



PRODUCT SUMMARY

Date: / / (DD/MM/YY)

Presented to: (Name of Proposer)

Signature of Proposer:

Name of Financial Adviser:

Signature of Financial Adviser:

PRODUCT INFORMATION

MyShield is a Medisave-Approved Integrated Medical Expense insurance plan that can be purchased using CPF Medisave. It covers eligible inpatient and outpatient expenses as a result of any illness or Accident subject to the limits as set out in the Benefits Schedule shown below depending on the plan you have chosen.

Any Insured Person of MyShield is also insured under MediShield operated by the Central Provident Fund Board (CPF) which is governed by the Central Provident Fund Act (Chapter 36) and Central Provident Fund (MediShield Scheme) Regulations provided he/she meets the eligibility criteria. The Insured Person shall enjoy all benefits of MediShield and shall be compensated based on the higher of benefits under the Enhancement Plan or MediShield as well as any premium discount if he/she satisfies the eligibility criteria.

Benefits Schedule in SG Dollars			
Hospital Ward Type	MyShield		
	Plan 1	Plan 2	Plan 3 ¹
	Any Private Ward	Any Government/Restructured Ward	B1 Government/Restructured Ward
A. Inpatient Benefits			
Daily Room & Board	As charged		
Intensive Care Unit			
Hospital Miscellaneous Services (including surgical implants and approved medical consumables)			
Surgical Benefits (including Radiosurgery ² & day surgery)			
Surgical Benefits for Major Organ Transplant (including cost of procuring organs from cadaveric donor)			
Accident Inpatient Dental Treatment (within 14 days following Accident)			
Daily In-Hospital Doctor's Visit			
Pre-Hospital Specialist's Consultation (within 90 days prior to admission)			
Pre-Hospital Diagnostic and Laboratory Services (within 90 days prior to admission)			
Post-Hospital Follow-Up Treatment (within 90 days after discharge)			
Confinement in Community Hospital (up to 45 days per Policy Year)			
Inpatient Congenital Anomalies (after waiting period of 24 months)			
Inpatient Pregnancy Complications (after waiting period of 10 months)			
Living Donor Organ Transplant (per Lifetime) (after waiting period of 24 months)	S\$50,000	S\$30,000	S\$20,000
B. Outpatient Catastrophic Treatments			
Outpatient Kidney Dialysis (including Erythropoietin drug as part of the treatment for chronic renal failure)	As charged		
Outpatient Cancer Treatment: Radiotherapy/Chemotherapy/Immunotherapy			
Major Organ Transplant - Approved Immunosuppressant Drugs (including Cyclosporin and Tacrolimus)			
C. Final Expenses Benefit³	S\$1,000		
D. Special Benefits			
Extra Inpatient Coverage for Heart Attack, Major Cancer, Stroke, End Stage Lung Disease and End Stage Liver Disease (per Policy Year)	S\$150,000	S\$100,000	S\$50,000
Inpatient Psychiatric Treatment (after 10 months of continuous coverage) (per Policy Year)	As charged up to 60 days	As charged up to 45 days	N.A.
Free Coverage for Child(ren) (under Plan 2 up to 20 years old at age next birthday provided both parents take up either Plan 1 or 2)	Yes	Yes	N.A.
Inpatient Medical Complaint outside Singapore	As charged (pegged to costs of Singapore Private Hospitals)	As charged (pegged to costs of Singapore Restructured Hospitals)	As charged (pegged to costs of B1 ward of Singapore Restructured Hospitals)

Benefits Schedule in SG Dollars

Benefits Schedule in SG Dollars			
E. Pro-ration Factor			
Private Hospital/Medical Institutions and Hospitals outside Singapore	N.A.	65% ⁴	50% ⁵
Restructured Hospitals - Class A	N.A.	N.A.	85% ⁵
Unsubsidised wards in Community Hospitals	N.A.	N.A.	85% ⁶
F. Annual Deductible⁷ for Insured Persons 80 years old and below age next birthday			
Inpatient			
C Class Ward	S\$1,000	S\$1,000	S\$1,000
B2 Class Ward	S\$1,500	S\$1,500	S\$1,500
B1 Class Ward	S\$2,000	S\$2,000	S\$2,000
A1 Class Ward/Private Hospital and Hospitals outside Singapore	S\$3,000	S\$3,000	S\$3,000
Day Surgery	S\$3,000	S\$3,000	S\$2,000
G. Co-Insurance (applicable to claimable amount after deductible)		10% Maximum S\$25,500 per Policy Year	
H. Maximum Claim Limits			
Policy Year Limit	S\$650,000	S\$400,000	S\$150,000
Lifetime Limit	Unlimited	Unlimited	Unlimited
I. Age Limits (Age Next Birthday)			
Last Entry Age	75 years old	75 years old	75 years old
Maximum Coverage Age	Lifetime	Lifetime	Lifetime
<p>¹ For Singapore Citizens only.</p> <p>² Radiosurgery includes Gamma Knife & Novalis Treatment which can be performed as an Inpatient or day surgery procedure. The applicable Annual Deductible and Pro-ration Factor for Radiosurgery will depend on its classification as an Inpatient or day surgery procedure.</p> <p>³ Final Expenses Benefit is a waiver of Annual Deductible and Co-Insurance amounts, up to the limit stated, upon death occurring during hospitalisation or within 30 days of discharge of the hospitalisation and provided death occurs as a result of the cause of the hospitalisation.</p> <p>⁴ Pro-ration Factor is applied to reduce overseas/higher class wards/private hospital bills to Singapore Restructured Hospital equivalent in the claims computation of Plan 2. This is not applicable to expenses incurred in a Singapore Restructured Hospital for Outpatient Catastrophic Treatments and day surgery.</p> <p>⁵ Pro-ration Factor is applied to reduce overseas/higher class wards/private hospital bills to B1 Restructured Hospital equivalent in the claims computation of Plan 3. This is not applicable to expenses incurred in a Singapore B1 Restructured Hospital for Outpatient Catastrophic Treatments and day surgery.</p> <p>⁶ Pro-ration Factor is applied to reduce the unsubsidised hospital charges to equivalent subsidised charges in a Community Hospital.</p> <p>⁷ Annual deductible will be increased by 50% for any Insured Person above 80 years old at age next birthday.</p>			

