* P O L C H G *

# Policy Servicing Health Declaration (for Life Products)

| POLICY DETAILS | | | | | |
|---|---|---|---|---|---|
| **Policy Number** | : | | | | |
| **Name of Assignee/Assured** | : | | **NRIC/Passport No.** | : | |
| **Name of Joint Assured** | : | | **NRIC/Passport No.** | : | |
| **Name of Life Assured** | : | | **NRIC/Passport No.** | : | |
| **Name of Joint Life Assured** | : | | **NRIC/Passport No.** | : | |

**Important Notes:**

- For IdealIncome plan, please complete section A, B, C, D, E and F
- For MyCoreCI plan, please complete section A, B, C and G
- For all other plans, please complete section A, B,C, D, E

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. 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 licensed Financial Adviser Representative but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Regulations based on the Singapore Income Tax Act (Chapter 134), Foreign Account Tax Compliance Act ("**FATCA**"), OECD Common Reporting Standard for Common Exchange of Financial Account Information ("**CRS**") require Aviva Ltd to collect certain information about an Account Holder's tax residence. We may be legally obliged to give the Inland Revenue Authority of Singapore (IRAS) this information, along with information relating to your policies, which may be shared between different countries' tax authorities.

To help us collect this information, we need you to complete the questions in Section A and Section B in the Declaration portion.

## Section A (Please fill in the details)

| DETAILS OF LIFE ASSURED AND/OR JOINT LIFE ASSURED | Life Assured | Joint Life Assured |
|---|---|---|
| Country of Residence | | |
| Occupation | | |
| Annual Fixed Income | | |
| Exact duties | | |
| Nature of Business | | |
| Name of Employer and address | | |



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**Section B** (Please tick (√) the appropriate box or/and fill in the details)

| DETAILS OF PREVIOUS & CONCURRENT INSURANCE APPLICATIONS | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 1. | Do you have life insurance coverage and/or are you also applying for insurance with another insurance company? If Yes, please provide the coverage amount in equivalent Singapore dollars below. | ☐ | ☐ | ☐ | ☐ |

| | Life (Death) | Total & Permanent Disability | Critical Illness | Personal Accident | Disability Income |
|---|---|---|---|---|---|
| Assured/Life Assured | | | | | |
| Joint Assured/Life Assured | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 2. | Have you ever filed any claims or 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 indicate name of company and give details below. | ☐ | ☐ | ☐ | ☐ |

| | Name of Company and Details |
|---|---|
| Assured/Life Assured | |
| Joint Assured/Life Assured | |

**Section C** (Please tick (√) the appropriate box or/and fill in the details)

| TRAVEL AND LIFESTYLE QUESTIONS | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 1. | In the last 12 months preceding the date of this application, have you been residing in Singapore for more than 183 days? | ☐ | ☐ | ☐ | ☐ |
| 2. | In the last 12 months/next 12 months, have you spent/plan to spend more than 30 days outside of your current country of residence (excluding holiday or leisure)? | ☐ | ☐ | ☐ | ☐ |

| | Country and city visited | Purpose and frequency of travel | Duration per trip |
|---|---|---|---|
| Assured/Life Assured | | | |
| Joint Assured/Life Assured | | | |

| | | | | | |
|---|---|---|---|---|---|
| 3. | Do you currently engage in or do you have definite plans to engage in any of the following (due to occupation or recreation/hobby): Scuba diving, mountain or rock climbing (excluding artificial wall climbing), private flying, parachuting or sky diving, motor sports (car, bike and boat), demolition, bomb disposal, naval diving and other extreme or hazardous activities?<br><br>If yes, please provide the activities and complete Hazardous Pursuits Supplementary Questionnaire (Q39) from Aviva's corporate website. | ☐ | ☐ | ☐ | ☐ |

**Section D** (Please tick (√) the appropriate box or/and fill in the details)

| GENERAL QUESTIONS | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 1. | What is your height and weight?<br>Height (m)<br>Weight (kg) | | | | |



