

# REQUEST FOR CHANGES TO INDIVIDUAL HEALTH POLICIES

(MyShield / MyShield Plus / Ideal Medical / Global Health)



Policy No. :			
Name of Life Assured / Insured Person :		NRIC / Passport No. :	
Name of Assured / Insured :		NRIC / Passport No. :	

Pursuant to Section 25(5) of the Insurance Act (Cap. 142), you are to disclose in this Request Form fully and faithfully all the facts which you know or ought to know, otherwise nothing may be payable under the Policy.

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 your Financial Adviser but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this Request Form and the Health Declaration Form.

## TYPE OF REQUESTS

<input type="checkbox"/> Change of Policyholder (Refer to Section A)
<input type="checkbox"/> Change of Payer (Refer to Section B)
<input type="checkbox"/> Change of Payment Frequency (Refer to Section C)
<input type="checkbox"/> Change of Personal Particulars (Refer to Section D)
<input type="checkbox"/> Change of Plan (Refer to Section E)
<input type="checkbox"/> Reinstatement (Refer to Section F – Please complete <b>Health Declaration Form</b> if your existing policy is under ‘Full Medical Underwriting’ acceptance terms)
<input type="checkbox"/> Others (Refer to Section G – Please complete <b>Health Declaration Form</b> , if applicable)
<input type="checkbox"/> Review of Underwriting Terms (Please complete <b>Health Declaration Form</b> )
<input type="checkbox"/> Amendments / Additional Information on New or Existing Medical Conditions (Please complete <b>Health Declaration Form</b> )

## DETAILS OF REQUESTS

### Section A: Change of Policyholder

Relationship of Insured Person to Policyholder:  Self  Spouse  Child  Parent  Grandparent

<b>Details of New Policyholder (Note: A copy of new policyholder's NRIC / Passport is required)</b>				
Name:	NRIC / Passport No.:			
Date of Birth (dd/mm/yyyy):	CPF Account No.:			
Residential Address:				
Contact Details:	(Home)	(Office)	(Mobile )	(Email Add)
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced
Nationality:	<input type="checkbox"/> Singaporean	<input type="checkbox"/> PR		
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female		

**Section B: Change of Payer**Relationship of Insured Person to Payer:  Self  Spouse  Child  Parent  Grandparent

Details of New Payer (Note: A copy of new payer's NRIC / Passport is required)			
Name:	NRIC / Passport No.:		
Date of Birth (DD/MM/YYYY):	CPF Account No.:		
Residential Address:			
Contact Details:	(Home)	(Office)	(Mobile ) (Email Add)
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Nationality:	<input type="checkbox"/> Singaporean	<input type="checkbox"/> PR	
Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	

**Section C: Change of Payment Frequency**

Change of Payment Frequency  Annually  Monthly  Quarterly

(Factor of 0.0853 to be applied) (Factor of 0.2548 to be applied)

\*Only applicable to Global Health and Ideal Medical

**Section D: Change of Personal Particulars**Please note:

- Kindly submit photocopy of NRIC/Passport and Deed Poll for Change of Name.
- Kindly submit photocopy of NRIC/Passport for Change of NRIC/Passport and Date of Birth

This Change of Particulars is for:	(Life Assured / Insured Person / Assured / Insured)		
Change of Name:	New Name:		
Change of NRIC / Passport No.:	New NRIC / Passport:		
Change of Date of Birth:	New Date of Birth (DD/MM/YYYY):		
Change of Address to:	<input type="checkbox"/> Residential Address <input type="checkbox"/> Correspondence Address <input type="checkbox"/> Both Addresses		
Change of Contact Details:	Residential No.:	Mobile No.:	Office No.:
	Email:		
Change of Signature: (Please ensure that the previous signature is signed)			
_____ Name of Signatory	_____ Previous Signature	_____ New Signature	

**Section E: Change of Plan (MyShield / MyShield Plus / Global Health / IdealMedical)**

**MyShield / MyShield Plus**

Please Note:

- For Upgrade of Plan and/or Adding of Option(s), please complete **Health Declaration Form** if your existing policy is under "Full Medical Underwriting" acceptance terms.
- Change of Plan will only be effective on the 1<sup>st</sup> of the policy anniversary month if the application is accepted by the Company no later than 15<sup>th</sup> of the month prior to the policy anniversary. Otherwise the Change of Plan will only be effective on the policy anniversary date of the following year.
- This form must be submitted at least 30 days before the next policy anniversary date. If the upgrade of plan results in further underwriting requirements, the plan can only take effect at the policy anniversary date after the acceptance of upgrade.
- Only Singapore Citizens can be covered under Plan 3
- An application to upgrade an existing plan may be subject to new counter-offer terms by Aviva after underwriting.
- Any successful upgrade of plan shall be subjected to the definition of pre-existing conditions as stated in the policy contract.
- MyShield Plus Plan Type (Option A and/or B) will be upgraded / downgraded to follow MyShield.

<input type="checkbox"/> Change from Current Plan to *:	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3
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<u>Applicable for <b>Existing</b> MyShield Plus Only</u>	<input type="checkbox"/> Option A (Covers Co-Insurance and 30 Major Illness) <b>OR</b>
<input type="checkbox"/> Addition of Option:	<input type="checkbox"/> Option B (Covers Deductible)
<u>Applicable for <b>Existing</b> MyShield Plus Only</u>	<input type="checkbox"/> Option A (Covers Co-Insurance and 30 Major Illness) <b>OR / AND</b>
<input type="checkbox"/> Deletion of Option(s):	<input type="checkbox"/> Option B (Covers Deductible)

**Global Health**

Please Note:

- For upgrade of plan, please complete **Health Declaration Form**.
- For Change of Current Deductible Amount to a Lower Deductible Amount, please complete **Health Declaration Form**.
- Change of Plan and/or Change of Current Deductible Amount will only be effective on the next policy anniversary date if the application is submitted at least 30 days prior to this date. If the upgrade of plan results in further underwriting requirements, the plan can only take effect at the policy anniversary date after the acceptance of upgrade.
- All Dependant Child(ren) must apply for the same plan type and deductible amount. The chosen plan type must not be higher than the Proposer / Spouse / Co-habitant's.
- For addition of Dental Benefit, please complete **Health Declaration Form**.

<input type="checkbox"/> Change from Current Plan to *:	<input type="checkbox"/> Classic <input type="checkbox"/> Supreme <input type="checkbox"/> Elite
<input type="checkbox"/> Change of Area of Cover to *:	<input type="checkbox"/> Area 1 - Worldwide <input type="checkbox"/> Area 2 – Worldwide excluding USA
<input type="checkbox"/> Change of Deductible Amount to *:	<input type="checkbox"/> No Deductible <input type="checkbox"/> US\$500 / £300 / €400 / S\$850 <input type="checkbox"/> US\$1,000 / £600 / €800 / S\$1,750 <input type="checkbox"/> US\$2,000 / £1,200 / €1,600 / S\$3,500

<input type="checkbox"/> Addition of Dental Benefit
<input type="checkbox"/> Deletion of Dental Benefit

**Section E: Change of Plan (MyShield / MyShield Plus / Global Health / IdealMedical) (continued)**

**Ideal Medical**

Please Note:

- For Upgrade of Plan, please complete **Health Declaration Form**.
- For Change of Current Deductible Amount to a Lower Deductible Amount, please complete **Health Declaration Form**.
- Change of Plan and/or Change of Current Deductible Amount will only be effective on the next policy anniversary date if the application is submitted at least 30 days prior to this date. If the upgrade of plan results in further underwriting requirements, the plan can only take effect at the policy anniversary date after the acceptance of upgrade.
- All Dependant Child(ren) must apply for the same plan type and deductible amount. The chosen plan type must not be higher than the Proposer / Spouse / Co-habitant's.

<input type="checkbox"/> Change from Current Plan to *:	<input type="checkbox"/> Classic <input type="checkbox"/> ClassicPlus <input type="checkbox"/> Supreme <input type="checkbox"/> SupremePlus
<input type="checkbox"/> Change of Deductible Amount to *:	<input type="checkbox"/> No Deductible <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000

**Section F: Reinstatement of Lapsed Medical Policy**

I wish to apply for reinstatement\* of the stated Policy and confirm that the declaration written on the Health Declaration Form is true to the best of my knowledge and no material facts have been withheld.  
*(Health Declaration form is not applicable for Insured Person(s) under Moratorium Underwriting terms)*

Payment of Outstanding Premiums : \$ \_\_\_\_\_ Cheque Number : \_\_\_\_\_

\*Reinstatement is only applicable for policy that has lapsed due to non-payment of premium.

**Section G: Others (Kindly indicate the changes below)**

## AUTHORISATION AND DECLARATION

I, the legal owner of this Policy, hereby request that this Policy be changed as indicated above 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.

I authorise the Central Provident Fund Board (the "CPF Board") to deduct premium(s) due for the Life/Lives to be covered as named under this application (the "Lives") from my Medisave account in accordance with the provisions of the Central Provident Fund Act. (Chapter 36, and the regulations 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.

I authorise the CPF Board to deduct premium(s) under this application from my new Medisave account should I be given a new Medisave account upon obtaining Singapore Permanent Residence status.

I further declare that I am not an undischarged bankrupt and that I have committed no act of bankruptcy within the last 12 months and no receiving order or adjudication order in bankruptcy has been made against me during that period.

I understand that the Policy will be reinstated and the insurance cover restored only when an official letter confirming reinstatement has been issued by Aviva Ltd. Aviva Ltd will not be liable for any claims arising between the date of lapsing of the Policy and the reinstatement date of the Policy. In addition, treatment provided to the Insured Person within 30 days of the reinstatement date will also not be covered unless the treatment received as an Inpatient is for injuries caused by an accident occurring after the reinstatement date. (Applicable for Section G)

I/We declare that all the information on this Form and Health Declaration Form is true and complete to the best of my knowledge and understand that any misrepresentation or concealment of facts shall render the policy to be issued null and void.

I/We agree to inform Aviva Ltd if there is any change in the state of my and/or my dependant(s)'s health/activities between the date of this form/Health Declaration form and the date of acceptance of terms by Aviva. I understand the terms of accepting me and/or my dependant(s) as a risk for insurance coverage may vary accordingly to such information received.

I/We authorize any medical source, insurance office, or organization to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organizations, relevant information concerning me/us at any time, regardless of whether the request/application is accepted by Aviva Ltd. A photographic copy of this authorization shall be valid as the original.

<b>Signature of Assured / Insured</b>	<b>Signature of Life Assured / Insured Person (16 years old and above)</b>	<b>Signature of New Policyholder</b>	<b>Signature of New Payer</b>	<b>Date of Declaration</b>
<b>Name of Adviser</b>	<b>Source Code</b>	<b>Name of Firm</b>	<b>Contact No</b>	