UNDERWRITING OPTIONS

This portion contains important information to explain how we underwrite Your Policy. You may choose from two underwriting options – the Full Medical Underwriting Option or the Moratorium Underwriting Option.

For the Full Medical Underwriting Option, You have to complete a medical history declaration fully disclosing the Insured Person's medical history which existed before the date of application for the Policy, including any Pre-Existing Condition, if any.

For the Moratorium Underwriting Option, We will not ask You to give details of the Insured Person's medical history. Instead, We will not cover any Pre-Existing Condition that existed prior to the commencement of cover of MyShield.

Please refer to "Key Product Provisions – (1) Exclusions" for more information.

Any new, unexpected eligible conditions arising after the the start of the Insured Person's cover will be covered immediately, subject to the terms and conditions of the Policy.

Important Notice: We strongly advise that You do not delay receiving medical advice and/or treatment when deemed necessary.

PREMIUM RATES

The premium payable is based on an Insured Person's age next birthday at the Policy Commencement Date and will increase when he/she enters into the next age band. You may withdraw up to:

- (a) \$800 (for Insured Persons below 81 years old at age next birthday) per Insured Person per year, or
- (b) \$1,150 (for Insured Persons 81 years old and above at age next birthday) per Insured Person per year

from Your Medisave Account to pay for the premium. Any premium in excess of the applicable annual Medisave withdrawal limit has to be paid by cash.

Annual Premium per person in SG Dollars (inclusive of 7% GST) (Premium rates are non-guaranteed)							
Age Next Birthday	Plan 1	Plan 2	Plan 3	Age Next Birthday	Plan 1	Plan 2	Plan 3
1 to 18	\$142.70	\$98.66	\$89.80	76 to 78*	\$4,123.03	\$3,064.65	\$2,352.96
19 to 30	\$158.55	\$109.61	\$89.80	79 to 80*	\$4,123.03	\$3,064.65	\$2,352.96
31 to 40	\$241.27	\$156.50	\$127.49	81 to 83*	\$5,740.15	\$4,174.90	\$3,202.39
41 to 45	\$446.70	\$314.05	\$248.85	84 to 85*	\$5,963.26	\$4,257.34	\$3,251.35
46 to 50	\$481.46	\$314.05	\$248.85	86 to 88*	\$6,096.86	\$4,355.97	\$3,364.08
51 to 55	\$717.42	\$531.80	\$409.10	89 to 90*	\$6,220.16	\$4,443.72	\$3,465.58
56 to 60	\$800.00	\$543.57	\$420.66	91 to 93*	\$6,344.59	\$4,532.52	\$3,569.52
61 to 65	\$1,224.97	\$911.42	\$695.55	94 to 95*	\$6,471.25	\$4,622.40	\$3,677.14
66 to 70	\$1,761.06	\$1,315.09	\$996.69	96 to 98*	\$6,601.29	\$4,715.49	\$3,787.19
71 to 73	\$2,525.23	\$1,887.22	\$1,437.78	99 and up*	\$6,732.44	\$4,810.71	\$3,899.69
74 to 75	\$2,964.91	\$2,206.32	\$1,680.20				

* For renewal only

ELIGIBILITY

- (a) the Proposer must be a Singapore Citizen or Singapore Permanent Resident, 75 years old or below, at age next birthday at the Policy Commencement Date of MyShield and the Proposer must be a member of CPF with a CPF Medisave Account;
- (b) cover can be extended to the Proposer's eligible dependants who must be 75 years old or below, at age next birthday as at the Policy Commencement Date of MyShield;
- (c) a newborn child from 15 days old or the date of discharge from the Hospital after birth, whichever is later is also eligible for cover; and
- (d) any applicant applying for Plan 3 must be a Singapore Citizen.

KEY PRODUCT PROVISIONS

The following are some key provisions found in the Policy contract of MyShield. 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 insurance adviser should You require further explanation.

1. Exclusions

There are certain conditions under which no benefit will be payable. These are stated as General Exclusions in the Policy contract. **You are advised to read the Policy contract for the precise terms and conditions of all exclusions.** The following is a simplified list of some of the exclusions applicable under MyShield. It is not exhaustive.

- (a) pre-existing condition
means any injury, illness, condition or symptom that existed prior to the Effective Date, the date of Upgrade or the date of the last reinstatement, whichever is later;
 - for which treatment, medication, advice or diagnosis has been sought or received or was foreseeable by You or the Insured Person; or
 - for which an ordinary and prudent person with such injury, illness, condition or symptom would have sought advice or treatment in connection with his/her health; or
 - for which You or the Insured Person knew existed, whether or not treatment, medication, advice or diagnosis was sought or received.

