



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

Backdated to (DD/MM/YY): Referral ID:

For Official Use Only

Contract No.:

Client No.(Main Life Assured):

Client No.(Assured/Joint Life Assured):

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 MAIN LIFE ASSURED

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)

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

Residential Address Block/Street No.: Street Name:

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

Correspondence Address (if different from address above): Block/Street No.: Street Name:

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

Address of Employer:

SECTION B: PARTICULARS OF ASSURED/JOINT LIFE ASSURED

Joint Application Third Party Application **Relationship to the Main Life Assured:**

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)

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

Residential Address (if different from Main Life Assured): Block/Street No.: Street Name:

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

Correspondence Address (if different from address above): Block/Street No.: Street Name:

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

Address of Employer:

SECTION C: DECLARATION OF FACT FIND OPTION

Is the policy sold in Singapore? Yes No

If 'Yes', please complete the following:

- Please indicate the type of fact find that was carried out before the sale of this plan.
 Full Fact Find Partial Fact Find Product Advice Only No Advice
- If basic plan or rider(s) applied for covers critical illness, reimbursement of medical expenses, disability income or long term care, please indicate the type of health 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

Basic Plan	Policy Term (years)/ Expiry Age	Premium Term	Sum Assured/Monthly Benefit/ Daily Benefit	Premium Payable

Supplementary Benefits	Policy Term (years)/ Expiry Age	Premium Term	Sum Assured/Monthly Benefit/ Daily Benefit	Premium Payable
Total Premium Payable				

SECTION F: INVESTMENT CHOICES (IF APPLICABLE)

Please indicate your choice of funds by filling in the allocation percentages, fund codes and fund names (if applicable) below.
 Please refer to www.aviva.com.sg for the complete list of funds available for investment.

Fund Code	Fund Name	Allocation (in whole numbers)
		%
		%
		%
		%
		%
		%
		%
		%
		%
		%
		%
		%
		%
		%
Total		100%

Note: Where discrepancy exists between fund codes and fund names, the Company will refer to the fund codes for investment application.

SECTION G: PAYMENT DETAILS

Contract Currency: SGD Others _____

Regular Premium Only:

Payment Frequency: Yearly Half-Yearly Quarterly Monthly *(For monthly frequency, minimum ONE month premium is required)*

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.

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.

(Applicable for MyProtector Plans (exclude MyProtector-Level Plus), Global Protection Plans, Global Savings Account and LifetimeFlexi)

UK Direct Debit

For plan account denominated in GBP currency and through a United Kingdom GBP bank account only.
Please complete the Direct Debit Instruction form separately.

Single Premium Only:

Easy Save Option *(Please indicate amount): (if applicable)*

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: _____

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 No.):*

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 and Section B):*

Block/Street No.:

Street Name:

Unit No.:

Building Name:

Country:

Postal/Zip Code:

SECTION H: GUARANTEED CASH COUPONS PAYOUT (IF APPLICABLE)

Option 1: To receive coupon payment via direct credit to bank account.

(Please fill in your Bank Account particulars so that your payouts will be credited to your bank account directly. If bank account is not furnished, the payment will be made via cheque. Please inform Aviva Ltd immediately or at least 3 weeks prior to payout date in the event of any changes to the details below.)

Name of Account Holder

Name of Bank

Bank Branch

Account No.:

(Please ensure that the bank account belongs to the Policy Owner. If the policy is created under trust or assigned, the account should belong to the trustee(s) or assignee. Payment to the specified account is deemed as final discharge of the liability of Aviva Ltd under the policy.)

Option 2: To receive coupon payment via cheque.

Option 3: To reinvest coupon payment with Aviva Ltd at the prevailing non-guaranteed interest rate.

