEASE NOTE: You are discouraged from switching from an existing accident and/or health insurance policy to a new one without considering whether the switch is detrimental, as there may be potential disadvantages with switching. A penalty may be imposed for early policy termination and the new policy may cost more or have fewer benefits at the same cost.

Declared in SINGAPORE on		Day:	Month:	Year:
	INSURED DEPENDANT 1	INSURED DEPENDANT 2	WITNESSED BY	
SIGNATURE OF APPLICANT/ OWNER*	SIGNATURE OF INSURED DEPENDANT(S)#		NAME & SIGNATURE OF AIA INSURANCE ADVISER(S)	

Please note: copies of the terms and conditions on which the insurance will be made, and this completed application form, will be available on your request.

* Applicant/Owner shall pay for the AIA Max VitalHealth premiums in Cash.

Signature is not required for a child of age 15 years and below.

Please sign Benefit Illustration/ Product Summary and Financial Health Review together with this application form.