



PRODUCT SUMMARY

Date: / / (DD/MM/YY)Presented to:
(Name of Proposer)Name of
Financial Adviser: Signature of
Proposer: Signature of
Financial Adviser:

PRODUCT INFORMATION

Global Health is a medical expense insurance plan that covers eligible inpatient and outpatient expenses as a result of an illness or accident, subject to the limits set out in the Benefit Schedule shown below. This plan provides transportability where your cover can continue even if you relocate to another country within the relevant Area of Cover. If your selected area of cover is 'Worldwide', you can elect to seek covered treatment anywhere in the world. If your selected area of cover is 'Worldwide, excluding USA' you may elect to seek covered treatment anywhere in the world, except the USA, where cover will be limited to Emergency Treatment only.

Benefit / Plan Type	Classic	Supreme	Elite
Annual Limits Per Insured Person	USD1,000,000 / £600,000 / €900,000/ SGD1,700,000	USD1,600,000 / £1,000,000 / €1,500,000/ SGD2,800,000	USD2,000,000 / £1,200,000 / €1,800,000/ SGD3,500,000
A. Hospital & Related Services			
In-Hospital Accommodation up to Standard Private Single Bed, Surgery, Treatment, Facilities & Services	In Full	In Full	In Full
Cancer Treatment (inpatient & outpatient)	In Full	In Full	In Full
Kidney Dialysis (inpatient & outpatient)	In Full	In Full	In Full
Physiotherapy Treatment	In Full	In Full	In Full
Inpatient Psychiatric Treatment (after 10 months of coverage)	USD10,000 / £6,000 / €9,000/ SGD18,000	USD10,000 / £6,000 / €9,000/ SGD18,000	USD10,000 / £6,000 / €9,000/ SGD18,000
Day Surgery	In Full	In Full	In Full
Casualty Ward Accident & Emergency Services	In Full	In Full	In Full
Pre-Hospital Specialist & Diagnostic Services (within 60 days prior to hospital admission)	In Full	In Full	In Full
Post-Hospital Follow-Up Treatment (up to 3 months after discharge)	In Full	In Full	In Full
Hospital Accommodation for Accompanying Parent (for insured child below age 18)	In Full	In Full	In Full
Local Ambulance Services	In Full	In Full	In Full
Emergency Treatment in the USA (not exceeding 3 consecutive months per trip in the USA and subject to reasonable & customary charges)	USD75,000 / £45,000 / €60,000/ SGD125,000	USD100,000 / £60,000 / €85,000/ SGD175,000	In Full
Accident Dental Treatment (within 14 days of accident)	In Full	In Full	In Full
Home Nursing Care Following Discharge from Hospital (up to max. 26 weeks per policy year)	In Full	In Full	In Full
Daily Hospital Cash for Non-Paying Patient (max. 30 days per disability per policy year)	USD150 / £100 / €125/ SGD250	USD200 / £120 / €175/ SGD350	USD300 / £175 / €250/ SGD500
B. Organ Transplantation			
Operation Costs for Kidney, Heart, Liver, Lung & Bone Marrow Transplants (excluding costs of obtaining donor organs)	In Full	In Full	In Full
C. Emergency Medical Evacuation & Repatriation			
Emergency Medical Evacuation & Assistance	In Full	In Full	In Full
Repatriation	In Full	In Full	In Full
Emergency Medical Advice & Assistance	Provided	Provided	Provided
International Travel Assistance Services	Provided	Provided	Provided

Benefit / Plan Type	Classic	Supreme	Elite
D. Outpatient Benefits			
General Practitioner (GP) Services	Not covered		
Specialist (SP) Services			
Outpatient Psychiatric Treatment (after 10 months of coverage)	USD4,000 / £2,000 / €2,800/ SGD6,000	USD7,000 / £3,500 / €4,900/ SGD10,000	USD10,000 / £5,000 / €7,000/ SGD15,000
Outpatient Laboratory, X-Ray & Diagnostic Services (including CT, PET & MRI scans)			
Prescribed Drugs	Up to 30 visits per year for SP	Up to 35 visits per year for GP & SP	Up to 40 visits per year for GP & SP
Prescribed Physiotherapy, Speech Therapy & Oculomotor Therapy			
Prescribed Medical Aids (such as artificial limbs & hearing aids)			
Prescribed Alternative Medicine (chiropractor, homeopathy, osteopathy, acupuncture)	USD500 / £300 / €450/ SGD900	USD1,000 / £600 / €900/ SGD1,800	USD1,500 / £900 / €1,300/ SGD2,500
E. Special Benefits			
Health Screen (biennial after 2 years of continuous coverage)	USD100 / £50 / €80/ SGD160	USD120 / £80 / €100/ SGD200	USD150 / £90 / €125 SGD250
F. Maternity Benefit (subject to waiting period)			
Delivery	Not covered	USD8,000 / £4,500 / €7,000/ SGD14,000	USD15,000 / £9,000 / €12,500/ SGD25,000
Complications			
Neo-Natal Cover For Standard Nursery Charges (up to age 7 days old)			
G. Dental Benefit (optional)			
Routine Dental Treatment	USD500 / £300 / €450/ SGD750	USD500 / £300 / €450/ SGD750	USD500 / £300 / €450/ SGD750
Restorative Dental Treatment (subject to 6 months waiting period)	USD3,000 / £1,800 / €2,500/ SGD5,000	USD3,000 / £1,800 / €2,500/ SGD5,000	USD3,000 / £1,800 / €2,500/ SGD5,000

PREMIUM RATES

The premium payable is based on the age last birthday and zone of the Usual Country of Residence of each Insured Person at the date of underwriting approval and will increase when the Insured Person enters the next age band or change when the Insured Person changes the Usual Country of Residence. The premium payable will be in the same currency as the benefit currency. Please refer to the appendix for the Annual Premium Rates Table.

1. Premium Discount Options

An annual deductible option is available to all three product plans – Classic, Supreme, and Elite, and is applicable to all medical benefits before they are payable.

Deductible	Premium Discount
USD500 / £300 / €400 / SGD850	20%
USD1,000 / £600 / €800 / SGD1,750	25%
USD2,000 / £1,200 / €1,600 / SGD3,500	30%

2. What is a deductible?

A deductible is the amount of covered claim(s) accumulated on a Policy Year basis, which has to be borne by the Insured Person during any one Policy Year before any benefit is payable under this policy.

Deductible is applicable to all medical benefits in the Benefit Schedule, unless otherwise stated.

3. Premium Payment Methods

- cheque
- bank draft
- giro
- credit card

4. Payment must be received by Aviva Ltd before any cover can be granted.

- mode of premium:
 - annual (for all payment methods)
 - quarterly / monthly (for credit card payment only)
- factors will be applied for monthly and quarterly mode of payment:
 - monthly payment: 0.0853
 - quarterly payment: 0.2548

ELIGIBILITY

As proposer:

This plan is made available to Singaporeans; Singapore Permanent Residents; or foreign nationals living outside his or her Home Country, who are eighteen (18) years old and above and below sixty-five (65) years old, at age last birthday, as at the effective date.