SECTION I: MORTGAGE INSURANCE APPLICATION ONLY

	Main Life Assured	Assured/Joint Life Assured
1. Please indicate whether you are the borrower, co-borrower(s), surety or guarantor of the mortgage loan?	<input type="checkbox"/> Borrower <input type="checkbox"/> Co-Borrower <input type="checkbox"/> Surety <input type="checkbox"/> Guarantor	<input type="checkbox"/> Borrower <input type="checkbox"/> Co-Borrower <input type="checkbox"/> Surety <input type="checkbox"/> Guarantor
2. Other than yourself and the joint life assured, are the other borrower(s)/surety applying or intending to apply for any other insurance policy to cover this mortgage loan? Name of Company: Currency: Sum Assured: Type of Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION J: GENERAL QUESTIONS (FOR PROTECTION BENEFITS ONLY)

1. What is the legal basis of your stay in the current country of residence? <i>(Please attach a copy of the document including date of issue and expiry)</i> <i>(If you have selected 'Others' or reside outside of Singapore, please complete the Residential Questionnaire.)</i>	<input type="checkbox"/> Citizen/Permanent Resident <input type="checkbox"/> Work Visa or Permit <input type="checkbox"/> Employment Pass <input type="checkbox"/> Dependent Pass <input type="checkbox"/> Others	<input type="checkbox"/> Citizen/Permanent Resident <input type="checkbox"/> Work Visa or Permit <input type="checkbox"/> Employment Pass <input type="checkbox"/> Dependent Pass <input type="checkbox"/> Others
2. What is your annual fixed income before tax (excluding fringe benefits such as allowance and commissions)?	Currency: <input type="text"/> Amount: <input type="text"/>	Currency: <input type="text"/> Amount: <input type="text"/>
3. Do you currently engage in or do you have definite plans to take up the following; scuba diving, mountain or rock climbing (excluding artificial wall climbing), flying (other than as a fare paying passenger), parachuting or sky diving, motor sports (car, bike, boat), other extreme or hazardous sport? If 'Yes' , please select the activity(ies): For scuba diving , please complete the following: a) Are you an instructor? b) Are you a certified diver? c) Do you ever dive over 40 metres? d) Do you ever dive alone or unaccompanied? e) Do you participate in cave or wreck diving or other more hazardous diving activities? If 'Yes' , please provide details.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Scuba diving and/or <input type="checkbox"/> Others (what activities) <input type="text"/> <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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Scuba diving and/or <input type="checkbox"/> Others (what activities) <input type="text"/> <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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
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 ? If 'Yes' , please complete the following: Name of Company: Type of Policy: Reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>
5. Do you have any other application outside of Aviva for Life, Critical Illness, Health or Disability insurance now pending or being contemplated ? If 'Yes' , please complete the following: Name of Company: Currency: Sum Assured: Type of Insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

SECTION J: GENERAL QUESTIONS (FOR PROTECTION BENEFITS ONLY) (continued)

	Main Life Assured	Assured/Joint Life Assured
6. Have you ever made any claim(s) on a Life, Critical Illness, Accident or Disability policy? If 'Yes' , please provide details of each claim and benefits received.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/>
7. Juvenile Applications Only: a) Does the child's parent (other than the Assured of this policy) have a life insurance policy in-force on his or her life? b) Does the child have any siblings? If 'Yes' , do all of them have a life insurance policy in-force on their life?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please provide details of the in-force life insurance policy(ies) for each family member.

Relationship to Main Life Assured	Name of Company	Please complete the Sum Assured in SGD currency	
		Life	Critical Illness

SECTION K: HEALTH QUESTIONS (FOR PROTECTION BENEFITS ONLY)

1. What is your height and weight?	Height: <input type="text"/> metres Weight: <input type="text"/> kg	Height: <input type="text"/> metres Weight: <input type="text"/> kg
2. Have you smoked tobacco or cigarettes in the last 12 months ? If 'Yes' , how many sticks per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> sticks per day	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> sticks per day
3. Do you drink alcohol? If 'Yes' , what is the average total number of standard alcoholic drinks do you drink per week ? 1 standard alcoholic drink equates to 330ml beer, 125ml glass of wine or 30ml nip of spirits.	<input type="checkbox"/> Yes <input type="checkbox"/> No Average number per week: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No Average number per week: <input type="text"/>
4. Have you ever taken or used addictive or illegal drugs , or been treated for drug addiction or alcoholism ? If 'Yes' , please complete the following: Substance used: Date when started taking: Date when ceased: Treatment:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
5. Do you have a regular doctor? If 'Yes' , please complete the following: Name: Address:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>
6. 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? b) High blood pressure or high cholesterol? c) Cancer, tumour, cyst, lump or growth of any kind including cancer screening tests that were not normal? 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 <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 K: HEALTH QUESTIONS (FOR PROTECTION BENEFITS ONLY) *(continued)*

- e) Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?
- f) Depression, anxiety, stress or any other mental or nervous disorder?
- g) Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?
- h) Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?
- i) Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?
- j) Hepatitis B or C, fatty liver, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?
- k) Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?
- l) Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?
- m) Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?
- n) Any other illness, disorder, operation, physical disability or injury not mentioned above?