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| GENERAL QUESTIONS (CONTINUED) | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 2. | Did you lose any weight in the last 12 months? (other than intentional weight loss due to diet control and/or exercise)? If Yes, please provide details if you are currently awaiting consultation, hospital referral, tests or investigations. | ☐ | ☐ | ☐ | ☐ |
| | Assured/Life Assured | | | | |
| | Joint Assured/Life Assured | | | | |
| 3. | Are you a smoker? If Yes, how many sticks do you smoke per day in the last 12 months? (including social smokers, cigar smokers or those who have given up within the last 12 months)<br>Sticks per day: | ☐ | ☐ | ☐ | ☐ |
| 4. | Do you drink alcohol? If Yes, what is the total number of standard alcoholic drinks you drink per week? (1 standard alcoholic drink equates to 330ml beer, 125ml glass of wine or 30ml nip of spirits)<br>Total per week: | ☐ | ☐ | ☐ | ☐ |

**Section E** (Please tick (√) the appropriate box or/and fill in the details)

| HEALTH QUESTIONS | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 1. | Have you ever been advised by a health care professional or a counsellor to reduce your alcohol use, see a specialist or attend a support group because of your alcohol use? | ☐ | ☐ | ☐ | ☐ |
| 2. | In the last 10 years have you taken or used addictive or illegal drugs (such as cocaine, ecstasy, heroin or cannabis) or been treated for drug addiction? | ☐ | ☐ | ☐ | ☐ |
| 3. | Has your spouse or partner been told to have or received any medical advice, counselling or treatment in connection with sexually transmitted diseases, HIV, AIDS, AIDS related complex or any other AIDS related condition? | ☐ | ☐ | ☐ | ☐ |
| 4. | Have you ever had or been told to have or been treated for congenital disorder, asthma, cancer, tumour, growth, cyst, disease or disorder of the heart (including high blood pressure, heart attack, heart murmur, heart valve disorder, chest pain), diabetes, epilepsy, fits, Hepatitis, liver disease, raised cholesterol, kidney or urinary disorder, stroke, blood disorder, mental disorder, respiratory disorder, endocrine disorder, musculo-skeletal disorder, gastrointestinal disorder, autoimmune disease, disease and disorder of the eye, ear, nose or throat, HIV infection, sexually transmitted disease or any other illness / physical deformity not listed above? | ☐ | ☐ | ☐ | ☐ |
| 5. | Have you ever had or been advised to undergo surgery or any diagnostic tests such as X-ray, ultrasound, biopsy, electrocardiogram, blood or urine tests?<br>If yes, please complete the following: | ☐ | ☐ | ☐ | ☐ |

| Assured/Life Assured | | | |
|---|---|---|---|
| Name of medical test | Date | Details of treatment, further test and results | Name and address of doctor consulted |
| | | | |
| | | | |

| Joint Assured/Life Assured | | | |
|---|---|---|---|
| Name of medical test | Date | Details of treatment, further test and results | Name and address of doctor consulted |
| | | | |
| | | | |



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| HEALTH QUESTIONS (CONTINUED) | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 6. | Other than any conditions, scans, tests or investigations you have already told us about, are you currently: | | | | |
| | a) Waiting for the results of any test or investigations? | ☐ | ☐ | ☐ | ☐ |
| | b) Taking any medication? (Exclude treatment for minor ailment such as cough, flu, fever) | ☐ | ☐ | ☐ | ☐ |
| | c) Experiencing symptoms or a condition that you're likely to seek medical advice or treatment for? | ☐ | ☐ | ☐ | ☐ |
| | d) Having any physical or mental condition that restricts or causes difficulty in performing your daily activities (such as housework, preparing meals, shopping, using public transport, a hobby been reduced or restricted in anyway due to your health)? | ☐ | ☐ | ☐ | ☐ |