As dependants:

Singaporeans; Singapore Permanent Residents; or foreign nationals living outside his or her Home Country who is the Insured's:

- (a) legal spouse below sixty-five (65) years old at age last birthday, who is not divorced or legally separated from the proposer, as at the effective date of the legal spouse's coverage; or
- (b) co-habitant of the proposer below sixty-five (65) years old at age last birthday, as at the effective date of the co-habitant's coverage; and/or
- (c) unmarried and unemployed child from one (1) day old, as at the effective date of the child's coverage.

A United States of America (USA) citizen or permanent resident (or equivalent) residing in the USA is not eligible to purchase this Policy.

Aviva Ltd reserves the right to impose or waive any restriction regarding residence or nationality at its sole and absolute discretion.

KEY PRODUCT PROVISIONS

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the policy contract. Please consult your financial adviser should you require further explanation.

1. Exclusions

There are certain conditions under which no benefit will be payable. These are stated as exclusions in the policy contract. The following is a list of some of the exclusions applicable under this plan. **You are advised to read the policy contract for the full list of exclusions.**

These exclusions include but are not limited, to the following:

- (a) pre-existing conditions:
means any injury, illness, condition or symptom:
 - for which treatment, medication, advice or diagnosis has been sought or received or was foreseeable by You or the Insured Person prior to the Insured Person's Effective Date or the date of Upgrade or the date of the last Reinstatement, whichever is later, for the Insured Person concerned; or
 - which originated or was known to exist by You or the Insured Person prior to the Insured Person's Effective Date or the date of Upgrade or the date of the last Reinstatement, whichever is later, whether or not treatment, medication, advice or diagnosis was sought or received.
- (b) routine medical examinations or check-ups, cosmetic treatments;
- (c) birth defects, congenital illnesses, hereditary conditions;
- (d) pregnancy, childbirth or miscarriage unless this benefit is stated in the Schedule as being covered by the policy;
- (e) self-inflicted injuries, suicide, abuse of alcohol, drug addiction or abuse, sexually transmitted diseases and AIDS or any AIDS related conditions or diseases;
- (f) treatment received outside area of cover unless due to an emergency as defined in the policy;
- (g) travel costs in respect of trips made specifically for the purpose of obtaining medical treatment unless in the course of an approved Emergency Medical Evacuation, and all Emergency Medical Evacuation costs which are not approved in advance by Us or Our appointed 24-hour Emergency Assistance Centre; and
- (h) war and terrorism.

2. Accuracy of Information

You must provide us with complete and accurate information when applying for this plan or when making any claim, as this may affect the validity of the policy and/or your rights under the policy may be reduced or lost.

3. Applicable Law

The terms and conditions of the policy will be governed by and construed, determined and enforced in accordance with the laws of Singapore.

4. Cancellation Clause

The Insured may cancel the policy by giving Aviva at least thirty (30) days prior notice in writing of his or her intention to cancel the policy.

Where the premium is charged on an annual basis and the Insured cancels the Policy during any Policy Year, the coverage under the policy for all Insured Persons will cease upon Aviva's receipt of the cancellation notice. The Insured will be entitled to a pro-rated refund of the annual premium paid to Aviva for the unexpired period of coverage. If a claim has arisen in respect of that Policy Year, no refund will be made.

Where premium is charged on other regular basis and the Insured cancels the policy, the coverage under the policy for all Insured Persons will cease on the Due Date after Our receipt of the cancellation notice. Aviva is entitled to the balance of the premium payable for the entire Policy Year if a claim arises in respect of that Policy Year. Aviva will deduct the balance of the premium from any claim amount due.

5. Change of Plans

The Insured may change the plan of an Insured Person, subject to Our approval in writing, by giving Us a written notice at least thirty (30) days prior to the Renewal Date of the policy. This is subjected to satisfactory evidence of insurability for each Insured Person at Your expense for any Upgrade and, where applicable, satisfaction of the terms of the Reinstatement provision, before the change can be effected on the Renewal Date or Reinstatement date, as applicable.

To effect a change of plan for an Insured Person classified as a Dependant child ("Dependant Child"), all Dependant Children must apply, at the same time, for a change of plan to a same plan.

In the event of an Upgrade, any claim arising from a Pre-Existing condition after the Upgrade and/or any claim arising during the applicable Waiting Period after the Upgrade, will be assessed under the terms and conditions of the plan prior to the Upgrade and if such a claim is admissible, any benefit payout would be limited to the benefits under the plan prior to the Upgrade.

6. Continuity of Benefits after Termination of Policy

If the policy is terminated as provided in the Termination Clause, covered benefits in respect of any valid claim will continue to be payable for up to a maximum period of thirty (30) days after the policy terminates but only if all of the following are satisfied:

- (a) the claim was reported and accepted by Us before the policy was terminated;
- (b) the Insured Person's Usual Country of Residence at the time of the Accident or Illness giving rise to the claim, was within the Area of Cover stated in the Schedule; and
- (c) the claim only relates to covered treatment obtained within the Area of Cover stated in the Schedule.

7. Co-ordination of Benefits

The policy will only provide compensation on a proportionate basis if the Insured Person has any other insurance in force or is entitled to indemnity from any other source in respect of the same Accident, illness, death or expense. Aviva has full rights where permitted by law to take proceedings in the Insured's or the Insured Person's name, but at Aviva's expense, to recover for Aviva's benefit, the amount of any payment Aviva has made under the policy.

8. Elective Treatment

The Insured Person has the flexibility to choose where, when and by whom they are treated, even in the USA, provided it is within their plan's Area of Cover. Subject to the terms of the policy, Area 1, which consists of Zone 1 under the policy, offers worldwide coverage including the United States of America while Area 2, which consists of Zones 2 to 8 under the policy, offers worldwide coverage excluding the United States of America.

9. Emergency Treatment in the United States of America

Charges for an Emergency Medical Complaint occurring during short period business or holiday travel not exceeding three (3) consecutive months per trip in the USA will be covered for Insured Persons, including those who are citizens of the USA, whose Area of Cover under the policy excludes the USA. This benefit is available to those whose Area of Cover under the policy includes the USA whereby the three (3) month requirement set out above will not apply. We will not cover any costs for treatment provided in a Hospital unless the hospitalisation begins within twenty-four (24) hours after the Emergency Medical Complaint arose.

Emergency Medical Complaint means a medical condition resulting from an Accident, or any sudden beginning or worsening of a severe illness that:

- (a) presents an immediate and serious threat to the Insured Person's health; and
- (b) requires immediate medical attention by a physician.

10. Material Changes

Aviva must be informed immediately in writing of any material change in information or circumstances whether relating to occupation, business, sporting activity or Usual Country of Residence (including if this is the Insured Person's Home Country) affecting You or any Insured Person. Provided the laws of the new Usual Country of Residence (including if this is the Insured Person's Home Country) allow, Aviva will continue cover for the Insured Person on terms and conditions, including premium rates, Aviva consider appropriate because of the material change in circumstances.

11. Non-Guaranteed Premium

Premium rates payable under this policy are not guaranteed and may be increased on the policy renewal date based on the claims experience of the portfolio.

12. Payment Guarantees & Direct Settlements

When furnished with adequate advance notice of a claim, Aviva or the 24-hour Emergency Medical Assistance Centre will provide the Insured Person a confirmation of the extent of insurance benefits, monitor claims procedures, issue (wherever reasonably possible) appropriate Payment Guarantees and/or arrange direct settlement of the bills rendered by Hospitals, Physicians or other service providers.