	Main Life Assured		Assured/Joint Life Assured	
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
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
g) 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
h) 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
i) 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
j) 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
k) 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
l) 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
m) 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
n) 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

If you have answered 'Yes' to any of the above Question 6(a) to 6(n), please complete the following:

MAIN LIFE ASSURED				
Name of Condition	Date of first symptoms or diagnosis	Have you made a full recovery with no further treatment, ongoing symptoms or complications?		Name and address of the doctor who you consulted
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name: <input style="width: 80%;" type="text"/> Address: <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/>
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name: <input style="width: 80%;" type="text"/> Address: <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/>
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name: <input style="width: 80%;" type="text"/> Address: <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/> <input style="width: 80%;" type="text"/>

ASSURED/JOINT LIFE ASSURED					
Name of Condition	Date of first symptoms or diagnosis	Have you made a full recovery with no further treatment, ongoing symptoms or complications?		Name and address of the doctor who you consulted	
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<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		<input type="checkbox"/> No What treatment or medication did you take? <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<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		<input type="checkbox"/> No What treatment or medication did you take? <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
Question () Condition: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<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	<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		<input type="checkbox"/> No What treatment or medication did you take? <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>

7. **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?

If **'Yes'**, please complete the following:

Main Life Assured	Assured/Joint Life Assured
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

MAIN LIFE ASSURED					
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 <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>
ASSURED/JOINT LIFE ASSURED					
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 <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name: <input style="width: 100%;" type="text"/> Address: <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/> <input style="width: 100%; height: 20px;" type="text"/>

SECTION K: HEALTH QUESTIONS (FOR PROTECTION BENEFITS ONLY) (continued)

8. **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?

Main Life Assured

Yes No

Assured/Joint Life Assured

Yes No

If **'Yes'**, please complete the following:

MAIN LIFE ASSURED			
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
	<input type="checkbox"/> 0 to 6 months	<input type="checkbox"/> 7 to 12 months	<input type="checkbox"/> 1 year or more

ASSURED/JOINT LIFE ASSURED			
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
	<input type="checkbox"/> 0 to 6 months	<input type="checkbox"/> 7 to 12 months	<input type="checkbox"/> 1 year or more

9. Have **any** of your **natural parents or siblings** died or suffered from cancer, heart disease, stroke, diabetes, kidney disease, Parkinson's disease, Alzheimer's disease or any other hereditary disease or disorder?

Yes No

Yes No

If **'Yes'**, please complete the following:

MAIN LIFE ASSURED			
Name of medical condition (specify exact condition e.g. if cancer, specify which type, if heart disease, name the condition)	Family member's relationship to you	Age when diagnosed	Age at death (if applicable)

ASSURED/JOINT LIFE ASSURED			
Name of medical condition (specify exact condition e.g. if cancer, specify which type, if heart disease, name the condition)	Family member's relationship to you	Age when diagnosed	Age at death (if applicable)

10. Have **you** or **your spouse** or partner been told to have, received any **medical advice, counselling** or **treatment** in connection with sexually transmitted diseases, AIDS, AIDS Related Complex or any other AIDS related condition?

Yes No

Yes No

If **'Yes'**, please provide details.

11. **Female Only:**

a) Are you currently pregnant?

Yes No

Yes 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?

Yes No

Yes No

i) What condition?

ii) How many months pregnant are you?

months

months

SECTION L: DISABILITY INCOME APPLICATION ONLY

	Main Life Assured	Assured/Joint Life Assured																								
1. Please list the main material duties in your occupation (office work, supervision, selling, etc). Include all significant duties requiring physical mobility (e.g. driving, lifting, cleaning, etc).	<table border="1"> <thead> <tr> <th>Duty:</th> <th>% of time:</th> </tr> </thead> <tbody> <tr><td>1. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>2. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>3. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>4. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td colspan="2" style="text-align: center;">Total 100%</td></tr> </tbody> </table>	Duty:	% of time:	1. <input type="text"/>	<input type="text"/>	2. <input type="text"/>	<input type="text"/>	3. <input type="text"/>	<input type="text"/>	4. <input type="text"/>	<input type="text"/>	Total 100%		<table border="1"> <thead> <tr> <th>Duty:</th> <th>% of time:</th> </tr> </thead> <tbody> <tr><td>1. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>2. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>3. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td>4. <input type="text"/></td><td><input type="text"/></td></tr> <tr><td colspan="2" style="text-align: center;">Total 100%</td></tr> </tbody> </table>	Duty:	% of time:	1. <input type="text"/>	<input type="text"/>	2. <input type="text"/>	<input type="text"/>	3. <input type="text"/>	<input type="text"/>	4. <input type="text"/>	<input type="text"/>	Total 100%	
Duty:	% of time:																									
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3. <input type="text"/>	<input type="text"/>																									
4. <input type="text"/>	<input type="text"/>																									
Total 100%																										
2. Have you been in your current occupation for 2 years or more ? If 'No' , a) what was your previous occupation? b) what type of work were you doing? c) how long were you in that position?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> <input type="text"/>																								
3. Do you hold more than one occupation? If 'Yes' , a) what are your duties? b) how many hours per week? c) what is your monthly salary?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> Currency: <input type="text"/> Amount: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="text"/> Currency: <input type="text"/> Amount: <input type="text"/>																								
4. Do you have any intention of changing your current occupation? If 'Yes' , a) what occupation? b) when is that likely to happen?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="checkbox"/> 0 to 6 mths <input type="checkbox"/> 7 months or more	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="checkbox"/> 0 to 6 mths <input type="checkbox"/> 7 months or more																								
5. How many hours on average do you work per week ?	<input type="checkbox"/> Less than 40 hours per week <input type="checkbox"/> 41 to 55 hours per week <input type="checkbox"/> 56 to 60 hours per week <input type="checkbox"/> 61 hours per week or more	<input type="checkbox"/> Less than 40 hours per week <input type="checkbox"/> 41 to 55 hours per week <input type="checkbox"/> 56 to 60 hours per week <input type="checkbox"/> 61 hours per week or more																								
6. Does your occupation require you to travel overseas? If 'Yes' , a) which countries? b) how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="checkbox"/> < 25% of the time overall per year <input type="checkbox"/> 26 to 40% of the time overall per year <input type="checkbox"/> 41 to 50% of the time overall per year <input type="checkbox"/> >51% of the time overall per year	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> <input type="checkbox"/> < 25% of the time overall per year <input type="checkbox"/> 26 to 40% of the time overall per year <input type="checkbox"/> 41 to 50% of the time overall per year <input type="checkbox"/> >51% of the time overall per year																								
7. For salaried persons: What is your monthly gross salary?	Currency: <input type="text"/> Amount: <input type="text"/>	Currency: <input type="text"/> Amount: <input type="text"/>																								
8. For self-employed persons: a) How long have you been self-employed? b) What is your annual taxable income as reported in your income tax returns for the last 2 years ?	<input type="checkbox"/> 0 to 2 years <input type="checkbox"/> 2 years or more Currency: <input type="text"/> Last year's amount: <input type="text"/> 2 year's ago amount: <input type="text"/>	<input type="checkbox"/> 0 to 2 years <input type="checkbox"/> 2 years or more Currency: <input type="text"/> Last year's amount: <input type="text"/> 2 year's ago amount: <input type="text"/>																								
9. Do you receive any income or remuneration from any other source? If 'Yes' , a) please state the source b) what is your annual income from the above stated source?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Currency: <input type="text"/> Amount: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="text"/> Currency: <input type="text"/> Amount: <input type="text"/>																								

Important Notes:

The proposed benefits together with those under similar insurance and earnings received during disability must not exceed 75% (for CPF contributor) or 65% (for non-CPF contributor) of your normal monthly earned income prior to disablement.

SECTION M: DECLARATION / REPLACEMENT OF EXISTING POLICY(IES)

1. Do you have any existing life insurance policy(ies) **outside of Aviva**?

Yes No If **'Yes'**, please complete the following:

MAIN LIFE ASSURED						
Name of Company	Please complete the Sum Assured in contract currency					Year Issued
	Life	TPD	Critical Illness	Disability Income	Others	

ASSURED/JOINT LIFE ASSURED						
Name of Company	Please complete the Sum Assured in contract currency					Year Issued
	Life	TPD	Critical Illness	Disability Income	Others	

2. Is this application to replace or intended to replace any life insurance policy(ies) or unit trust(s), with Aviva Ltd or any other insurance company, bank, or financial adviser?

Yes No If **'Yes'**, please complete the following:

MAIN LIFE ASSURED			
Name of Company	Type of Policy	Sum Assured	Year Issued

ASSURED/JOINT LIFE ASSURED			
Name of Company	Type of Policy	Sum Assured	Year Issued

Warning:

If you are replacing your existing life insurance policy with this new application, some of the disadvantages of replacing your existing plan may be:

- a) you may not be insurable on standard terms
- b) you may have to pay a different premium in view of older age
- c) you may lose the financial benefit accumulated over the years
- d) the terms and conditions may be different

If you are replacing your existing investment-linked insurance policy or unit trust with this application, you should find out whether you are entitled to free switching within your existing plan, as some of the disadvantages may be:

- a) you may incur transaction costs without gaining any real benefit
- b) 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 a higher cost
- c) you may incur penalties for terminating the policy
- d) the new policy may be less suitable for you

In your own interest, we would advise that you consult your present financial adviser before making a final decision. Hear from both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

SECTION N: DECLARATION

Applicable to policies sold in Singapore:

1. I/We declare that I/we have received a copy of the following documents:

- i) Benefit Illustration;
- ii) Product Summary;
- iii) Fact Find;
- iv) Your Guide to Life Insurance;
- v) Fund Summary and Product Highlights Sheet (applicable to Investment-Linked plans only);
- vi) Latest edition of the respective Fund Prospectus* (applicable to Global Investment Account and Global Savings Account plans only);
- vii) Your Guide to Health Insurance (if applicable)

and that the contents of these documents have been explained to my/our satisfaction.

* I/We am/are aware that the latest edition of the respective Fund Prospectuses may be found on the website (www.aviva.com.sg) and I/we have read and understood the applicable sections of the most recent edition of the respective Fund Prospectuses in relation to the application for this plan. (Applicable to Global Investment Account and Global Savings Account plans only)

Applicable to policies sold outside Singapore[^]:

1. I/We declare that I/we have received a copy of all the documents that are required to be given by the adviser under the law of the country in which I/we have applied for this Policy, and that the contents of these documents have been explained to my/our satisfaction.

2. I/We am/are aware that the latest edition of the respective Fund Prospectuses may be found on the website (www.aviva.com.sg) and I/we have read and understood the applicable sections of the most recent edition of the respective Fund Prospectuses in relation to the application for this plan. (Applicable to Global Investment Account and Global Saving Account plans only)

[^] Limited only to a selected number of other territories where it is lawful for Aviva Ltd to sell and where Aviva Ltd has expressly authorised the sale of the product through financial advisers in that territory. (Applicable to Global Savings Account and Global Investment Account plans and Global Protection plans only)

Applicable to ALL policies:

1. I/We understand that the insurance shall not take effect until this application is accepted, the full premium is received and the policy is issued by Aviva Ltd.

2. I/We declare that I/we have received a copy of the Interim Cover Terms and Conditions. I/We hereby acknowledge that the Interim Cover Terms and Conditions have been explained to me in detail and that I/we fully understand the Interim Cover Terms and Conditions. (Applicable to MyProtector and Global Protection plans only)

3. I/We declare that no material fact, that is, any fact likely to influence the assessment and acceptance of this application has been withheld and to the best of my/our knowledge and belief, the information furnished is true and complete. I/We agree to inform Aviva Ltd if there is any change in the state of my/our and/or any proposed life assured's health or activities between the date of this application and the date the policy is issued by Aviva Ltd to me/us.

4. I/We agree that all medical examination reports done for the purpose of this application are properties of Aviva Ltd to be used solely for insurance purposes.

5. I/We am/are aware that the product I/we am/are 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 Savings Account and Global Investment Account plans and Global Protection plans only) and I/we acknowledge that I/we am/are responsible for ensuring that the laws and regulations applicable to my/our nationality and country of residence allow my/our purchase of this product. I/We 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/our purchase of this product.

6. I/We further declare that I/we am/are not undischarged bankrupt and that I/we 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/us during that period.

