AIA SINGAPORE
HEALTH CERTIFICATE

WARNING: In accordance with **Section 23(5) of the Insurance Act 1966**, 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 Number(s)

For changes to Occupation and Smoker status, please note that changes will be applied to all policies which you are a party to.

A. Particulars of Insured

Name	NRIC/Passport/FIN No.

B. Particulars of Policy Owner *(if different from Insured)*

Name	NRIC/Passport/FIN No.

C. Health and Lifestyle Questions

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.
(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC)*	
Questions for Personal Accident Plan Only	**Yes**	**No**	**Yes**	**No**
1. Do you have or have you had any physical defects, impairments, deformities, and/or any conditions affecting mobility, sight and/or hearing?	☐	☐	☐	☐
2. Do you engage or intend to engage in hazardous sports (including but not limited to motor sports, scuba diving, mountaineering) or fly other than a fare paying passenger on a licensed air service within recognized scheduled routes?	☐	☐	☐	☐
Questions for All Policies (Including Life, Critical Illness, Health and Disability Plans)				
3. Please provide your current height and weight (in meters and kilograms).	m		m	
	kg		kg	
4. Was there any weight change in the past year? If yes, how much and state the reason:	☐	☐	☐	☐

Applicant Owner/Payor (applicable for PB/PBC)	
Insured/Dependant	

5. Please indicate the following

	Name and Address of the doctor	Date, reason and result of the last consultation
Applicant Owner/Payor (applicable for PB/PBC)		
Insured/Dependant		

	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
6. Are you 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? If yes, please give details.	☐	☐	☐	☐

	Country & Cities visited	Frequency per year	Duration per trip (in months)
Applicant Owner/Payor (applicable for PB/PBC)			
Insured/Dependant			

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AIA Singapore Private Limited (Reg No. 201106386R)
New Business Department, 3 Tampines Grande, #09-01,
AIA Tampines, Singapore 528799
AIA Customer Care Hotline: 1800 248 8000 AIA.COM.SG

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC)*	
	Yes	**No**	**Yes**	**No**
7. Are you now a member of a military force (except NS men) or are you engaged in any private flying or hazardous sports (including but not limited to motor sports, scuba diving, mountaineering) or races other than as a fare-paying passenger on a regular scheduled airline?	☐	☐	☐	☐
8. Is any application for or reinstatement of your life, critical life, 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).	☐	☐	☐	☐
9. Have you smoked any cigarettes in the past 12 months? If yes, please state how many cigarettes per day.	☐	☐	☐	☐

	Number of cigarettes (per day)
Applicant Owner/Payor (applicable for PB/PBC)	
Insured/Dependant	

10. Do you drink? If yes, how many glasses of alcohol do you consume every week?	☐	☐	☐	☐

	Beer (330ml per can)	Wine (100ml per glass)	Spirits (30 ml per tots)
Applicant Owner/Payor (applicable for PB/PBC)			
Insured/Dependant			

11. Have you ever used any habit forming drugs or narcotics or been treated for drug habits or alcohol excessively or been treated for alcoholism?	☐	☐	☐	☐

Additional Health Details Of Juvenile Insured/Dependant – Only for Insured/Dependant below Age 16 years and above (Attained Age)

12. Has the Insured/Dependant received medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition, been told the Insured/Dependant has any of these; or that the Insured/Dependant 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?	☐	☐
13. To the best of your knowledge and belief, has any member of the Insured/Dependant's immediate family ever had tuberculosis, diabetes, cancer, cardiomyopathy, polycystic disease, mental disease or any AIDS related condition?	☐	☐

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

14. Has the Insured/Dependant ever had, or have been told or been treated for:		
i. any respiratory disease, prolonged cough, bronchitis, asthma, heart problems, fits, epilepsy or disorder affecting the nervous system?	☐	☐
ii. any heart disorder, blood disorder, diabetes, endocrine disorder, liver disease or any gastrointestinal disorder, kidney problems, nephritis or abnormality of the genitourinary system?	☐	☐
iii. condition affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any cancer, growth, tumor?	☐	☐

FOR SINGAPOREANS AND SINGAPORE RESIDENTS:

Where your total insurance coverage under all policies issued by insurers in Singapore (including this and concurrent insurance applications), 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 test results

FOR ALL APPLICANTS:

You are not required to disclose results if genetic tests are done for biomedical research.

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC)*	
	Yes	**No**	**Yes**	**No**
15. In the past 5 years, has the Insured/Dependant had any (other than for immunization or vaccination) i. of the following tests done? If yes, please give details as indicated below	☐	☐		

Test	Date	Reason	Results	Test	Date	Reason	Results
a. Blood Test				g. Liver Function Tests			
b. Biopsy				h. PAP Smear			
c. Chest X-Ray				i. Ultrasound			
d. CT Scan				j. Urine			
e. ECGs				k. Others. Please specify			
f. Cholesterol							

	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
ii. illness, operation, medical advice, investigations or hospital treatment not mentioned above?	☐	☐		

Additional Health Details Of Applicant Owner/Payor/Insured – Adult Age 16 years and above (Attain Age)

16. Have you ever had or been told to have or been treated for:	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
i. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	☐	☐	☐	☐
ii. diabetes, thyroid disorders or any other endocrine disorders?	☐	☐	☐	☐
iii. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat?	☐	☐	☐	☐
iv. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	☐	☐	☐	☐
v. 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?	☐	☐	☐	☐
vi. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	☐	☐	☐	☐
vii. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	☐	☐	☐	☐
viii. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐	☐	☐	☐
ix. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐	☐	☐	☐
x. cancer, tumours, cysts or growths of any kind?	☐	☐	☐	☐
xi. 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?	☐	☐	☐	☐
xii. any other illness, disorder, operation, physical disability or accident not mentioned above?	☐	☐	☐	☐

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.

Question	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor *(applicable for PB/PBC)* Yes	Applicant Owner/Payor *(applicable for PB/PBC)* No
17. 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?	☐	☐	☐	☐
18. Have you ever had HIV testing done?	☐	☐	☐	☐

If yes, please state reason, date and results:

	Reason	Date	Results
Applicant Owner/Payor (applicable for PB/PBC)			
Insured/Dependant			

Question	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
19. 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?	☐	☐	☐	☐

If yes, please state reason, date and results:

	Reason	Date	Results
Applicant Owner/Payor (applicable for PB/PBC)			
Insured/Dependant			

FOR SINGAPOREANS AND SINGAPORE RESIDENTS:

Where your total insurance coverage under all policies issued by insurers in Singapore (including this and concurrent insurance applications), 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 test results

FOR ALL APPLICANTS:

You are not required to disclose results if genetic tests are done for biomedical research.

Question	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
20. In the past 5 years, have you had any (other than for immunization or vaccination) i. of the following tests done? If yes, please give details as indicated below	☐	☐	☐	☐

Test	Date	Reason	Results	Test	Date	Reason	Results
a. Blood Test				g. Liver Function Tests			
b. Biopsy				h. PAP Smear			
c. Chest X-Ray				i. Ultrasound			
d. CT Scan				j. Urine			
e. ECGs				k. Others. Please specify			
f. Cholesterol							

Question	Insured/Dependant Yes	Insured/Dependant No	Applicant Owner/Payor Yes	Applicant Owner/Payor No
ii. illness, operation, medical advice or hospital treatment not mentioned above?	☐	☐	☐	☐

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC)*	
	Yes	**No**	**Yes**	**No**
21. 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 provide details below.	☐	☐	☐	☐

	Relationship	Age at Onset	Current Age	Illness/Age at Death (if deceased)
Applicant Owner/Payor (applicable for PB/PBC)				
Insured/Dependant				

22. **Female ONLY**

i. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?	☐	☐	☐	☐
ii. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	☐	☐	☐	☐
iii. 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?	☐	☐	☐	☐
iv. 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).	☐	☐	☐	☐
v. Are you now pregnant? If yes, please indicate:	☐	☐	☐	☐

Expected delivery date: ☐ dd ☐ mm ☐ yyyy

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

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): ☐

Additional Question for Platinum Series Life Insurance (HNW)

23. Since the date of the application of the policy, has your pattern or frequency of travel change? If yes, please complete Residency and Travel Questionnaire.	☐	☐	☐	☐
24. Since the date of the application of the policy or the date you attended the medical examination, has your smoking habit changed? If yes, please give details below:	☐	☐	☐	☐

Type of tobacco	Number of sticks	Date of last smoked (applicable for former smoker)

Remarks

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Declaration and Authorisation

1. 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 Private Limited ("AIA Singapore").
2. I understand and agree that the application of the Contracts (Rights of Third Parties) Act 2001 and any subsequent revision or replacement thereof is expressly excluded insofar as this contract of insurance is concerned.
3. 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 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 this application. Please check to ensure you are fully satisfied with the information declared in this application. Additionally and without prejudice to the parties' rights and obligations whether under law or otherwise, following the submission of your application, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

Signature of Insured	Signature of Policy Owner
Date	Date

** If different from Insured*

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