If you have answered 'Yes' to any one of Questions 1, 2, 3, 4, 5 and/or 6, please complete the following (with clear indication of Question No.):

| Question no: | Medical condition and exact diagnosis: | Date of first symptoms or diagnosis<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs | Details of tests, dates and results |
|---|---|---|---|
| ☐ Assured/ Life Assured<br><br>☐ Joint Assured/ Life Assured | Have you made a full recovery with no further treatment, symptoms or complications? | | Name and address of doctor consulted |
| | ☐ Yes<br>*(to provide duration since full recovery)*<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs | ☐ No<br>*(to provide treatment and medication given)* | |

| HEALTH QUESTIONS (CONTINUED) | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 7. | Have any of your natural parents or siblings been diagnosed with or died from any of the following before the age of 60: Alzheimer's disease, bowel or colon cancer, breast or ovarian cancer, cardiomyopathy, coronary artery disease, diabetes, heart attack, heart failure, huntington's disease, ischaemic heart disease, motor neurone disease, multiple sclerosis, muscular dystrophy, parkinson's disease, polycystic kidney disease, stroke or any other hereditary disease or disorder?<br>If Yes, please complete the following: | ☐ | ☐ | ☐ | ☐ |

| Assured/Life Assured | | | |
|---|---|---|---|
| Medical condition | Relationship | Age at diagnosis | Age at death (if deceased) |
| | | | |
| | | | |

| Joint Assured/Life Assured | | | |
|---|---|---|---|
| Medical condition | Relationship | Age at diagnosis | Age at death (if deceased) |
| | | | |
| | | | |



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**Section F** (Please tick (√) the appropriate box or/and fill in the details)

| FOR IDEALINCOME PLAN | | Life Assured | | Joint Life Assured | |
|---|---|---|---|---|---|
| | | Yes | No | Yes | No |
| 1. | Are you a CPF contributor? | ☐ | ☐ | ☐ | ☐ |
| 2. | Have you been self-employed for less than 2 years? If Yes, please provide details below: | ☐ | ☐ | ☐ | ☐ |

| Date of self-employment | Job designation | Nature of previous occupation and exact duties | Annual Fixed Income (Joint Assured/Life Assured) |
|---|---|---|---|
| | | | |

| | | | |
|---|---|---|---|
| 3. | In your occupation, what percentage of your time do you spend performing manual or physical duties (eg. Driving, lifting, and cleaning)?<br>a) Less than 25%<br>b) 25% to 50%<br>c) 51% to 75%<br>d) More than 75%<br>If it is 25% or more, please provide details on the exact manual or physical duties/ nature of work. | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ |
| 4. | How many hours on average do you work per week?<br>a) < 40 hours<br>b) 40 to 55 hours<br>c) 56 to 60 hours<br>d) > 60 hours<br>If you work < 40 hours per week, is this a part time job? | ☐<br>☐<br>☐<br>☐ | ☐<br>☐<br>☐<br>☐ |
| 5. | Have you been in your current occupation for less than 2 years?<br>If Yes, are there any similarities between your current and previous job duties and nature of work?<br>If No, please provide details of your previous occupation. (job designation, job duties, job duration, nature of work) | ☐ ☐ | ☐ ☐ |
| 6. | Does your occupation require you to travel overseas for more than 25% of the time? If Yes, please provide details:<br>a) 26% to 40%<br>b) 41% to 50%<br>c) 50%<br>Name of countries, cities, frequency, and duration of each stay. | ☐ ☐<br>☐<br>☐<br>☐ | ☐ ☐<br>☐<br>☐<br>☐ |
| 7. | Do you hold more than one occupation?<br>If Yes, how many hours do you work per week in this occupation?<br>a) < 40 hours<br>b) 40 to 55 hours<br>c) 56 to 60 hours<br>d) > 60 hours<br>Please provide details of your additional occupation. (job duties, nature and monthly salary) | ☐ ☐<br>☐<br>☐<br>☐<br>☐ | ☐ ☐<br>☐<br>☐<br>☐<br>☐ |



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**Section G** (Please tick (√) the appropriate box or/and fill in the details)

| FOR MYCORECI PLAN | | Life Assured Yes | Life Assured No |
|---|---|---|---|
| 1. | What is your height and weight?<br>Height (m) :<br>Weight (kg) : | | |
| 2. | Are you a smoker? If Yes, how many sticks of cigarettes do you smoke per day in the last 12 months? (including social smokers, cigar smokers or those who have given up within the last 12 months)<br>Sticks per day | ☐ | ☐ |
| 3. | Do you suffer from any of the following conditions as advised or diagnosed by a doctor? If '**Yes**', please provide details. | | |

| Conditions | Life Assured Yes | Life Assured No | Latest reading within the last 12 months as provided by a doctor |
|---|---|---|---|
| Diabetes Mellitus/ Pre-diabetes/ Gestational Diabetes<br>Please tick accordingly<br>☐ Type 1 Diabetes Mellitus<br>☐ Type 2 Diabetes Mellitus<br>Year your condition was first diagnosed _____<br>☐ Pre-diabetes: Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT)<br>☐ Gestational Diabetes Mellitus (GDM) | ☐ | ☐ | HbA1c value<br>☐ % |
| High Blood Pressure | ☐ | ☐ | Systolic : ☐<br>Diastolic : ☐ |
| Raised Total Cholesterol | ☐ | ☐ | Total Cholesterol<br>☐ mg/dL |
| Raised Triglycerides | ☐ | ☐ | Tick the range that your latest Triglycerides reading fall under:<br>☐ < 501 mg/dL<br>☐ 501 – 750 mg/dL<br>☐ 751 – 1000 mg/dL<br>☐ 1001 – 1250mg/dL<br>☐ > 1250 mg/dL |

| | | | |
|---|---|---|---|
| 4. | Have you ever had or been treated for heart disease, chest pain, stroke or Transient Ischaemic Attack, cancer, carcinoma-in-situ, tumours, lumps, nodules, polyps, cysts, liver disease, disease of the respiratory system, kidney disease (including protein or blood in urine), diabetic eye disease (e.g retinopathy), diabetic ketoacidosis, diabetic nerve damage (peripheral neuropathy) or neurological disease (e.g. epilepsy), HIV infection or any deformity/ disability? | ☐ | ☐ |



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| FOR MYCORECI PLAN (CONTINUED) | Life Assured Yes | Life Assured No |
|---|---|---|

If you have answered 'Yes' to Question 4 above, please complete the following:

| Question no: | Medical condition and exact diagnosis: | Date of first symptoms or diagnosis<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs | Details of tests, dates and results |
|---|---|---|---|
| ☐ Assured/ Life Assured | Have you made a full recovery with no further treatment, symptoms or complications?<br>☐ Yes *(to provide duration since full recovery)*<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs<br>☐ No *(to provide treatment and medication given)* | | Name and address of doctor consulted |

| | | Yes | No |
|---|---|---|---|
| 5. | (a) In the last 5 years, have you experienced recurring signs and symptoms, been advised to seek medical consultation, investigation (eg. imaging, mammogram, biopsy, prostate examination etc.) and treatment for a condition other than high blood pressure, elevated total cholesterol/ triglycerides and high blood sugar? | ☐ | ☐ |
| | (b) In the last 5 years, other than routine medical check-up and minor illnesses such as but not limited to flu or cold, had you been hospitalized for at least 7 consecutive days? | ☐ | ☐ |

If you have answered 'Yes' to Question 5 (a) and (b) above, please complete the following:

| Question no: | Medical condition and exact diagnosis: | Date of first symptoms or diagnosis<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs | Details of tests, dates and results |
|---|---|---|---|
| ☐ Assured/ Life Assured | Have you made a full recovery with no further treatment, symptoms or complications?<br>☐ Yes *(to provide duration since full recovery)*<br>☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 1 – 2 yrs ☐ 2 – 3 yrs<br>☐ 3 – 5 yrs ☐ > 5 yrs<br>☐ No *(to provide treatment and medication given)* | | Name and address of doctor consulted |

| | | Yes | No |
|---|---|---|---|
| 6. | Have two or more of your biological parents, brothers or sisters ever suffered from cancer before age 50? If Yes, please complete the following: | ☐ | ☐ |

| Assured/Life Assured | | | |
|---|---|---|---|
| Type of cancer | Relationship | Age at diagnosis | Age at death (if deceased) |
| | | | |
| | | | |



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## DECLARATION

**Section A: Declaration of US Indicia**

| | **Assured / Assignee**<br>Name:_____ | **Joint Assured**<br>Name:_____ | **Trustee / Beneficiary**<br>Name:_____ | **Trustee / Beneficiary**<br>Name:_____ |
|---|---|---|---|---|
| **Do you have one or more US Indicia*?** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Do you give standing instructions to transfer funds to an account maintained in the US?** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Do you give effective power of attorney or signatory granted to a person with a US address?** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

If you have ticked **'Yes'**, please complete the **United States of America (US) Person Declaration form** that is available at http://www.aviva.com.sg/fatca/resources-downloads.html and return to Aviva.
**US Resident / Citizen / Place of Birth / Taxpayer ID number / Mailing or Residential Address / Contact Number/US "in-care-of" or "hold mail" address*

**Section B: Declaration of Tax Residency under the Common Reporting Standard (CRS)**

| | **Assured / Assignee**<br>Name:_____ | **Joint Assured**<br>Name:_____ | **Trustee / Beneficiary**<br>Name:_____ | **Trustee / Beneficiary**<br>Name:_____ |
|---|---|---|---|---|
| **Is there any change in the information that you have provided to Aviva Ltd that would result in a change in your tax residency status (for e.g. change in your residence/mailing/in-care of address, telephone number)?** | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

If you have ticked '**Yes**', please complete the **CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable)** that is available at http://www.aviva.com.sg/CRS/resources-downloads.html and return to Aviva.

I/We understand that the insurance shall not take effect until this application is accepted, the full premium is received and the endorsement of the benefit(s) is issued by Aviva Ltd.

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 life assured's health or activities between the date of this application and the date the benefit(s) is issued by Aviva Ltd to me/us.

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.



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**DECLARATION (CONTINUED)**

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 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.

I/We understand that any payment made at the time of signing this application or thereafter shall be held as a deposit placed with the Company until acceptance of this application by the Company, subject to the terms and conditions contained in the receipt issued in respect of the said payment. I/We agree to pay to the Company the medical fees incurred in assessing the risk under this application (if any) should I/we decide not to accept at the standard rates or revised terms offered by the Company. Should the Company decline the application, then I/we shall be entitled to a full refund of the amount tendered for this application. I/We further understand that the assurance granted shall be subject to the conditions in and endorsed on the Policy issued.

I/We also understand that if this application is submitted for reinstatement of Policy, the Policy will be reinstated and the insurance cover restored only when an official letter confirming the reinstatement has been issued by the Company. The Company will not be liable for any claims arising between the date of lapsing of the Policy and the reinstatement date of the Policy.

I am/We are aware that insurance is a long term commitment and I am/we are aware that I/we can seek advice from a licensed Financial Adviser Representative before I/we sign this application. Should I/we choose not to, I/we take sole responsibility to ensure that this application is appropriate to meet my/our financial needs and insurance objectives.

I/We further declared that I am/we are not an 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.

I/We acknowledge that the Company may reject any of my/our instructions including, but not limited to, those that, in the Company's sole and absolute discretion, are deemed incomplete, unclear or ambiguous, or if my/our signature(s) differ(s) from what was originally provided as a specimen to the Company, and the Company will not be responsible for any losses that may be incurred by me/us due to such rejection of any of my/our instructions.

I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy/policies, account(s) and/or managing my/our relationship with Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

| Signature of Main Life Assured<br>► *For age next birthday 17 years and above* ► *Your signature must be consistent with our record* | Signature of Assured / Joint Life Assured<br>► *Your signature must be consistent with our record* | Signature of Assignee/ Trustee(s)*<br>► *Your signature must be consistent with our record* | Signature of Financial Adviser Representative | Date<br>► *DD/MM/YYYY* |
|---|---|---|---|---|
| Name<br>► *As in NRIC / Passport* | Name<br>► *As in NRIC / Passport* | Name<br>► *As in NRIC / Passport* | Name<br>► *As in NRIC / Passport* | |
| NRIC / Passport Number | NRIC / Passport Number | NRIC / Passport Number | NRIC / Passport Number | |
| Mobile Number | Mobile Number | Mobile Number | Mobile Number | |
| Email address | Email address | Email address | Email address | |

**Note:**
a) *Signature of Trustee(s)/Assignee are required for policies under Trust/Assignment.
b) Mobile number and email address provided will replace our records accordingly.
c) Both the Assured and Life Assured above the age of 16 are to sign on this Application.
d) The Assured will declare on behalf of the Life Assured below the age of 16.



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