



TO: INDIVIDUAL HEALTH SERVICES

Name of Insured

NRIC/ Passport No.

Policy No. -

Please tick (✓) appropriate box and complete the request accordingly.

I am aware that insurance is a long-term commitment and I can seek advice from a licensed financial adviser representative before I sign this application. Should I choose not to, I take sole responsibility to ensure that this application is appropriate to meet my financial needs and insurance objectives. I understand that by making changes to my Policy, I may be losing valuable benefits and it may not be possible for me to obtain a similar level of protection on the same terms in the future.

I, the legal owner of this Policy, hereby request that this Policy to be changed as indicated below with the understanding and agreement that the change when effected shall be an amendment to and will form part of the Original Policy issued and also be binding on any person who shall have or claim any interest under the above Policy.

Alterations on Policy

1. **Change from current plan to**
(You are required to do a health declaration if you are changing to a higher plan)

Supreme Plus Supreme ClassicPlus Classic

For Insured Person: _____

2. **Change of deductible amount to**
(You are required to do a health declaration if you are changing to a lower deductible)

\$0 \$1,000 \$2,000 \$3,000
 \$5,000 \$8,000 \$10,000

For Insured Person: _____

Alterations on Premium Payments (Mode/Frequency)

3. **Change of Payment Frequency to**

Annually Quarterly Monthly

4. **Cancellation of payment through Giro with immediate effect**

My/Our Bank A/C No.: _____

5. **Change of Payment Mode to**

Giro (Please complete the Interbank GIRO Application form.
Kindly pay 2 months' premium upfront by cash/cheque if monthly Giro mode is selected; 3 months' premium if quarterly Giro is selected; annual premium if annual Giro is selected as Giro deduction is effected upon renewal only.)

Cheque (Applicable for annual mode only)

Credit Card (Please complete the Card Payment Authorisation below)

Card Payment Authorisation
I authorise Aviva Ltd, until further notice in writing, to charge my card account, the premiums in respect of this insurance policy as and when these become due. I will advise in writing immediately if the card becomes stolen or if I wish to close my card account or cancel the authorisation.

Visa MasterCard

Cardholder's Name (as it appears on credit card) _____

Card No. _____ CSV No. _____

Bank _____ Expiry Date (mm/yy) _____

Cardholder's signature _____ Date _____