Pre-Existing Conditions are excluded under this Policy unless

- (i) if You have chosen the Full Medical Underwriting Option, the Pre-Existing Condition has been declared by You and specifically accepted by Us in writing to be covered under the Policy; or
- (ii) if You have chosen the Moratorium Underwriting Option, during the period of 5 years' continuous insurance from the date of commencement of cover or the date of the last reinstatement or the date of Upgrade, whichever is later, under the Policy, the Insured Person has not, in relation to a Pre-Existing Condition:
 - experienced symptoms;
 - sought advice or tests from a Physician, a Specialist or Alternative Medicine Provider (including checkups for that Pre-Existing Condition);
 - required treatment or medication; or
 - received treatment or medication

in which case, We will cover the Pre-Existing Condition under the Policy. This 5-year period is known as the Moratorium. If an Insured Person has experienced any of the above during the Moratorium period, then that particular Pre-Existing Condition shall be permanently excluded from the Policy.

For the avoidance of doubt, the Moratorium will not apply to the following list of Pre-Existing Conditions and these Pre-Existing Conditions shall be permanently excluded under the Policy if You have selected Moratorium Underwriting:

- Heart attack, heart bypass, angioplasty
- Chronic obstructive lung disease, chronic cor pulmonale, pulmonary hypertension
- Stroke
- Liver cirrhosis
- Paralysis
- Osteoporosis
- AIDS or HIV infection
- Thalassaemia Intermediate/Major
- Diabetes with complications such as protein in urine or eye problem
- Kidney failure
- Organ transplantation
- Systemic lupus erythematosus (SLE)
- Muscular dystrophy
- Multiple sclerosis
- Alzheimer's disease
- Dementia
- Any form of Cancer (other than skin cancer)
- Autism

- (b) entire period of hospitalisation if admission to Hospital is before the Policy Commencement Date;
- (c) overseas medical treatment other than Inpatient Medical Complaint outside Singapore as covered under MyShield;
- (d) any transport trips to obtain medical treatment;
- (e) private nursing charges/services;
- (f) routine medical examination or check-ups, elective cosmetic treatments, vaccination;
- (g) congenital anomalies or birth defects, hereditary conditions except as provided for and covered under Inpatient Congenital Anomalies benefit under MyShield;
- (h) pregnancy or childbirth, except as provided for and covered under Inpatient Pregnancy Complications benefit under MyShield; self-inflicted injuries, suicide, abuse of alcohol, drug addiction;
- (i) sexually transmitted diseases and any treatment or test in connection with Human Immunodeficiency Virus (HIV) Infection and all HIV infection-related conditions or diseases, except HIV infection acquired through blood transfusion in Singapore or HIV acquired while performing regular professional duties in a medical profession in Singapore;
- (j) hazardous sports or activity;
- (k) war and terrorism;
- (l) mental illness or personality disorder except as provided for and covered under Inpatient Psychiatric Treatment benefit under MyShield;
- (m) experimental or pioneering medical and surgical techniques not commonly available or not approved by MOH.

2. Pro-ration Factor, Annual Deductible and Co-Insurance

The actual benefit payable will be subjected to the following factors as specified in the Benefit Schedule:

- (a) **Pro-ration Factor:** If an Insured Person is admitted to a ward higher than what he/she is entitled to under the plan he/she has chosen, or received Inpatient treatment outside Singapore, the Pro-ration Factor (if applicable), which is expressed as a percentage, will be applied to the actual charges incurred and covered under the Policy, including charges in respect of Pre-Hospital and Post-Hospital Treatment received in connection with hospitalisation, or the Reasonable and Customary Charges for equivalent medical treatment in any Singapore Private Hospital or at the Singapore General Hospital, depending on the Plan covered, whichever is lower.
- (b) **Annual Deductible:** Before a claim is payable by Us, an Insured Person has to pay the Annual Deductible which is the accumulative total amount of covered expenses incurred by him/her during any one Policy Year. Any covered expenses incurred under Outpatient Catastrophic Treatment are not subject to the Annual Deductible.
- (c) **Co-Insurance:** In the event a claim is payable by Us, an Insured Person has to pay the amount of Co-Insurance up to the maximum amount as stated in the Benefits Schedule. The amount payable by him/her is obtained by multiplying the benefit payable in excess of Annual Deductible with a fixed percentage as stated in the Benefits Schedule.

3. Non-Guaranteed Premium

Premium Rates payable under MyShield are not guaranteed and may be increased on the Policy renewal date based on the claims experience of the portfolio.

4. Renewal

MyShield is automatically renewed for a further period of 12 months by payment of the renewal premium before the Renewal Date. We may vary the benefits, cover, premium, clauses and conditions to all the Policies under this class of insurance by giving You 30 days advance notice in writing but will not cancel any individual Policy.

5. Termination Clause

An Insured Person's cover under MyShield will automatically terminate on the date any one of the following events first occurs:

- (a) upon his/her death;
- (b) on the expiry of the 30-day notice following Your request for Cancellation;
- (c) non-payment of premium after the Grace Period;
- (d) failure to refund Us money due to/owing to Us for any prior payment made by Us (if any); or
- (e) upon successful commencement of another Medisave-approved Integrated Shield Plan issued by another insurance company covering the Insured Person.

6. Reinstatement

If MyShield terminates due to non-payment of premium, You may apply to reinstate MyShield within 30 days of the date of notice of Termination by providing Us with satisfactory evidence of insurability at your expense. All Insured Persons must be 75 years old or below at age next birthday at the date of reinstatement. All outstanding premiums must be received by Us before MyShield can be reinstated. Treatment provided to the Insured Person after the date of Termination and within 30 days of the date of notice of reinstatement will not be covered unless the treatment received as an Inpatient is for Injuries caused by an Accident occurring after the date of notice of reinstatement.