Aviva will not provide Payment Guarantees or direct settlements if neither Aviva nor the 24-hour Emergency Medical Assistance Centre is contacted reasonably in advance.

Covered Outpatient Services are not subject to Payment Guarantees or direct settlement and must be paid by the Insured Person and reimbursed subsequently under the policy.

If Aviva makes any payment under the Payment Guarantee or direct settlement which payment should have been made by the Insured, the Insured shall reimburse the amount(s) paid by Aviva within thirty (30) days of being notified.

13. Reinstatement

If the policy terminates due to non-payment of premium, You may apply to reinstate this policy within thirty (30) days of the date of notice of termination by providing Us with satisfactory evidence of insurability for each Insured Person at Your expense, provided the Insured Person for whom reinstatement is requested is not older than age sixty-five (65) on the date of reinstatement. All outstanding premiums must be received by Us before the policy can be reinstated.

Treatment provided to the Insured Person after the date of termination and within thirty (30) days of the date of notice of reinstatement will not be covered unless the treatment is for injuries caused by an Accident occurring after the date of notice of reinstatement.

14. Termination Clause

The cover of an Insured Person under this policy will automatically terminate on the date any one of the following events first occurs:

- (a) upon death of the Insured Person;
- (b) upon request of cancellation of an Insured Person's coverage under this policy by the Insured;
- (c) non-payment of premium after the grace period; or
- (d) the Insured Person, who is a citizen or permanent resident (or equivalent) of the USA, returns to the USA for three (3) consecutive months or more.

15. Terms of Renewal

The policy is automatically renewed for the next insurance year by payment of the renewal premium before the Due Date provided the existing plan the Insured has selected for the policy is still available. On the renewal date, Aviva may vary the benefits, cover and/or premium or even cancel all policies in a particular age group or of a plan type by giving you thirty (30) days advance notice in writing to the Insured, but Aviva will not cancel any individual policy.

16. Waiting Period

means the period of time applicable to specific benefits under the policy as set out under the relevant benefit provisions, starting from:

- (a) the Insured Person's Effective Date under the policy; or
- (b) the date of the last notice of Reinstatement; or
- (c) the date of Upgrade.

whichever is later, during which the policy will not provide for that respective benefit regardless of treatment made necessary by any cause.

17. Aviva's Promise of Service

We wish to provide You with a high standard of service and to meet any claims covered by this Policy honestly, fairly and promptly. Information on the distribution costs will be made available at your request.

Please note that the product and prices available may be subject to change at short notice due to regulatory changes, tax or other matters outside of Aviva's control.

18. Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme, and is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for Your Policy is automatic and no further action is required from You. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Us or visit the LIA or SDIC web-sites (www.lia.org.sg or www.sdic.org.sg).

Note: This is only product information provided by us and does not form part of any contract of insurance. Full details of the terms, conditions and exceptions of this insurance are provided in the policy and will be sent to you upon acceptance by Aviva Ltd. For avoidance of doubt, only the terms and conditions as appeared in the policy will bind the parties. You have a "Free Look" period of 14 working days from the date you receive the policy. Please inform Aviva Ltd within 14 working days if you do not want the policy. It will be cancelled from its commencement date and any premium that you may have paid will be refunded in full after deducting any expenses incurred in assessing the risk under the policy, so long as no claim has arisen. This policy is governed by and shall be construed in accordance with the laws of Singapore.

APPENDIX

Annual Premium Rates Table (exclusive of prevailing Goods & Services Tax)

A prevailing Goods & Services Tax will be applicable if you are residing in Singapore.