7. I/We authorise Aviva Ltd to act where it is prepared to do so, upon instructions given by facsimile or by electronic means with regard to the Units subscribed for (and any further Units purchased) or any matter in connection with them or any of them without liability in respect of any transfer, payment or any other act done according to such instructions and notwithstanding that such instructions emanate from unauthorised persons, provided that reasonable care was exercised by Aviva Ltd in verifying the signature of the purported authorised person. I/We agree to indemnify Aviva Ltd in respect of (i) any loss arising in respect of acting on instructions given by facsimile or by electronic means (notwithstanding that such instructions emanate from unauthorised persons, provided that reasonable care was exercised by Aviva Ltd in verifying the signature of the purported authorised person) or (ii) a decision not to act on the basis of such instructions or (iii) for any loss arising from the non-receipt of such instructions. (Applicable to Global Investment Account and Global Saving Account plans only)

8. I/We consent that any communication (including but not limited to the sending of notices, confirmations, annual and semi-annual fund reports, and transaction and performance statements or reports) from Aviva Ltd may be sent to me/us via any form of electronic dissemination, including by electronic mail, or by ordinary mail or any other means of dissemination as Aviva Ltd may determine in its sole discretion and I/we understand that I/we may contact Aviva Ltd and request for a copy of the relevant communication. (Applicable to Investment Linked plans only)

9. For DBS property loan customers only (applicable to sales through DBS/POSB only): I/We consent to DBS disclosing the information in the property loan application form and letter of offer as well as any information relating to the loan application and other relevant particulars of my/our account to Aviva Ltd in order to enable Aviva Ltd to process my/our application for the mortgage insurance.

SECTION N: DECLARATION *(continued)*

10. I/We agree on my/our behalf and on behalf of all proposed insured lives, 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 or any insured life or proposed insured life, 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.

11. 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 and/or any proposed life assured 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 Main Life Assured *(For age next birthday 17 years & above)*

Name:

Identity Card/Passport No.:

Date (DD/MM/YY):

(IF APPLICABLE)

Signature of Assured
/Company Stamp* *(applicable, if different from the Main Life Assured)*

Name:

Identity Card/Passport No.:

Date (DD/MM/YY):

* The signatory warrants that he or she has the authority to sign for and on behalf of _____ (Name of Company) and bind the Company by his or her signature.

Signature of Witness/Adviser

Name of Witness/Adviser:

Identity Card/Passport No.:

Date (DD/MM/YY):

For E-GIRO Use

I have verified that the Account holder, Account number, NRIC number & signature as stated under the Application for Interbank GIRO* form are identical to the records maintained in DBS/POSB.

(*Only if nominated account is a DBS/POSB account).



Verified By:

Name, Signature & Specimen Signature No.

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:
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

- a) I/We hereby instruct you to process Aviva's instruction to debit my/our account.
- b) You are entitled to reject Aviva's debit instruction if my/our account does not have sufficient funds and charge me/us 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/our address last known to you or upon receipt of my/our written revocation through Aviva.
- d) The use of correction tape is not allowed. Amendments made on this form must be countersigned by applicant.

My/Our Bank Account Name(s): Mr/Mdm/Ms/Dr

My/Our NRIC Number(s):

My/Our Bank Account Number:

My/Our Contact Number (Home/Handphone):

My/Our Signature(s)/Thumbprint(s)^ (as in Bank's Record):

My/Our Residential Address:
(if address differs from Section A and Section B)

^ 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 2 7 0 2 7 0 0 0 7 5 9 7
Bank Branch Account Number to be Debited

FOR BANK'S COMPLETION

To: Aviva Ltd
This Application(s) 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 _____

Name of Approving Officer:
Authorised Signature: Date:

Please delete where applicable

Intentionally Left Blank

Interim Cover Terms and Conditions (Applicable to MyProtector and Global Protection plans only)

This certificate contains the Terms and Conditions of Interim Cover. You (Applicant/Joint Applicant) are advised to keep this in a safe place.

All capitalised terms used in the Interim Cover Terms and Conditions shall have the meanings ascribed to them in the General Provisions, unless otherwise stated.

The Company agrees to insure the Main Life Assured/Joint Life Assured against Accidental Death for an interim period ("Interim Cover"), subject to the terms and conditions below:

1. Definitions

"The Company" means Aviva Ltd, any of Aviva Ltd's associated companies or affiliates, or National General Insurance Company Psc (only applicable in respect of insurance policies reinsured by Aviva Ltd), whichever is applicable as at the time of the Application.

"Main Life Assured" or "Joint Life Assured" means the person(s) named in the Application.

"Accident" means an event caused solely and independently of all other causes and directly by violent, unexpected, external and visible means.

"Accidental Death" means death caused by Accident.

"Application" means the application form signed and submitted by the person(s) named in the application to purchase the Policy from The Company, including any written statement, representation and/or document given to The Company to support the said application.

2. The Main Life Assured/Joint Life Assured is entitled to an Interim Accidental Death cover ("Interim Cover"), provided that his or her age next birthday is less than sixty (60) years on the date of Application and comply with the duty of disclosure as set out in the Application Form.

3. The Interim Cover provides the Interim Cover benefit for the Accidental Death of Main Life Assured proposed under the Policy, or in the case of a joint-lives proposal, the first of the two lives (Main Life Assured or Joint Life Assured) proposed to be covered under the Policy who suffers an Accidental Death, during the period starting from the date of the Application is signed to the earliest of the following:

- (a) the Policy Issue Date;
- (b) ninety (90) days from the date Application is signed;
- (c) thirty (30) days from the date of The Company's Letter of Conditional Acceptance (such number of days to be reduced accordingly in the event of acceptance by you of The Company's Letter of Conditional Acceptance);
- (d) the date you withdraw your Application;
- (e) the date your Application is rejected or postponed by The Company; or
- (f) the Accidental Death of the Main Life Assured proposed under this Policy or in the case of a joint-lives proposal, the first of the two lives (Main Life Assured or Joint Life Assured) proposed to be covered under the Policy who suffers an Accidental Death.

4. The Interim Cover benefit payable under the Interim Cover is the Sum Assured, but subject to the maximum sum (in the contract currency under the Policy, as applicable) as stated below, regardless of the aggregate of the benefits treated as payable under each policy pending issuance by The Company (in the event that there is more than one policy pending issuance) in respect of the Interim Cover benefit.

Maximum Interim Cover for each available contract currency					
SGD	USD	GBP	EUR	AUD	HKD
500,000	300,000	175,000	250,000	400,000	2,500,000

5. If the claim for the Interim Cover benefit is to be admitted for multiple policies with different contract currencies, all policies that are not denominated in Singapore Dollars (SGD) will be converted to Singapore Dollars (SGD) based on the exchange rates as determined by The Company at the time of conversion for the purpose of aggregation.

6. The Interim Cover is in respect of Accidental Death only. No benefit shall be payable under Interim Cover in respect of death directly or indirectly, wholly or partly caused by or arising from or contributed to by:

- (a) suicide, attempted suicide or other intentional self-inflicted injury while sane or insane;
- (b) active participation in war (declared or undeclared), civil war, war-like actions and/or acts of terrorism;
- (c) resulting from or in connection with the use of nuclear, biological and/or chemical weapons in any act of war (declared or undeclared), civil war, war-like actions and/or acts of terrorism;

- (d) any navy, army, air force, military or police duties;
 - (e) participation in any aerial activity such as parachuting and sky-diving, racing of any kind other than on foot, mountaineering or underwater activity;
 - (f) travel on any type of aircraft except as a fare-paying passenger or a crew member of an international airline operating on a regularly-scheduled passenger flight of a licensed commercial aircraft;
 - (g) any violation or attempted violation of law, or resistance to lawful arrest or imprisonment; or
 - (h) the influence of alcohol or drugs unless administered or taken at the direction of a Registered Medical Practitioner;
 - (i) any medical condition or injury not caused by an Accident; or
 - (j) consumption of poison or any substance which may be fatal if consumed, whether voluntary or involuntary.
7. Upon receiving the Application and all the required supporting documents and information, The Company reserves the right to revoke the Interim Cover by notifying you immediately if The Company determines that there is more than the standard life risk to cover.
8. If a claim is made under the Interim Cover and the claim is admitted by The Company, The Company will pay the Interim Cover benefits after deducting an amount equal to the Regular Premium which would have been required to be paid for the first cover Year, subject to the maximum amount stated in Clause 4.