7. Cancellation Clause

You may cancel MyShield by giving Us 30 days notice in writing. There will be a pro-rated refund based on the number of unused days for the rest of the Policy Year. The cover under MyShield will cease at the requested date of Termination. Cover under the MediShield will continue to remain in force as long as he/she still satisfies the eligibility criteria under MediShield. If You wish to terminate the cover under MediShield, you will have to notify the Central Provident Fund Board separately.

8. Change of Plan

You may change the plan of an Insured Person, subject to Our approval in writing, by giving Us a written notice at least 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 upgrading of plan before the change can be effected on the Renewal Date.

In the event of an Upgrade whereby the Insured Person fails to satisfy the Moratorium of the upgraded plan, any claim arising from a Pre-Existing Condition after the Upgrade will be assessed under the terms and conditions of the plan prior to the Upgrade.

If such a claim is admissible after having satisfied the Moratorium of the plan prior to the Upgrade, any benefit payout would be limited to the benefits under the plan prior to the Upgrade.

Any Pre-Existing Condition which has been permanently excluded under the Policy as provided in the General Conditions clause of the Policy Contract will remain permanently excluded under the upgraded plan.

9. Last Payer Status

If the Insured Person has other medical insurance, including medical benefits under any employment contract, which makes provision for reimbursement of medical expenses, We shall be the last payer reimbursing the claim. If benefits payable under this Policy has been made to You first before a claim is made under any other medical insurance policies or employee benefits, the other medical insurers or employer will need to reimburse Us their share. You shall provide Us with the full details of such other insurance policies or employee benefits and all relevant documentary proof necessary to make a claim.

For every claim, the total reimbursement to be made should not exceed the expenses actually incurred.

10. Waiting Period

This is applicable to specific benefits under the Policy as set out under the relevant benefit provisions, starting from:

- (a) the date which the benefit first becomes effective under the Policy;
- (b) the Policy Commencement Date of the Policy;
- (c) the date of last reinstatement; or
- (d) the date of Upgrade (applicable to any increased or additional benefit(s)).

whichever is the latest, during which this Policy will not provide for those specific benefits regardless or treatment made necessary by any cause.

11. Full Disclosure

You are required to disclose fully and truthfully all material facts and circumstances to Aviva up to the date full cover is provided in respect of any Insured Person. Otherwise, We can declare the Policy void and avoid all liabilities existing under the Policy contract. If You were previously covered under MediShield or a Medisave-Approved Plan offered by another insurer, only Your cover under MediShield will be reinstated. We will refund You all premiums paid provided You have not made any claim under MyShield.

12. Free Coverage for Child(ren)

We will cover Your children up to 20 years old at age next birthday for free under Plan 2 (up to a maximum of four (4) children) if We accept their application in writing and both parents are insured under Plan 1 or 2. You only need to start paying premiums at renewal when Your children reach 21 years old at age next birthday in order to let them enjoy continuous coverage.

13. Aviva's Promise of Service

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

14. 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. Full details of the terms, conditions and exceptions of this insurance are provided in the MyShield Policy and will be sent to You upon acceptance by Aviva Ltd. You have a "Free Look" period of two (2) calendar months from the Policy Commencement Date or fourteen (14) days from the date of receipt of the MyShield Policy, whichever is the later. You are assumed to have received the MyShield Policy within seven (7) days after We have sent it by post. Please inform Aviva Ltd in writing within the "Free Look" period if You do not want the MyShield Policy. It will be cancelled from Policy 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, as long as no claim has been admitted under the Policy. MyShield is governed by and shall be construed according to the laws of Singapore.



PRODUCT SUMMARY

Date: / / (DD/MM/YY)

Presented to: (Name of Proposer)

Signature of Proposer:

Name of Financial Adviser:

Signature of Financial Adviser:

PRODUCT INFORMATION

MyShield Plus is a rider to MyShield that provides complementary protection on top of what MyShield covers, specifically to meet your needs to reduce the uncertainty of out-of-pocket expenses in your MyShield coverage.

Benefits Schedule in SG Dollars			
Hospital Ward Type	MyShield		
	Plan 1	Plan 2	Plan 3
	Any Private Ward	Any Government/ Restructured Ward	B1 Government/ Restructured Ward
OPTION A	As incurred under MyShield		
1) Co-Insurance Benefit	As incurred under MyShield		
2) Critical Illness Benefit (up to age 65) (per Lifetime)	S\$10,000	S\$10,000	S\$10,000
3) Hospital-Related Benefits			
(a) Hospital Cash Benefit [^]	S\$300 per day if admitted to any Singapore Government / Restructured Ward	S\$150 per day if admitted to class B1 or lower of Singapore Government / Restructured Ward	S\$100 per day if admitted to class B2 or lower of Singapore Government / Restructured Ward
(b) Ambulance Fees/Transport by Taxi to Hospital (per injury or illness)	S\$80	S\$80	S\$80
(c) Accommodation Benefit for Parent/Guardian of Insured Child ⁺ (per day)	S\$80 Up to 10 days	S\$65 Up to 10 days	S\$50 Up to 5 days
(d) Post-Hospital Follow-Up TCM [#] Treatment (up to 90 days after discharge) (per visit)	S\$45	S\$45	S\$45
4) Free Coverage for Child(ren)*	Yes	Yes	N.A.
OPTION B	As incurred under MyShield		
5) Deductible Benefit	As incurred under MyShield		

[^] For admission to government/restructured hospitals of wards lower than that of chosen plan. This excludes day surgery, confinement in Community Hospital and confinement in Private Hospital.
⁺ Insured child refers to the Insured Person who is below 19 years old at age next birthday.
[#] Traditional Chinese Medicine
^{*} Based on benefits under Option A Plan 2, up to 20 years old at age next birthday, provided both parents take up MyShield Plus Plan 1 or 2 and are covered under Option A.