Classic Plan

Age Last Birthday	Zone 1				Zone 2				Zone 3				Zone 4				Zone 5				Zone 6				Zone 7				Zone 8						
	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro
Below 18	1,957	979	1,410	2,700	1,574	788	1,134	2,173	1,138	570	819	1,570	911	456	657	1,257	847	424	611	1,169	774	388	558	1,069	683	342	492	942	638	320	460	880			
18 - 24	3,206	1,604	2,309	4,425	2,579	1,290	1,858	3,560	1,864	933	1,342	2,573	1,491	746	1,075	2,058	1,388	695	1,000	1,915	1,268	635	914	1,750	1,119	560	806	1,544	1,044	522	752	1,441			
25 - 29	3,983	1,992	2,868	5,497	3,205	1,603	2,308	4,423	2,316	1,159	1,668	3,196	1,853	927	1,335	2,557	1,724	863	1,242	2,379	1,575	788	1,134	2,174	1,390	696	1,001	1,918	1,297	649	935	1,791			
30 - 34	4,282	2,141	3,084	5,910	3,446	1,724	2,482	4,755	2,490	1,246	1,794	3,436	1,992	997	1,435	2,749	1,853	927	1,335	2,557	1,693	847	1,220	2,337	1,495	748	1,077	2,063	1,395	698	1,005	1,925			
35 - 39	4,564	2,282	3,287	6,298	3,672	1,837	2,644	5,068	2,654	1,328	1,911	3,663	2,124	1,062	1,529	2,931	1,974	987	1,422	2,725	1,805	903	1,300	2,492	1,592	796	1,147	2,198	1,486	744	1,070	2,051			
40 - 44	5,169	2,585	3,722	7,133	4,158	2,079	2,995	5,739	3,006	1,503	2,165	4,148	2,404	1,203	1,732	3,317	2,236	1,119	1,610	3,086	2,044	1,022	1,473	2,821	1,803	902	1,299	2,489	1,684	843	1,213	2,324			
45 - 49	5,896	2,949	4,246	8,137	4,744	2,372	3,416	6,547	3,429	1,715	2,469	4,732	2,743	1,372	1,976	3,786	2,551	1,276	1,837	3,521	2,331	1,166	1,679	3,218	2,057	1,029	1,482	2,840	1,920	960	1,383	2,650			
50 - 54	6,600	3,301	4,753	9,108	5,311	2,656	3,825	7,331	3,837	1,919	2,763	5,296	3,071	1,536	2,212	4,238	2,855	1,428	2,056	3,941	2,610	1,306	1,880	3,602	2,303	1,152	1,658	3,179	2,150	1,076	1,548	2,967			
55 - 59	8,211	4,106	5,913	11,332	6,608	3,305	4,758	9,120	4,775	2,388	3,438	6,589	3,820	1,910	2,751	5,273	3,553	1,777	2,558	4,903	3,247	1,624	2,339	4,481	2,865	1,433	2,064	3,954	2,675	1,338	1,926	3,691			
60 - 64	10,367	5,184	7,465	14,307	8,342	4,171	6,006	11,512	6,027	3,014	4,340	8,319	4,822	2,411	3,473	6,654	4,485	2,243	3,230	6,189	4,099	2,050	2,952	5,657	3,617	1,809	2,604	4,991	3,376	1,689	2,431	4,659			
65 - 69	14,733	7,367	10,609	20,332	11,855	5,928	8,536	16,361	8,566	4,283	6,168	11,822	6,853	3,427	4,934	9,457	6,373	3,187	4,589	8,795	5,825	2,913	4,194	8,038	5,140	2,571	3,702	7,094	4,798	2,400	3,455	6,622			
70	16,720	8,361	12,039	23,073	13,453	6,727	9,687	18,566	9,721	4,861	7,000	13,416	7,777	3,889	5,600	10,733	7,233	3,617	5,208	9,982	6,610	3,306	4,760	9,123	5,833	2,917	4,200	8,050	5,444	2,722	3,920	7,512			
71	16,965	8,483	12,216	23,412	13,652	6,827	9,830	18,840	9,864	4,932	7,103	13,613	7,891	3,946	5,682	10,890	7,339	3,670	5,285	10,128	6,708	3,354	4,830	9,257	5,919	2,960	4,262	8,169	5,525	2,763	3,978	7,625			
72	17,212	8,606	12,394	23,753	13,850	6,925	9,972	19,114	10,008	5,005	7,207	13,811	8,007	4,004	5,765	11,050	7,446	3,724	5,362	10,276	6,806	3,404	4,901	9,392	6,005	3,003	4,324	8,288	5,604	2,803	4,036	7,735			
73	17,478	8,740	12,585	24,120	14,064	7,032	10,127	19,409	10,162	5,081	7,318	14,024	8,130	4,065	5,854	11,219	7,560	3,780	5,444	10,433	6,911	3,456	4,976	9,537	6,098	3,050	4,392	8,415	5,691	2,846	4,099	7,854			
74	17,751	8,876	12,831	24,496	14,283	7,142	10,284	19,710	10,320	5,160	7,431	14,242	8,257	4,129	5,946	11,394	7,679	3,840	5,530	10,597	7,019	3,510	5,054	9,686	6,192	3,097	4,459	8,545	5,780	2,890	4,162	7,976			
75	19,353	9,677	13,935	26,707	15,572	7,786	11,212	21,490	11,252	5,626	8,102	15,529	9,002	4,502	6,482	12,423	8,372	4,187	6,029	11,554	7,652	3,827	5,510	10,560	6,752	3,376	4,862	9,318	6,302	3,152	4,538	8,697			
76	19,619	9,810	14,126	27,074	15,786	7,893	11,367	21,785	11,407	5,704	8,214	15,741	9,125	4,563	6,570	12,593	8,487	4,244	6,111	11,712	7,757	3,879	5,585	10,705	6,844	3,422	4,928	9,445	6,388	3,195	4,599	8,815			
77	19,883	9,942	14,316	27,439	15,999	8,000	11,520	22,080	11,561	5,781	8,325	15,954	9,249	4,625	6,660	12,764	8,601	4,301	6,193	11,870	7,862	3,932	5,661	10,850	6,937	3,469	4,995	9,573	6,475	3,238	4,662	8,936			
78	20,173	10,087	14,525	27,839	16,232	8,117	11,688	22,401	11,729	5,865	8,446	16,186	9,383	4,692	6,756	12,949	8,727	4,364	6,284	12,044	7,976	3,988	5,744	11,008	7,038	3,519	5,068	9,712	6,568	3,285	4,730	9,064			
79	20,445	10,223	14,721	28,214	16,452	8,226	11,846	22,704	11,888	5,945	8,560	16,405	9,510	4,756	6,849	13,124	8,845	4,423	6,369	12,206	8,083	4,042	5,821	11,156	7,133	3,567	5,136	9,844	6,657	3,329	4,794	9,188			
80 & Above	22,111	11,056	15,921	30,515	17,793	8,897	12,812	24,555	12,856	6,429	9,256	17,741	10,285	5,143	7,406	14,194	9,565	4,783	6,887	13,200	8,743	4,372	6,295	12,065	7,714	3,857	5,555	10,645	7,200	3,601	5,185	9,937			

Supreme Plan

Age Last Birthday	Zone 1				Zone 2				Zone 3				Zone 4				Zone 5				Zone 6				Zone 7				Zone 8						
	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro
Below 18	2,701	1,351	1,945	3,728	2,173	1,087	1,565	2,999	1,570	786	1,131	2,168	1,256	628	906	1,734	1,169	585	843	1,613	1,068	535	770	1,475	942	472	679	1,300	880	440	635	1,215			
18 - 24	4,367	2,184	3,145	6,027	3,514	1,757	2,531	4,849	2,539	1,270	1,829	3,504	2,032	1,017	1,464	2,805	1,889	945	1,361	2,608	1,727	864	1,244	2,383	1,524	763	1,098	2,104	1,422	711	1,024	1,963			
25 - 29	5,434	2,718	3,913	7,500	4,373	2,187	3,149	6,035	3,160	1,581	2,276	4,361	2,528	1,265	1,821	3,489	2,351	1,176	1,694	3,245	2,149	1,075	1,548	2,966	1,896	949	1,365	2,616	1,770	886	1,275	2,443			
30 - 34	5,751	2,876	4,142	7,937	4,628	2,315	3,333	6,387	3,345	1,673	2,409	4,616	2,676	1,338	1,927	3,693	2,488	1,245	1,792	3,434	2,275	1,138	1,638	3,140	2,007	1,004	1,445	2,770	1,874	937	1,350	2,586			
35 - 39	6,281	3,141	4,523	8,667	5,053	2,527	3,639	6,974	3,651	1,826	2,630	5,039	2,922	1,461	2,105	4,032	2,717	1,359	1,957	3,750	2,484	1,243	1,789	3,428	2,192	1,097	1,579	3,026	2,046	1,023	1,474	2,824			
40 - 44	7,024	3,513	5,058	9,693	5,653	2,827	4,070	7,801	4,084	2,043	2,942	5,636	3,268	1,634	2,354	4,510	3,039	1,520	2,189	4,194	2,778	1,390	2,001	3,834	2,451	1,226	1,766	3,383	2,287	1,144	1,648	3,157			
45 - 49	8,126	4,064	5,852	11,214	6,539	3,270	4,709	9,024	4,725	2,363	3,402	6,521	3,780	1,890	2,722	5,217	3,516	1,758	2,532	4,853	3,213	1,607	2,315	4,435	2,835	1,418	2,042	3,913	2,646	1,323	1,906	3,652			
50 - 54	9,067	4,534	6,529	12,513	7,297	3,649	5,255	10,070	5,273	2,637	3,797	7,276	4,218	2,110	3,038	5,822	3,923	1,962	2,825	5,414	3,585	1,793	2,582	4,948	3,164	1,583	2,279	4,366	2,953	1,477	2,127	4,076			
55 - 59	10,810	5,406	7,784	14,919	8,699	4,350	6,264	12,004	6,285	3,143	4,526	8,673	5,028	2,514	3,621	6,939	4,676	2,339	3,368	6,454	4,274	2,137	3,078	5,898	3,771	1,886	2,716	5,204	3,520	1,760	2,535	4,858			
60 - 64	13,832	6,917	9,960	19,088	11,130	5,565	8,014	15,360	8,042	4,022	5,791	11,099	6,434	3,218	4,633	8,879	5,983	2,992	4,309	8,258	5,469	2,735	3,938	7,548	4,826	2,413	3,476	6,661	4,504	2,253	3,244	6,215			
65 - 69	19,966	9,984	14,376	27,554	16,067	8,034	11,568	22,172	11,609	5,805	8,360	16,021	9,288	4,645	6,688	12,818	8,638	4,319	6,220	11,920	7,894	3,947	5,684	10,894	6,966	3,483	5,016	9,613	6,501	3,251	4,681	8,972			
70	22,852	11,427	16,454	31,535	18,388	9,194	13,240	25,376	13,286	6,644	9,567	18,336	10,629	5,315	7,653	14,668																			

APPENDIX

Elite Plan

Age Last Birthday	Zone 1				Zone 2				Zone 3				Zone 4				Zone 5				Zone 6				Zone 7				Zone 8			
	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD
Below 18	3,208	1,605	2,310	4,427	2,581	1,291	1,859	3,563	1,865	933	1,343	2,574	1,493	747	1,076	2,060	1,389	695	1,000	1,917	1,269	635	914	1,752	1,120	560	807	1,546	1,045	523	753	1,443
18 - 24	5,107	2,554	3,678	7,047	4,109	2,055	2,959	5,670	2,970	1,485	2,139	4,099	2,376	1,188	1,711	3,279	2,210	1,105	1,591	3,050	2,020	1,011	1,455	2,787	1,782	892	1,284	2,460	1,664	832	1,199	2,296
25 - 29	6,216	3,108	4,477	8,579	5,002	2,502	3,602	6,902	3,615	1,808	2,603	4,988	2,892	1,446	2,083	3,992	2,690	1,346	1,937	3,712	2,459	1,230	1,771	3,393	2,169	1,085	1,562	2,993	2,025	1,013	1,459	2,795
30 - 34	6,782	3,392	4,884	9,360	5,458	2,729	3,931	7,533	3,944	1,972	2,841	5,444	3,156	1,579	2,273	4,355	2,934	1,467	2,113	4,049	2,682	1,341	1,931	3,702	2,367	1,184	1,705	3,267	2,209	1,105	1,591	3,049
35 - 39	7,259	3,630	5,227	10,017	5,842	2,922	4,207	8,061	4,220	2,111	3,039	5,825	3,377	1,689	2,432	4,661	3,141	1,571	2,262	4,335	2,870	1,436	2,067	3,961	2,533	1,267	1,824	3,496	2,364	1,183	1,703	3,263
40 - 44	8,183	4,092	5,892	11,293	6,585	3,293	4,742	9,087	4,758	2,380	3,427	6,566	3,807	1,904	2,741	5,254	3,540	1,771	2,550	4,885	3,236	1,619	2,330	4,465	2,855	1,428	2,056	3,941	2,665	1,333	1,920	3,679
45 - 49	9,167	4,584	6,601	12,651	7,377	3,689	5,311	10,180	5,330	2,665	3,838	7,356	4,265	2,133	3,071	5,886	3,966	1,984	2,856	5,474	3,625	1,813	2,611	5,003	3,199	1,600	2,304	4,415	2,986	1,494	2,150	4,121
50 - 54	10,481	5,241	7,547	14,463	8,433	4,217	6,073	11,638	6,094	3,048	4,388	8,410	4,876	2,439	3,511	6,729	4,534	2,267	3,265	6,257	4,144	2,072	2,985	5,719	3,657	1,829	2,634	5,047	3,413	1,707	2,457	4,710
55 - 59	12,624	6,312	9,089	17,421	10,157	5,079	7,314	14,017	7,340	3,670	5,285	10,130	5,872	2,936	4,229	8,103	5,460	2,730	3,932	7,535	4,991	2,496	3,595	6,888	4,404	2,202	3,171	6,078	4,110	2,055	2,960	5,673
60 - 64	16,869	8,435	12,146	23,279	13,574	6,788	9,774	18,732	9,807	4,904	7,062	13,535	7,846	3,923	5,649	10,828	7,297	3,649	5,255	10,070	6,670	3,335	4,803	9,205	5,885	2,943	4,237	8,121	5,493	2,747	3,956	7,580
65 - 69	23,508	11,754	16,926	32,441	18,916	9,459	13,620	26,105	13,668	6,835	9,842	18,863	10,934	5,468	7,873	15,089	10,169	5,085	7,322	14,033	9,294	4,648	6,692	12,826	8,201	4,101	5,906	11,317	7,654	3,828	5,512	10,562
70	26,940	13,471	19,398	37,178	21,678	10,840	15,609	29,916	15,663	7,832	11,279	21,616	12,531	6,266	9,023	17,293	11,653	5,827	8,391	16,082	10,652	5,326	7,670	14,699	9,398	4,699	6,767	12,969	8,772	4,386	6,316	12,106
71	27,376	13,688	19,711	37,779	22,028	11,015	15,861	30,400	15,917	7,959	11,461	21,966	12,734	6,368	9,169	17,573	11,842	5,921	8,528	16,343	10,824	5,412	7,794	14,938	9,550	4,776	6,877	13,180	8,914	4,458	6,419	12,301
72	27,808	13,905	20,022	38,375	22,376	11,188	16,112	30,879	16,167	8,084	11,641	22,311	12,934	6,467	9,313	17,849	12,029	6,015	8,662	16,601	10,994	5,497	7,916	15,172	9,701	4,851	6,986	13,388	9,055	4,528	6,520	12,495
73	28,407	14,204	20,453	39,202	22,858	11,430	16,458	31,545	16,516	8,259	11,892	22,793	13,214	6,607	9,515	18,235	12,289	6,145	8,849	16,959	11,231	5,616	8,088	15,500	9,910	4,955	7,136	13,677	9,250	4,626	6,661	12,765
74	29,008	14,504	20,886	40,031	23,341	11,671	16,806	32,211	16,866	8,433	12,144	23,275	13,492	6,747	9,715	18,619	12,548	6,274	9,035	17,316	11,469	5,735	8,258	15,827	10,119	5,060	7,286	13,965	9,445	4,723	6,801	13,035
75	32,586	16,293	23,463	44,969	26,221	13,111	18,879	36,186	18,946	9,474	13,641	26,145	15,157	7,579	10,914	20,918	14,096	7,048	10,150	19,453	12,884	6,442	9,277	17,780	11,368	5,684	8,185	15,687	10,611	5,306	7,640	14,643
76	33,179	16,590	23,890	45,788	26,698	13,349	19,223	36,843	19,291	9,646	13,890	26,622	15,432	7,717	11,112	21,297	14,353	7,177	10,335	19,808	13,118	6,560	9,445	18,104	11,575	5,788	8,334	15,973	10,803	5,402	7,779	14,908
77	33,786	16,894	24,327	46,626	27,186	13,594	19,575	37,517	19,644	9,822	14,144	27,109	15,715	7,858	11,315	21,687	14,615	7,308	10,524	20,170	13,358	6,680	9,618	18,433	11,787	5,894	8,487	16,266	11,000	5,500	7,921	15,180
78	34,175	17,088	24,606	47,161	27,499	13,750	19,800	37,949	19,870	9,936	14,307	27,420	15,895	7,948	11,445	21,936	14,783	7,392	10,644	20,402	13,512	6,756	9,729	18,646	11,922	5,961	8,584	16,453	11,127	5,564	8,012	15,356
79	34,571	17,286	24,892	47,708	27,817	13,909	20,029	38,387	20,100	10,050	14,473	27,737	16,080	8,040	11,579	22,191	14,955	7,478	10,768	20,637	13,668	6,835	9,842	18,863	12,060	6,031	8,684	16,643	11,256	5,628	8,105	15,534
80 & Above	36,927	18,464	26,588	50,959	29,713	14,857	21,394	41,005	21,470	10,736	15,459	29,628	17,175	8,588	12,367	23,702	15,973	7,987	11,501	22,043	14,600	7,300	10,512	20,148	12,882	6,441	9,275	17,777	12,023	6,012	8,657	16,592

Optional Dental

Optional Dental Plan	Zone 1				Zone 2				Zone 3				Zone 4				Zone 5				Zone 6				Zone 7				Zone 8			
	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD	USD	£	Euro	SGD
Classic / Supreme / Elite	1,613	807	1,162	2,226	1,298	649	935	1,792	938	470	676	1,295	750	375	541	1,036	699	350	503	964	638	320	460	880	563	282	406	777	525	263	378	725

Important Notes

1. Premium rates are not guaranteed.
2. Age 65 and above are for renewal only.
3. Premium rates excludes relevant taxes (eg. VAT, GST, IPT, etc)
4. Please note that the product and prices available may be subject to change at short notice due to regulatory changes, tax or other matters outside of Aviva's control.

AREA GUIDE

The following is the list of countries in each of the 8 zones. Please choose Zone 1 if you reside in USA* or if you like to have USA in your cover. Otherwise, choose the zone based on the country you will be residing in.

* Not available to USA Citizens, USA Permanent Residents or equivalent.

Zone 1	Zone 2	Zone 3	Zone 4
USA	China Hong Kong Israel	Bahrain Greece Guatemala Honduras Mexico	Indonesia Japan Jersey Singapore Switzerland Taiwan United Kingdom
Zone 5 Alderney American Samoa Anguilla Antigua and Barbuda Argentina Aruba Bahamas Bangladesh Barbados Belize Bermuda Bolivia Brazil Canada Canary Islands Cayman Islands Chile Colombia Costa Rica	Cuba Dominica Dominican Republic Ecuador El Salvador Falkland Islands (Malvinas) Germany Gibraltar Grenada Guadeloupe Guernsey Guyana Haiti Holy See (Vatican City State) Iran (Islamic Republic of) Iraq Ireland Isle of Man Italy Jamaica	Kenya Kuwait Lebanon Liechtenstein Madeira Martinique Monaco Mongolia Montserrat Netherlands Netherlands Antilles Nicaragua Norway Panama Paraguay Peru Portugal Puerto Rico Russian Federation Saint Helena	Saint Kitts and Nevis Saint Lucia Saint Pierre and Miquelon Sark Saudi Arabia Spain St Vincent and the Grenadines Sth Georgia & Sth Sandwich Islands Sudan Suriname Sweden Syrian Arab Republic Trinidad and Tobago Turks and Caicos Islands UAE Uruguay Venezuela Virgin Islands (British) Virgin Islands (U.S) Yemen
Zone 6 Andorra Antarctica Armenia Australia Austria Azores Belarus Belgium Bhutan Bulgaria Burkina Faso Burundi Central African Republic Christmas Islands Cocos (Keeling) Islands Congo Congo The Democratic Republic Cook Islands Cyprus East Timor Equatorial Guinea Estonia Fiji Finland	France French Guiana French Polynesia French Southern Territories Gabon Georgia Guam Heard and McDonalds Islands Herm Jordan Kiribati Korea Democratic People's Rep Kyrgyzstan Laos People's Democratic Rep Latvia Lesotho Liberia Libyan Arab Jamahiriya Lithuania Macau Malawi Maldives Marshall Islands Mauritius Mayotte	Micronesia Federated States Moldova Republic of Montenegro Myanmar Namibia Nauru Nepal New Caledonia Niger Nigeria Niue Norfolk Islands Northern Mariana Islands Oman Palau Pitcairn Qatar Reunion Rwanda Samoa San Marino Sao Tome and Principe Senegal Serbia Seychelles	Sierra Leone Solomon Islands Somalia South Africa Svalbard and Jan Mayen Swaziland Tajikistan Thailand Tokelau Tonga Tunisia Turkey Turkmenistan Tuvalu Uganda Ukraine United Republic of Tanzania Uzbekistan Vanuatu Vietnam Wallis and Futuna Islands Western Sahara Zambia Zimbabwe
Zone 7 Afghanistan Albania Azerbaijan Benin Bosnia and Herzegovina Botswana Bouvet Island British Indian Ocean Territory Brunei Darussalam Cambodia Cameroon	Cape Verde Chad Cote D'Ivoire Croatia Czech Republic Denmark Djibouti Egypt Faroe Islands Gambia Ghana Greenland	Guinea Guinea-Bissau Hungary Iceland India Kazakhstan Republic of Korea Luxembourg Madagascar Malaysia Malta Mauritania	Morocco New Zealand Pakistan Papua New Guinea Philippines Poland Republic of Macedonia Romania Slovakia Slovenia Togo
Zone 8 Algeria Angola	Comoros Eritrea Ethiopia	Mali Mozambique Sri Lanka	

Please note that the product and prices available may be subject to change at short notice due to regulatory changes, tax or other matters outside of Aviva's control.



APPLICATION FORM

IMPORTANT: Please attach the following documents to your application:

- Copy of Identity Card or Passport (for non-Singaporeans)
- If address is not available in the Identity Card/Passport, copy of fixed line telephone, utility, tax bill or any documents issued by a local government body.

Particulars of Adviser

Name:

Source Code:

Name of Firm:

Contact No.: (HP) (O)

Email Address:

For Adviser Use Only

Referral ID:

Select the person(s) to be insured:

- Proposer:
- Dependant 1:
- Dependant 2:
- Dependant 3:
- Dependant 4:

For Official Use Only

Contract No.:	Client No.:
<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"/>

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

This policy is underwritten by Aviva Ltd and will be entered into the register of Singapore policies. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Singapore.

Please complete in capital letters and tick boxes as appropriate.

SECTION A: PARTICULARS OF PROPOSER

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr

Family Name: Given Name:

Gender: Male Female Marital Status: Single Married Widowed Divorced Others

Identity Card/Passport No.: Race: Chinese Malay Indian Others

Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)

Usual Country of Residence:

Contact No.: (HP) (O) (H) Email Address:

Residential Address Block/Street No.: Street Name:

Unit No.: Building Name: Postal/Zip Code: Country:

Correspondence Address Block/Street No.: Street Name:

(if different from address above):

Unit No.: Building Name: Postal/Zip Code: Country:

For existing policyholder with Aviva Ltd: Employment Status: Employed Self-employed Unemployed

If correspondence address differs from our records, Occupation:

do you wish to update the above address in all your Name of Employer:

other policy(ies)? Yes No Address of Employer:

SECTION B: PARTICULARS OF DEPENDANT(S)

DEPENDANT 1

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr

Family Name: Given Name:

Gender: Male Female Marital Status: Single Married Widowed Divorced Others

Identity Card/Passport No.: Race: Chinese Malay Indian Others

Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)

Usual Country of Residence:

Relationship to Proposer: Spouse Partner / Co-habitant Child Others

Employment Status: Employed Self-employed Unemployed Occupation:

Name of Employer:

Address of Employer:

SECTION B: PARTICULARS OF DEPENDANT(S) (continued)**DEPENDANT 2**

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr
 Family Name: Given Name:
 Gender: Male Female Marital Status: Single Married Widowed Divorced Others _____
 Identity Card/Passport No.: Race: Chinese Malay Indian Others _____
 Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)
 Usual Country of Residence:
 Relationship to Proposer: Spouse Partner / Co-habitant Child Others _____
 Employment Status: Employed Self-employed Unemployed Occupation:
 Name of Employer:
 Address of Employer:

DEPENDANT 3

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr
 Family Name: Given Name:
 Gender: Male Female Marital Status: Single Married Widowed Divorced Others _____
 Identity Card/Passport No.: Race: Chinese Malay Indian Others _____
 Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)
 Usual Country of Residence:
 Relationship to Proposer: Spouse Partner / Co-habitant Child Others _____
 Employment Status: Employed Self-employed Unemployed Occupation:
 Name of Employer:
 Address of Employer:

DEPENDANT 4

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr
 Family Name: Given Name:
 Gender: Male Female Marital Status: Single Married Widowed Divorced Others _____
 Identity Card/Passport No.: Race: Chinese Malay Indian Others _____
 Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)
 Usual Country of Residence:
 Relationship to Proposer: Spouse Partner / Co-habitant Child Others _____
 Employment Status: Employed Self-employed Unemployed Occupation:
 Name of Employer:
 Address of Employer:

SECTION C: DECLARATION OF FACT FIND OPTION

Is the policy sold in Singapore? Yes No
 If **'Yes'**, please indicate the type of fact find that was carried out before the sale of this plan.
 Full Fact Find Product Advice Only No Advice

SECTION D: DECLARATION OF BENEFICIAL OWNERSHIP

If there is any Beneficial Owner(s) in relation to the policy, we are required by regulation to request the details of such Beneficial Owner(s). Please provide the details such as Name and Identity Card/Passport No. of the Beneficial Owner(s) and your personal relationship(s) with them and submit a copy of their Identity Card/Passport to us.

Please provide relevant details here:

"Beneficial Owner" as defined in the MAS Notice on Prevention of Money Laundering and Countering the Financing of Terrorism means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over a body corporate or unincorporate.

For the avoidance of doubt, completion of this section is not a nomination of beneficiary(ies) under the policy.

SECTION E: PLAN DETAILS

	Proposer	Spouse/Partner/Co-Habitant	Child(ren) <small>(Plan must not be higher than Proposer/Spouse/Co-habitant's. All children must be under the same plan with same deductible, if any)</small>
Plan Type			
Optional Annual Deductible			
Zone <i>(if applicable)</i>			
Optional Dental Cover <i>(if applicable)</i> <small>(subject to payment of additional premium)</small>			

If your Spouse/Partner/Co-Habitant is insured or to be insured, please provide his / her particulars:

Family Name: Given Name:
 Gender: Male Female Identity Card/Passport No.:

SECTION F: PAYMENT DETAILS

Contract Currency: SGD Others

Regular Premium:

Payment Frequency: Yearly Quarterly *(Factor of 0.2548 to be applied)*
 Monthly *(For monthly frequency, minimum ONE month premium is required. Factor of 0.0853 to be applied)*

Initial Premium Payment Method:

Cash / Cheque / Bank Draft / Credit Advice *(Deposit slip must be submitted)*

Cheque must be drawn from a bank in the country of domicile of the cheque's currency.
 Payment must be made payable to Aviva Ltd and in your chosen contract currency at the time of application.
 Cheque No.: Issuing Bank:

Credit Card

Please complete the section on Visa/Mastercard Authorisation below.

Subsequent Premium Payment Method:

Interbank GIRO

For plan account denominated in SGD currency and through a local Singapore SGD bank account only.
 Please complete the attached Application for Interbank GIRO Form.

Cash / Cheque / Bank Draft

Credit Card

Please complete the section on Visa/Mastercard Authorisation below.

VISA/MASTERCARD AUTHORISATION

I authorise Aviva Ltd to charge the premium(s) to my credit card account for this insurance policy. This authorisation is to remain in effect until I terminate it by written notification to Aviva Ltd at least 30 days in advance of the intended date of termination.

Name of Cardholder *(as shown in Identity Card/Passport)*:

Identity Card/Passport No.:

Card Number:

Card Expiry Date (MM/YY):

Signature of Cardholder:

Visa Mastercard

Issuing Bank:

Address of Credit Cardholder *(if address differs from Section A)*:

Block/Street No.:

Street Name:

Unit No.:

Building Name:

Country:

Postal/Zip Code:

SECTION G: HEALTH QUESTIONS

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. What is your height?	<input type="text"/> metres	<input type="text"/> metres	<input type="text"/> metres	<input type="text"/> metres	<input type="text"/> metres
2. What is your weight?	<input type="text"/> kg	<input type="text"/> kg	<input type="text"/> kg	<input type="text"/> kg	<input type="text"/> kg
3. Have you smoked tobacco or cigarettes in the last 12 months ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION G: HEALTH QUESTIONS (continued)

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
4. Have you had an application, reinstatement or renewal of a Life, Critical Illness, Health, Accident or Disability policy deferred, declined or accepted with special terms ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes' , please complete the following:					

<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
Name of Company: <input type="text"/>				
Reason: <input type="text"/>				
Type of Policy: <input type="text"/>				
<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
Name of Company: <input type="text"/>				
Reason: <input type="text"/>				
Type of Policy: <input type="text"/>				
<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
Name of Company: <input type="text"/>				
Reason: <input type="text"/>				
Type of Policy: <input type="text"/>				
<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
Name of Company: <input type="text"/>				
Reason: <input type="text"/>				
Type of Policy: <input type="text"/>				

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
5. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)?					
a) Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) High blood pressure or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Cancer, tumour, cyst, lump or growth of any kind including cancer screening tests that were not normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Depression, anxiety, stress or any other mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Drug or alcohol addiction or abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k) Hepatitis B or C, fatty liver, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) AIDs, HIV or sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m) Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n) Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o) Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p) Any other illness, disorder, operation, physical disability or injury not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION G: HEALTH QUESTIONS (continued)

If you answered 'Yes' to any of the above Questions 5(a) to 5(p), please complete the following:

<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<input type="checkbox"/> Proposer <input type="checkbox"/> Dependant 1 <input type="checkbox"/> Dependant 2 <input type="checkbox"/> Dependant 3 <input type="checkbox"/> Dependant 4			
Name of Condition Question () Condition: <input type="text"/>	Date of first symptoms or diagnosis <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Have you made a full recovery with no further treatment, ongoing symptoms or complications? <input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	Name and address of the doctor who you consulted <input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION G: HEALTH QUESTIONS (continued)

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
6. Other than conditions that you have already told us about, in the last 5 years have you had any abnormal medical test result from medical test(s) such as X-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), HIV test, blood or urine test, prostate check, pap smear or mammogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes' , please complete the following:					

<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4	
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of the doctor who you consulted?
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , what was the result? <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , please provide details	Name: <input type="text"/> Address: <input type="text"/> <input type="text"/> <input type="text"/>

<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4	
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of the doctor who you consulted?
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , what was the result? <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , please provide details	Name: <input type="text"/> Address: <input type="text"/> <input type="text"/> <input type="text"/>

<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4	
Name of medical test	Date of initial test	Have you had a follow-up test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of the doctor who you consulted?
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , what was the result? <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	If 'Yes' , please provide details	Name: <input type="text"/> Address: <input type="text"/> <input type="text"/> <input type="text"/>

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
7. Other than for conditions that you have already told us about, are you currently experiencing symptoms or considering seeking medical advice or treatment for your health other than minor illnesses such as cold or flu?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'Yes' , please complete the following:					

<input type="checkbox"/> Proposer	<input type="checkbox"/> Dependant 1	<input type="checkbox"/> Dependant 2	<input type="checkbox"/> Dependant 3	<input type="checkbox"/> Dependant 4
What symptoms or condition?	Date of first symptoms			Date of any planned medical consultation
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more			
What symptoms or condition?	Date of first symptoms			Date of any planned medical consultation
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more			
What symptoms or condition?	Date of first symptoms			Date of any planned medical consultation
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more			

SECTION G: HEALTH QUESTIONS (continued)

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
8. Female Only:					
a) Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Do you have, or does your doctor expect you to have any complications such as high blood pressure, abnormal blood sugar, gestational diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) What condition?	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ii) How many months pregnant are you?	<input type="text"/> months	<input type="text"/> months	<input type="text"/> months	<input type="text"/> months	<input type="text"/> months

SECTION H: DECLARATION

DECLARATION BY PROPOSER

- I have received Your Guide to Health Insurance, Fact Find Form and the Product Summary and they have been explained to my satisfaction. (Applicable if you have seen an adviser)
- I am aware that I can seek advice from a qualified adviser before I sign this application form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives. (Applicable to Direct Marketing)
- I am aware that the product that I am applying for (i) is authorised for sale in Singapore (applicable to all Aviva Ltd's products) and (ii) in certain cases, may be sold in a limited number of other territories where it is lawful for Aviva Ltd to sell and Aviva Ltd has expressly authorised the sale of the product through financial advisers in that territory (applicable to Global Health plan only) and I acknowledge that I am responsible for ensuring that the laws and regulations applicable to my nationality and country of residence allows my purchase of this product, I understand that no liability can be accepted by Aviva Ltd for any legal consequences under the laws of any other country or any tax implications that may arise in connection with my purchase of this product.
- I further declare that I am not an undischarged bankrupt and that I have committed no act of bankruptcy within the last twelve months and no receiving order or adjudication order in bankruptcy has been made against me during that period.
- I am aware and agree that I make/provide these declarations and authorisations on behalf of myself and all dependants who are below 16 years old.
- I agree that this application shall be the basis of the contract of insurance between me and Aviva Ltd.

DECLARATION BY PROPOSER AND/OR DEPENDANTS

- I/We understand that the insurance shall not become effective until this application is accepted, the full premium is received and the policy is issued by Aviva Ltd.
- I/We declare that all the information on this application form is true and complete. I/We am/are unaware of the existence of any medical condition or circumstance foreseeably requiring hospitalisation in the future.
- I/We understand that benefits will not apply to treatment or expense arising from medical conditions which originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in the Policy unless such conditions are fully disclosed to and accepted by Aviva Ltd prior to the inception of the Policy.
- I/We agree to inform Aviva Ltd if there is any change in the state of my/our and/or any dependant's health/activities between the date of this application form and the date the policy is issued by Aviva Ltd. I/We understand the terms of accepting me/us and/or any dependant as a risk for insurance coverage may vary accordingly to such information received.
- I/We am/are aware and agree that any Zone 1 (USA) insurance cover which I/we may purchase shall terminate automatically when I/we who is/are USA citizen(s) or USA Permanent Resident(s)(or equivalent) has/have been residing in the USA for three (3) consecutive months or more. (Applicable to Global Health only)
- I/We agree that in addition to the release of information to any medical source, insurance office, or other organisation mentioned in this section, Aviva Ltd is authorised to use and/or disclose as it reasonably deems fit, any information obtained from any source in respect of me/us, that is held by Aviva Ltd to employees, representatives and relevant third parties (including but not limited to companies within the Aviva Group, reinsurers, my/our financial advisers, financial institutions, credit agencies, direct marketing service providers, investigators, regulatory, governmental and statutory authorities) whether within or outside Singapore. As far as possible Aviva Ltd will release such information to such parties on the understanding that the information will be kept strictly confidential.

SECTION H: DECLARATION (continued)

7. I/We authorise any medical source, insurance office or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any medical source, insurance office or organisation, to the extent permitted by law, relevant information concerning me/us at any time, regardless of whether the application is accepted by Aviva Ltd. A photographic or electronic copy of this authorisation shall be as valid as the original.

Important Notes:

If a material fact is not disclosed in this application, 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 adviser but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Signature of Proposer:

Name:

Identity Card/Passport No.:

Date (DD/MM/YY):

Signature of all Dependants who are 16 years old and above.

Signature of Dependant 1:

Signature of Dependant 2:

Signature of Dependant 3:

Signature of Dependant 4:

Signature of Witness/Adviser:

Name of Witness/Adviser:

Identity Card/Passport No.:

Date (DD/MM/YY):



APPLICATION FOR INTERBANK GIRO (Please submit original form to Aviva)

FOR APPLICANT'S COMPLETION

Date (DD/MM/YY): Name of Billing Organisation ("BO"): **Aviva Ltd**
To: Name of Bank: Bank Branch:

Policy Number*:	Name of Policy Owner:	NRIC Number:

* Please write the Policy Number which you wish to apply for GIRO using this bank account number only.

- a) I hereby instruct you to process Aviva's instruction to debit my account.
- b) You are entitled to reject Aviva's debit instruction if my account does not have sufficient funds and charge me a fee for this. You may also at your discretion allow the debit even if this results in an overdraft on the account and impose charges accordingly.
- c) This authorisation will remain in force until terminated by your written notice sent to my address last known to you or upon receipt of my written revocation through Aviva.
- d) The use of correction tape is not allowed. Amendments made on this form must be countersigned by applicant.

My Bank Account Name: Mr/Mdm/Ms/Dr My NRIC Number:

 My Bank Account Number: My Contact Number (Home/Handphone):
 My Signature(s)/Thumbprint^ (as in Bank's Record): My Residential Address:
 (if address differs from Section A)

^ If your account is operated by thumbprint, your thumbprint needs to be witnessed and verified by the bank's staff.

FOR BILLING ORGANISATION'S COMPLETION

Bank Branch Aviva's Bank Account Number Aviva's Customer Reference No.:
7 1 7 1 0 0 3 0 0 3 9 0 0 1 8 8 6
 Bank Branch Account Number to be Debited

FOR BANK'S COMPLETION

To: Aviva Ltd
 This Application is hereby **REJECTED** (please tick) for the following reason(s):
 Signature/Thumbprint# differs/irregular# from bank's records
 Signature/Thumbprint# is incomplete/unclear#
 Account operated by Signature/Thumbprint#
 Wrong account number
 Amendments not countersigned by customer
 Others _____
 # Please delete where applicable

Name of Approving Officer:
 Authorised Signature: Date: