AIA SINGAPORE

APPLICATION FORM FOR HEALTH INSURANCE (PARTNERSHIP DISTRIBUTION)

Insurance Representative's Unit Code:		Referral's Unit Code:	
Insurance Representative's Code:		Referral's Code:	
Insurance Representative's Name/Channel:		Referral's Name:	

Corporate ID: WM ☐☐☐☐ Master Policy No. (For Worksite Marketing Only) ☐☐☐☐☐☐☐☐☐☐

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. If a foreign currency policy is applied for, the equivalent of returns in Singapore-dollars will depend on the prevailing exchange rate (as determined by AIA Singapore), which may be highly volatile.

1 DETAILS OF APPLICANT/OWNER (Please tick the circles as appropriate)

Name (shown on NRIC/FIN/Passport):

Date of Birth: dd mm yyyy

Gender: ◯ Male ◯ Female

Place of Birth:

NRIC/FIN/Passport No.:

For AIA HealthShield Gold Max application, please fill in NRIC/FIN No. only.

Marital Status: ◯ Single ◯ Married ◯ Widowed / Divorced / Separated

CPF Account No. (If different from NRIC No.):

Current Residence Address:

Citizenship:
if not Singaporean

Country of Residence:

Residency Status: ◯ Singapore ◯ Singapore PR ◯ Pass Holders ◯ Others

If the Proposed Insured/ Applicant (Payor) is not Singaporean or Singapore PR, he/she must hold of the 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 or Dependant Pass.

Postal Code:

Foreign Permanent Residence Address - *Please write in English (Compulsory for non-Singaporeans.)*

Singapore Mailing Address: - if different from Current Residence Address (Use of P.O. Box is not allowed)

Postal Code:

Please provide the reason if:
1. Your "Current Residence Address" is different from your identity documents and/or
2. Your "Singapore Mailing Address" is different from your "Current Residence Address"

Note: Please provide separate reasons if all the addresses are not matched.

Occupation:

Company Name:

Exact Duties (please provide in details):

Contact Details

Home: Country Code - Phone No.

Office: Country Code - Phone No.

Mobile: Country Code - Phone No.

Email:

Nature of Business:

Business Address:

Postal Code:

PART0005 (01/2017 02/2017 01/2018)

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2 DETAILS OF INSURED DEPENDANT(S)

Name of **Insured Dependant 1** (shown on NRIC/FIN/Passport):

Date of Birth: dd mm yyyy

Place of Birth:

Gender: ◯ Male ◯ Female

NRIC/FIN/Passport No.:

For AIA HealthShield Gold Max application, please fill in NRIC/FIN No. only.

Occupation:

Country of Residence:

Company Name:

Exact Duties (please provide in details):

Nature of Business:

Residency Status: ◯ Singapore ◯ Singapore PR ◯ Pass Holders ◯ Others

If the Proposed Insured/ Applicant (Payor) is not Singaporean or Singapore PR, he/she must hold of the 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 or Dependant Pass.

Relationship of Applicant/Owner to Insured Dependant 1:
◯ Child ◯ Parent ◯ Grandchild ◯ Spouse

Citizenship:
if not Singaporean

Name of **Insured Dependant 2** (shown on NRIC/FIN/Passport):

Date of Birth: dd mm yyyy

Place of Birth:

Gender: ◯ Male ◯ Female

NRIC/FIN/Passport No.:

For AIA HealthShield Gold Max application, please fill in NRIC/FIN No. only.

Occupation:

Country of Residence:

Company Name:

Exact Duties (please provide in details):

Nature of Business:

Residency Status: ◯ Singapore ◯ Singapore PR ◯ Pass Holders ◯ Others

If the Proposed Insured/ Applicant (Payor) is not Singaporean or Singapore PR, he/she must hold of the 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 or Dependant Pass.

Relationship of Applicant/Owner to Insured Dependant 2:
◯ Child ◯ Parent ◯ Grandchild ◯ Spouse

Citizenship:
if not Singaporean

3 DETAILS OF PLAN APPLIED FOR

	Applicant/Owner	**Insured Dependant 1**	**Insured Dependant 2**
AIA HealthShield Gold	H ◯ Max A ◯ Max B ◯ Max B Lite ◯ Standard Plan ◯ Max A Foreigner	H ◯ Max A ◯ Max B ◯ Max B Lite ◯ Standard Plan ◯ Max A Foreigner	H ◯ Max A ◯ Max B ◯ Max B Lite ◯ Standard Plan ◯ Max A Foreigner
AIA Max Essential (Not applicable to Standard Plan)	◯ Yes For AIA Healthshield Gold Max A, please indicate : ◯ Plan A ◯ Plan A Saver	◯ Yes For AIA Healthshield Gold Max A, please indicate : ◯ Plan A ◯ Plan A Saver	◯ Yes For AIA Healthshield Gold Max A, please indicate : ◯ Plan A ◯ Plan A Saver
Please complete AIA Vitality Application form	◯ +AIA Vitality	◯ +AIA Vitality	◯ +AIA Vitality
Existing HealthShield Gold Max Assured?	◯ Yes	◯ Yes	◯ Yes
AIA Hospital Income	P ◯ Plan 1 ◯ Plan 2 ◯ Plan 3	P ◯ Plan 1 ◯ Plan 2 ◯ Plan 3	P ◯ Plan 1 ◯ Plan 2 ◯ Plan 3

4 PREMIUM PAYMENT DETAILS

	Mode	Method
AIA Healthshield Gold Max	Annual	◯ CPF Medisave
AIA Hospital Income	◯ Annual ◯ Semi-Annual ◯ Monthly	◯ Cash/Cheque
AIA Max Essential	◯ Annual ◯ Monthly	◯ Cash/Cheque

	Mode +	Method
◯ AIA Healthshield Gold Max A Foreigner	◯ Annual	◯ Cash/Cheque ◯ CPF Medisave
	◯ Monthly	◯ Cash/Cheque

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

Insurance Adviser(s) is not allowed to collect cash payment on behalf of AIA. Please refer to AIA website for the list of payment methods.

5 CREDIT CARD AUTHORISATION

I authorise AIA Singapore to charge to my credit card and issuer of the card the initial premium, including additional premiums levied (if any), and all subsequent premiums payable to AIA Singapore. Should payment not be successfully effected pursuant to this authorisation for any reason, AIA Singapore shall under no circumstances be held responsible or liable for any non-inception, lapse or termination of the policy due to late or non-payment of premiums. This authorisation shall be binding and remain valid, notwithstanding death of the cardholder, irrespective of whether or not this application is accepted by AIA Singapore.

Name of Cardholder (as shown on Credit Card): Contact No.(HP): Credit Card No.: ❒ Visa ❒ Mastercard

Card Expiry Date (MM/YY): / Relationship of Cardholder to the Policyowner Name of Issuing Bank: Country of Issuing Bank:

Recurring Payment: ❒ Yes - applicable to monthly, quarterly and semi-annually modes for the FIRST YEAR'S premum only
❒ No

Cardholder's Signature (as per Credit Card)	Date (DD/MM/YYYY)

Important Notes

1. Credit Card payments for renewal premium and single premium policies will NOT be accepted.
2. Credit Card deduction will be processed upon receipt of this authorisation by AIA Singapore. The deduction does not constitute approval of the application.
3. For applications on monthly mode, premiums for the first two months will be deducted for initial premium.
4. Recurring Credit Card Payment is not applicable to AIA Healthshield Gold Max Plans.

6 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
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? **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 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, my previous Integrated Shield Plan 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. - The new policy 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 policy 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 old plan by upgrading to this plan and I have existing medical conditions that are currently covered by my old plan, I am aware that I may not enjoy the enhanced benefits for those conditions.	○	○	○
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).	○ ○	○ ○	○ ○
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).	○ ○	○ ○	○ ○

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.	○	○	○	○

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?	○	○	○	○
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).	○	○	○	○
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?	○	○	○	○
	b. any heart disorder, blood disorder, diabetes, endocrine disorder, liver disease or any gastrointestinal disorder, kidney problems, nephritis or abnormality of the genitourinary system?	○	○	○	○
	c. condition affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any cancer, growth, tumor?	○	○	○	○
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.	○	○	○	○
	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?	○	○	○	○

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.		/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).	○	○	○	○	○	○
3. a. Height (metres):		m		m		m
b. Weight (kilograms):		kg		kg		kg
c. Was there any weight change in the past year? If yes, how much and state the reason.	○	○	○	○	○	○

d. Please indicate the following

	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?	○	○	○	○	○	○
5.	Have you ever had or been told to have or been treated for:						
	a. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	○	○	○	○	○	○
	b. diabetes, thyroid disorders or any other endocrine disorders?	○	○	○	○	○	○
	c. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat?	○	○	○	○	○	○
	d. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	○	○	○	○	○	○
	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?	○	○	○	○	○	○
	f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	○	○	○	○	○	○
	g. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	○	○	○	○	○	○
	h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	○	○	○	○	○	○
	i. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	○	○	○	○	○	○
	j. cancer, tumours, cysts or growths of any kind?	○	○	○	○	○	○
	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?	○	○	○	○	○	○
	l. any other illness, disorder, operation, physical disability or accident not mentioned above?	○	○	○	○	○	○
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?	○	○	○	○	○	○
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.	○	○	○	○	○	○
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?	○	○	○	○	○	○
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).	○	○	○	○	○	○

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?	○	○	○	○	○	○
b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	○	○	○	○	○	○
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?	○	○	○	○	○	○
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)	○	○	○	○	○	○
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.	○	○	○	○	○	○
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).	○	○	○	○	○	○

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)

7 DECLARATION

1. **RESIDENCY** – Please answer according to your Citizenship/Residency that you are holding.	Applicant/ Owner ǂ		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?	○	○	○	○	○	○
A.2 Are you currently residing in Singapore?	○	○	○	○	○	○
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?	○	○	○	○	○	○
C. For student pass or long term visit pass holders						
C.1 Does your pass have a duration of less than 90 days?	○	○	○	○	○	○
C.2 Have you resided in Singapore continuously for less than 90 days during the 12 months preceding the date of application?	○	○	○	○	○	○
D. If you do not belong to any of the above categories, please tick here	○		○		○	

ǂ 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

○	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
○	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).

8 DECLARATION OF APPLICANT/OWNER (CPF MEDISAVE ACCOUNT HOLDER) & DEPENDANT(S) TO BE INSURED

1. I authorise the Central Provident Fund Board (the "CPFB") 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 Medisave account (including any new 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 (Chapter 36), the MediShield Life Scheme Act (Act No. 4 of 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 CPFB 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 CPFB 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 Medisave account and my Medisave account balance;
   (ii) the making of refunds under the PMIS, as the CPFB 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

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 the AIA Singapore's or the CPFB's possession, between AIA Singapore and the CPFB for the purpose of assessing the insurability of me/us 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 has advised me/ us that all Singapore Citizens and Permanent Residents will be covered by MediShield Life. An Integrated Shield Plan comprises two parts - a MediShield Life portion provided by the Central Provident Fund Board (CPFB) and an additional private insurance coverage 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.

9 ADDITIONAL DECLARATION

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 Essential, which is a complementary and non Medisave-approved health insurance plan.
2. I/We will pay the premium for AIA Max Essential 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 first 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
    a. 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
    b. 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
    c. 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
    d. 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/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**") 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. **Marketing Consent**

I (being the Applicant/Owner, for the purposes of this clause) consent to allow AIA Persons to collect, use, disclose, store, retain and/or process Personal Data that had/has been provided to AIA Persons and/or that AIA Persons possess about me (whether from me or a third party) for the purposes of conducting consumer, marketing related or other similar research and analysis and to provide marketing and promotional information relating to existing or future products and/or services, by the following modes of communication where I have indicated my consent below:

(a) postal mail to my *postal address(es); ◯

(b) electronic transmission to or through my *email address(es) and/or *social media account(s); ◯

(c) with respect to all my *telephone number(s) (of which I confirm I am the user and/or subscriber), by way of:

(i) Phone/ Voice Call; and ◯

(ii) SMS/MMS ◯

* which are in AIA Persons' records as may be updated from time to time by notice to AIA Persons

In relation to one or more of the above purposes, I consent to my Personal Data being disclosed to independent third parties and their representatives and such third parties processing my Personal Data.

Note:

- I may withdraw one or more consents provided by me at anytime via AIA Customer Care Hotline at 1800-248-8000 or AIA e-Care (for policyholders) or my Insurance Adviser (for policyholders and non-policyholders). I will stop receiving marketing messages via the selected modes of communication after 30 days. I will continue to receive marketing messages via other modes of communication where my consent has been given and information arising from my AIA policies or programmes.
- The consent provided by me in this form is in addition to and does not supersede, vary or nullify any consent which I may have provided previously in respect of the above purposes, unless my consent is withdrawn in the manner specified by AIA.

14. I/We understand and agree that AIA Singapore is entitled not to accept or process this application should a person connected with the relevant Policy be found to be a Prohibited Person, meaning a person or entity (including any director or direct / indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, beneficiaries or my/our beneficial owners or beneficiaries' beneficial owners therein) subject to any laws, regulations and/or sanctions administered by any regulatory authorities in any country, which have the effect of prohibiting AIA Singapore from providing insurance coverage, transacting business with or otherwise offering any economic benefits to me/us or any other beneficiaries or assignees under the relevant Policy, and the decision of AIA Singapore shall be final. I/We further agree that in the event that AIA Singapore becomes aware subsequently that a person connected with the relevant Policy has become a Prohibited Person, AIA Singapore may block and/or terminate the relevant Policy, including but not limited to, making or receiving any payments under the relevant Policy. 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 persons. If an application is accepted or processed by AIA Singapore despite a person connected with the relevant Policy being a Prohibited Person, AIA Singapore shall be entitled to block and/or terminate the relevant Policy at any time, whether with effect from inception of the relevant Policy or otherwise.

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.

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.

† If applying for AIA HealthShield Gold Max where premiums are to be paid through CPF Medisave Account, Applicant/Owner shall be the CPF member whose monies in the CPF Medisave Account shall be used to pay the AIA HealthShield Gold Max premiums hereunder.

* Applicant/Owner shall pay for the AIA Max Essential 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.