PREMIUM RATES

Premium payable is based on an Insured Person's age next birthday at the Policy Commencement Date and will increase when he/she enters into the next age band. The Plan chosen must be the same as MyShield and premium must be paid by cash. If the plan of any Insured Person is different from the plan insured under MyShield, and the premium paid as a result is insufficient, We will collect the shortfall in premiums in cash or deduct from any claim payable under this Policy. Premium rates are not guaranteed and may increase at policy renewal at the full discretion of the Company.

MyShield Plus Option A

Annual Premium per person in SG Dollars (inclusive of 7% GST) (Premium rates are non-guaranteed)							
Age Next Birthday	Plan 1	Plan 2	Plan 3	Age Next Birthday	Plan 1	Plan 2	Plan 3
1 to 30	\$52.00	\$37.45	\$27.05	76 to 78*	\$690.20	\$538.50	\$386.70
31 to 40	\$79.00	\$54.05	\$41.60	79 to 80*	\$804.55	\$627.85	\$422.05
41 to 45	\$145.55	\$103.95	\$72.80	81 to 83*	\$1,014.50	\$773.35	\$519.75
46 to 50	\$158.00	\$118.50	\$108.10	84 to 85*	\$1,110.10	\$829.55	\$555.05
51 to 55	\$237.05	\$182.95	\$166.35	86 to 88*	\$1,130.90	\$846.10	\$571.70
56 to 60	\$326.40	\$280.65	\$255.75	89 to 90*	\$1,153.80	\$862.75	\$590.40
61 to 65	\$465.75	\$407.45	\$367.95	91 to 93*	\$1,176.65	\$879.35	\$607.05
66 to 70	\$469.85	\$411.65	\$374.20	94 to 95*	\$1,199.50	\$898.10	\$623.70
71 to 73	\$476.05	\$415.80	\$378.45	96 to 98*	\$1,224.45	\$914.70	\$642.40
74 to 75	\$550.90	\$457.35	\$382.55	99 to 100*	\$1,247.35	\$935.50	\$663.15

MyShield Plus Option B

Annual Premium per person in SG Dollars (inclusive of 7% GST) (Premium rates are non-guaranteed)							
Age Next Birthday	Plan 1	Plan 2	Plan 3	Age Next Birthday	Plan 1	Plan 2	Plan 3
1 to 30	\$195.05	\$142.20	\$118.70	76 to 78*	\$905.65	\$752.35	\$659.00
31 to 40	\$223.45	\$162.90	\$127.00	79 to 80*	\$916.85	\$759.35	\$683.00
41 to 45	\$224.90	\$163.55	\$129.60	81 to 83*	\$1,050.30	\$779.45	\$706.90
46 to 50	\$226.40	\$164.15	\$132.20	84 to 85*	\$1,122.25	\$867.80	\$776.50
51 to 55	\$227.90	\$164.80	\$134.85	86 to 88*	\$1,159.05	\$1,003.90	\$879.70
56 to 60	\$229.40	\$180.35	\$137.45	89 to 90*	\$1,342.30	\$1,153.80	\$991.60
61 to 65	\$314.85	\$219.85	\$188.45	91 to 93*	\$1,544.05	\$1,318.65	\$1,066.30
66 to 70	\$544.85	\$441.05	\$380.15	94 to 95*	\$1,657.25	\$1,408.40	\$1,156.40
71 to 73	\$798.20	\$611.70	\$490.40	96 to 98*	\$1,775.15	\$1,520.20	\$1,273.40
74 to 75	\$838.55	\$665.85	\$573.10	99 to 100*	\$1,902.20	\$1,624.60	\$1,367.60

* For renewal only

ELIGIBILITY

The Insured Person must be:

- between 15 days old and 75 years old at age next birthday as at the Policy Commencement Date; and
- already insured under MyShield.

COVERAGE OPTIONS

Besides choosing the appropriate MyShield Plus Plan based on the desired hospital/ward type, the Insured Person may also choose to be covered on benefits under:

- Option A only; or
- Option B only; or
- Option A and Option B.

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 insurance adviser should You require further explanation.

1. Covered Benefits

The Company's liability is limited to the coverage as provided for in the policy contract.

(a) Option A Benefits

(i) Co-Insurance Benefit

The Co-Insurance portion for MyShield will not have to be borne by you in the event of hospitalisation if the claim is payable under MyShield and the claim does not exceed the maximum claim limits as stated in the MyShield Benefits Schedule.

(ii) Critical Illness Benefit

To be eligible for the Critical Illness Benefit under this Policy, you must be aged between one year old and 65 years old at age next birthday at the point of commencement of cover. Any Insured Person below one year old will be only eligible for Critical Illness Benefit when he attains the age of one.

A lump sum benefit of \$10,000 will be paid upon your first diagnosis of any one of the following 30 Critical Illnesses. The list of 30 Critical Illnesses includes Heart Attack, Coronary Artery By-Pass Surgery, Heart Valve Surgery, Aorta Surgery, Primary Pulmonary Hypertension, Kidney Failure, Major Organ/Bone Marrow Transplantation, Fulminant Hepatitis, End Stage Liver Failure, End Stage Lung Disease, Major Cancers, Stroke, Coma, Multiple Sclerosis, Muscular Dystrophy, Alzheimer's Disease/Severe Dementia, Motor Neurone Disease, Parkinson's Disease, Apallic Syndrome, Major Head Trauma, Aplastic Anaemia, HIV Due to Blood Transfusion and Occupationally Acquired HIV, Deafness (Loss of Hearing), Blindness (Loss of Sight), Loss of Speech, Terminal Illness, Major Burns, Paralysis (Loss of Use of Limbs), Progressive Scleroderma and Benign Brain Tumour.

(iii) Hospital-Related Benefits

Hospital Cash Benefit

In the event of hospitalisation at the recommendation of a Physician, we will pay a cash benefit of up to S\$300 per day of hospitalisation provided that the Insured Person stays in a hospital ward lower than what he/she is entitled to under his/her chosen plan and the claim is payable under MyShield (other than MediShield). We will not pay the Hospital Cash Benefit in the event of a day surgery, confinement in community hospital, confinement in private hospital or if there is no hospital stay involved.

Ambulance Fees or Transport by Taxi to Hospital

We will pay for the one-way transportation within Singapore, of the Insured Person by either road ambulance or land taxi to a hospital, provided the Insured Person is hospitalised within 24 hours for treatment of an illness or injury covered under the MyShield Policy and the claim is payable under MyShield (other than MediShield).

Accommodation Benefit for Parent/Guardian of Insured Child

If one parent or guardian is a lodger sharing the hospital room of an Insured Person who is below 19 years old at age next birthday, we will pay for the accommodation charges incurred by the parent or guardian provided the Insured Person is hospitalised for treatment of an illness or injury covered under the MyShield Policy and the claim is payable under MyShield (other than MediShield).

Post-Hospital Follow-Up TCM Treatment

As result of an accident, if the Insured Person is referred by the attending Physician of a restructured hospital to a Traditional Chinese Medicine (TCM) clinic of any restructured hospital, we will pay for the post-hospital follow-up TCM treatment by a registered TCM practitioner within 90 days after hospital discharge. The TCM treatment must be for the same injury or illness for which the Insured Person was hospitalised and the hospitalisation claim must first be payable under MyShield (other than MediShield).

We will not pay this benefit following day surgery, confinement in Community Hospital or if there is no hospital stay involved.

(iv) Free Coverage for Child(ren)

Your dependant child who is eligible for free coverage under MyShield, is also eligible for free coverage under Option A Plan 2 of MyShield Plus if both parents are also insured under MyShield Plus and covered under Option A. The child shall enjoy the same benefits as provided for under Option A Plan 2 of the Benefits Schedule except for the Critical Illness Benefit, whereby a lump sum of \$10,000 will be paid only on the dianosis of any one of the five Critical Illnesses namely Major Cancer, Major Organ/Bone Marrow Transplantation, Major Burns, Major Head Trauma and Kidney Failure.

(b) Option B Benefit

(i) Deductible Benefit

We shall reimburse You the amount of Annual Deductible payable by You in respect of a covered claim under your MyShield policy.

2. Material Changes

We must be informed immediately in writing of any material change in information or circumstances whether relating to occupation, business or sporting activity affecting You or any Insured Person. We reserve the right either to continue cover for the Insured Person on terms and conditions We consider appropriate because of the material change in information or circumstances or to decline to continue cover under this Policy.

3. Renewal

MyShield Plus is automatically renewed subject to payment of the renewal premium. We may vary the benefits, cover, premium, clauses and conditions to all the Policies under this class of insurance by giving You thirty (30) days advance notice in writing but will not cancel any individual Policy.

4. Termination of Insurance

An Insured Person's cover under this Policy will terminate automatically on the date any one of the following events first occurs:

- (a) upon death of an Insured Person;
- (b) upon request for cancellation by the Insured;
- (c) non-payment of required premium due after the grace period; or
- (d) upon the termination of your MyShield plan.

The Critical Illness Benefit of the Policy will terminate automatically on the date any one of the following events first occurs:

- (a) if a valid claim for Critical Illness Benefit has been made; or
- (b) on the expiry of the Policy Year during which the Insured Person attains the age of 65 years old.

5. Cancellation Clause

You may cancel MyShield Plus by giving us thirty (30) days notice in writing. If you cancel MyShield Plus only, your cancellation of this Policy will not affect the validity of MyShield.

Where premium is charged on an annual basis and the Insured cancels the Policy during the Policy Year after the Free Look Period, there will be a pro-rated refund based on the number of unused days for the rest of the Policy Year. However, if a claim has arisen in respect of that Policy Year, no refund will be made.

Where premium is charged on a non-annual basis and the Insured cancels the Policy, the Company is entitled to the balance of the premium payable for the entire Policy Year if a claim arises in respect of that Policy Year. The Company may deduct the balance of the premium from any claim amount due.

The Company reserves the right to terminate coverage of this Policy on the renewal date by giving you thirty (30) days notice in writing. If this occurs, it will affect the whole class of policies in that category and not any individual policy in particular.

6. Underwriting Method

The same method of underwriting MyShield will apply for your MyShield Plus.

7. Waiting Period

For Major Cancers, Coronary Artery By-Pass Surgery and Heart Attack, the Critical Illness Benefit will only be payable if they are diagnosed 90 days after the date an Insured is first covered under this Policy or the date of reinstatement of this Policy (whichever is later).

8. Survival Period

The Critical Illness Benefit will be payable after the end of the period of 30 days from the date on which an Insured Person is diagnosed as suffering from a Critical Illness.

9. Co-ordination of Benefits

If, at the time of claim, the Insured Person has other medical insurance which makes provision for reimbursement of medical expenses, you shall advise us of the details of such other policies and we shall not be liable to contribute more than the rateable proportion of such reimbursement.

10. Exclusions

There are certain conditions under which no benefit will be payable. In addition to the exclusions defined under MyShield policy. The following are excluded under this plan. It is not exhaustive. You are advised to read the MyShield and MyShield Plus policy contracts for the precise terms and conditions of the exclusions.

- (a) pre-existing conditions are excluded, unless
 - You have chosen the Full Medical Underwriting Option and the Pre-Existing Conditions have been declared by you and specifically accepted by Us in writing to be covered under the Policy; or
 - You have chosen the Moratorium Underwriting Option and satisfy the Moratorium terms and conditions as stated in the Policy. However, the Moratorium will not apply to the Critical Illness Benefit.
- (b) any costs incurred from admission to hospital before the Effective Date of the Policy.

11. 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. Full details of the terms, conditions and exceptions of this insurance are provided in the MyShield Plus Policy and will be sent to You upon acceptance by Aviva Ltd. You have a "Free Look" period of fourteen (14) days from the date of receipt of the MyShield Plus Policy. You are assumed to have received the MyShield Plus Policy within seven (7) days after We have sent it by post. Please inform Aviva Ltd in writing within the "Free Look" period if You do not want the MyShield Plus Policy. We will cancel from it from its Start Date and refund in full the premium You have paid after deducting any expenses incurred in assessing the risk under the Policy, as long as no claim has been admitted under the Policy. MyShield Plus is governed by and shall be construed according to the laws of Singapore.



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: <input type="checkbox"/> Proposer: <input type="checkbox"/> Dependant 1: <input type="checkbox"/> Dependant 2: <input type="checkbox"/> Dependant 3: <input type="checkbox"/> Dependant 4:	For Official Use Only		
		MyShield Contract No.: _____	MyShield Plus Contract No.: _____	Client No.: _____

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 _____

CPF Account No. (Proposer must have a CPF account to apply for MyShield): _____

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

Usual Country of Residence: _____ Nationality ID Type: Singaporean Singapore PR

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 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: _____ Nationality ID Type: Singaporean Singapore PR Others _____

Relationship to Proposer: Spouse Parent Child Grandparent

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: Nationality ID Type: Singaporean Singapore PR Others
 Relationship to Proposer: Spouse Parent Child Grandparent
 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: Nationality ID Type: Singaporean Singapore PR Others
 Relationship to Proposer: Spouse Parent Child Grandparent
 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: Nationality ID Type: Singaporean Singapore PR Others
 Relationship to Proposer: Spouse Parent Child Grandparent
 Employment Status: Employed Self-employed Unemployed Occupation:
 Name of Employer:
 Address of Employer:

SECTION C: DECLARATION OF FACT FIND OPTION

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 TYPE

Any eligible child (subject to a maximum of four (4) children), up to 20 years old at age next birthday will be covered for free under Plan 2 provided both parents are covered under Plan 1 or Plan 2. For MyShield Plus, free coverage refers to coverage under Option A only and both parents must be covered under Option A. If the Proposer has indicated Plan 2 FOC coverage but his or her child is not eligible, we will proceed to charge the appropriate premium for the child under Plan 2. If any applicant crosses the age band while the application is being processed, we will proceed to charge the appropriate premium according to the age at next birthday.

Please tick the box according to your plan selection.

MyShield <i>(Each individual may select one plan only)</i> Note: Please do not tick if you have an existing MyShield Plan. This is not applicable for upgrading/downgrading of plan)	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Plan 1					
Plan 2					
Plan 2 (FOC for child if applicable [^])	Not Applicable				
Plan 3 (For Singaporean only)					
MyShield Plus <i>(Each individual may select more than one option)</i> Note: MyShield Plus Plan Type will follow MyShield.	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Option A (covers Co-Insurance)					
Option A (covers Co-Insurance) (FOC for child if applicable [^])	Not Applicable				
Option B (covers Deductible)					
[^] FOC for child if applicable					
For our records, please indicate: Other parent's name: <input type="text"/> NRIC No.: <input type="text"/>					

SECTION F: PAYMENT DETAILS (FOR MYSHIELD PLUS ONLY)

Regular Premium:

Payment Frequency: Yearly 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.

AXS

Please submit a copy of AXS payment slip.

Subsequent Premium

Payment Method:

Interbank GIRO

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 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 G: UNDERWRITING OPTIONS

Please choose an underwriting option and complete this section fully. The underwriting option chosen for MyShield Plus must be the same as MyShield. If you have indicated a different underwriting option in this form for any applicant, the same method of underwriting MyShield will apply for MyShield Plus.

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Have you had an application, reinstatement or renewal of a Life, Critical Illness, Health, Accident or Disability policy deferred or declined ?	<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 table below and also select the **full medical underwriting** option at Question 2.

<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"/>	Type of Policy: <input type="text"/>			
Reason: <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 Company: <input type="text"/>	Type of Policy: <input type="text"/>			
Reason: <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 Company: <input type="text"/>	Type of Policy: <input type="text"/>			
Reason: <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 Company: <input type="text"/>	Type of Policy: <input type="text"/>			
Reason: <input type="text"/>	<input type="text"/>			

2. Please select an underwriting option:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I/We confirm that I/we have read and understood the Product Summary, which includes the exclusions and pre-existing conditions that shall be permanently excluded under Moratorium Underwriting.	Moratorium Underwriting	Moratorium Underwriting	Moratorium Underwriting	Moratorium Underwriting	Moratorium Underwriting
	or	or	or	or	or
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Full Medical Underwriting	Full Medical Underwriting	Full Medical Underwriting	Full Medical Underwriting	Full Medical Underwriting

SECTION H: FULL MEDICAL UNDERWRITING ONLY

This section must be fully completed ONLY if you have selected FULL Medical Underwriting. DO NOT complete this section if you had chosen Moratorium Underwriting. Any disease or condition of health, which existed before the date of application, will not qualify for benefit unless it is fully disclosed to and accepted by us. You must, therefore, ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the policy commencement date. Should you require more space for your answers, please continue on a separate sheet, sign and date it.

If you are unsure whether any information is material or not, you are advised to disclose it.

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
4. 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

SECTION H: FULL MEDICAL UNDERWRITING (continued)

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

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<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 you answered 'Yes' to any of the above Questions 4(a) to 4(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	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:	<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?
				Name: _____ Address: _____ _____ _____ _____
<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	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:	<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?
				Name: _____ Address: _____ _____ _____ _____
<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	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:	<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?
				Name: _____ Address: _____ _____ _____ _____

SECTION H: FULL MEDICAL UNDERWRITING (continued)

<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	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:	<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?	
				Name: <input type="text"/> Address: <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	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:	<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?	
				Name: <input type="text"/> Address: <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	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:	<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?	
				Name: <input type="text"/> Address: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

5. **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:

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
<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"/> 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="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="text"/>

SECTION H: FULL MEDICAL UNDERWRITING (continued)

<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 <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%;" type="text"/> <input style="width: 100%;" type="text"/>

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
6. 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			

<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			

<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			

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
7. 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?	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>
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 I: DECLARATION

AUTHORISATION & DECLARATION BY PROPOSER (CPF ACCOUNT HOLDER)

1. I authorise the Central Provident Fund Board (the "CPFBoard") to deduct premium(s) due for the Life/Lives to be covered as named under this application (the "Lives") from my Medisave account in accordance with the provisions of the Central Provident Fund Act (Chapter 36), and the regulations made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPFBoard from time to time.
2. I authorise the CPFBoard to deduct premium(s) due under this application from my new Medisave account should I be given a new Medisave account upon obtaining Singapore Permanent Residence status.
3. I authorise the CPFBoard to disclose information/seek information on a confidential basis to/from any insurer(s) relating to:
 - (i) payment of premiums due under this application, including the deduction of premiums from my Medisave account/new Medisave account; and
 - (ii) the making of refunds under this application, as the CPFBoard shall reasonably consider appropriate.
4. I confirm that I have been explained to my satisfaction (a) the underwriting options applicable to this policy; (b) Your Guide to Health Insurance; (c) Product Summary; (d) Fact Find; (e) Interim Cover Terms & Conditions, and a copy of (b) to (e) have been received. (Applicable if you have seen an adviser)
5. 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 for my financial needs and insurance objectives. (Applicable to Direct Marketing)
6. I am aware that the product I am applying for is authorised for sale in Singapore 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.
7. 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.
8. 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.

AUTHORISATION & DECLARATION BY PROPOSER AND/OR DEPENDANTS

1. I/We, hereby consent to the automatic termination of:
 - (i) the MediShield cover(s) (applicable only for the Life/Lives who is/are not eligible to be covered under MediShield pursuant to an integrated medical insurance plan, as such term is defined in the regulations made under the Central Provident Fund Act (Chapter 36), or
 - (ii) any other existing medical insurance policy (if any) under the Private Medical Insurance Scheme (PMIS) for the Life/Lives upon the commencement of this cover.
2. I/We, hereby consent to the transfer and disclosure, at any time without notice or liability to me/us, of any medical information on me/us, in the insurer's or the CPFBoard's possession, between:
 - (i) Aviva Ltd and the CPFBoard, and
 - (ii) Aviva Ltd and other insurers administering or operating an insurance scheme referred to in section 77(1)(k) of the Central Provident Fund Act (Chapter 36) for the purpose of assessing the insurability of me/us and/or the making of a claim under the Central Provident Fund (MediShield Scheme) Regulations (Rg.20) or under an insurance scheme referred to in section 77(1)(k) of the Central Provident Fund Act (Chapter 36).
3. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.
4. I/We declare that all the information on this Application Form is true and complete and to the best of my/our knowledge and understand that any misrepresentation or concealment of facts shall render the policy to be issued null and void.
5. 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 and the date full insurance coverage is provided by Aviva Ltd to me/us and/or any dependant. 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.
6. 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 I: DECLARATION

7. I/We authorise:

(i) any medical source, insurance office, or organisation to release to Aviva Ltd and similarly

(ii) 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:
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Signature of Dependant 3:	Signature of Dependant 4:
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Signature of Witness/Adviser:

Name of Witness/Adviser:

Identity Card/Passport No.:

Date (DD/MM/YY):

Intentionally Left Blank



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	<input type="text"/>
Bank	Branch	Account Number to be Debited	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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: