



Policy Servicing Health Declaration (for Life Products)

POLICY DETAILS	
Policy Number	: <input type="text"/>
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:	
<ul style="list-style-type: none"> • 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 <p>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.</p> <p>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.</p> <p>To help us collect this information, we need you to complete the questions in Section A and Section B in the Declaration portion.</p>	

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		

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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		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.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		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?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		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? If yes, please provide the activities and complete Hazardous Pursuits Supplementary Questionnaire (Q39) from Aviva's corporate website.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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? Height (m) Weight (kg)			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
<table border="1"> <tr> <td>Assured/Life Assured</td> <td></td> </tr> <tr> <td>Joint Assured/Life Assured</td> <td></td> </tr> </table>		Assured/Life Assured		Joint Assured/Life Assured					
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) Sticks per day:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
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) Total per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
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? If yes, please complete the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
<table border="1"> <thead> <tr> <th colspan="4">Assured/Life Assured</th> </tr> <tr> <th>Name of medical test</th> <th>Date</th> <th>Details of treatment, further test and results</th> <th>Name and address of doctor consulted</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="4">Joint Assured/Life Assured</th> </tr> <tr> <th>Name of medical test</th> <th>Date</th> <th>Details of treatment, further test and results</th> <th>Name and address of doctor consulted</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 <input type="checkbox"/> 0 – 6 mths <input type="checkbox"/> 7 – 12 mths <input type="checkbox"/> 1 – 2 yrs <input type="checkbox"/> 2 – 3 yrs <input type="checkbox"/> 3 – 5 yrs <input type="checkbox"/> > 5 yrs	Details of tests, dates and results
<input type="checkbox"/> Assured/ Life Assured <input type="checkbox"/> Joint Assured/ Life Assured	Have you made a full recovery with no further treatment, symptoms or complications? <input type="checkbox"/> Yes (to provide duration since full recovery) <input type="checkbox"/> No (to provide treatment and medication given) <input type="checkbox"/> 0 – 6 mths <input type="checkbox"/> 7 – 12 mths <input type="checkbox"/> 1 – 2 yrs <input type="checkbox"/> 2 – 3 yrs <input type="checkbox"/> 3 – 5 yrs <input type="checkbox"/> > 5 yrs		Name and address of doctor consulted

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? If Yes, please complete the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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)	

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
2.	Have you been self-employed for less than 2 years? If Yes, please provide details below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
	<table border="1"> <thead> <tr> <th>Date of self-employment</th> <th>Job designation</th> <th>Nature of previous occupation and exact duties</th> <th>Annual Fixed Income (Joint Assured/Life Assured)</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Date of self-employment	Job designation	Nature of previous occupation and exact duties	Annual Fixed Income (Joint Assured/Life Assured)								
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3.	<p>In your occupation, what percentage of your time do you spend performing manual or physical duties (eg. Driving, lifting, and cleaning)?</p> <p>a) Less than 25%</p> <p>b) 25% to 50%</p> <p>c) 51% to 75%</p> <p>d) More than 75%</p> <p>If it is 25% or more, please provide details on the exact manual or physical duties/ nature of work.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
4.	<p>How many hours on average do you work per week?</p> <p>a) < 40 hours</p> <p>b) 40 to 55 hours</p> <p>c) 56 to 60 hours</p> <p>d) > 60 hours</p> <p>If you work < 40 hours per week, is this a part time job?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
5.	<p>Have you been in your current occupation for less than 2 years?</p> <p>If Yes, are there any similarities between your current and previous job duties and nature of work?</p> <p>If No, please provide details of your previous occupation. (job designation, job duties, job duration, nature of work)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
6.	<p>Does your occupation require you to travel overseas for more than 25% of the time? If Yes, please provide details:</p> <p>a) 26% to 40%</p> <p>b) 41% to 50%</p> <p>c) 50%</p> <p>Name of countries, cities, frequency, and duration of each stay.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
7.	<p>Do you hold more than one occupation?</p> <p>If Yes, how many hours do you work per week in this occupation?</p> <p>a) < 40 hours</p> <p>b) 40 to 55 hours</p> <p>c) 56 to 60 hours</p> <p>d) > 60 hours</p> <p>Please provide details of your additional occupation. (job duties, nature and monthly salary)</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

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

FOR MYCORECI PLAN		Life Assured																							
		Yes	No																						
1.	What is your height and weight? Height (m) : <input type="text"/> Weight (kg) : <input type="text"/>																								
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) Sticks per day <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
3.	Do you suffer from any of the following conditions as advised or diagnosed by a doctor? If 'Yes', please provide details.																								
	<table border="1"> <thead> <tr> <th rowspan="2">Conditions</th> <th colspan="2">Life Assured</th> <th rowspan="2">Latest reading within the last 12 months as provided by a doctor</th> </tr> <tr> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td> Diabetes Mellitus/ Pre-diabetes/ Gestational Diabetes Please tick accordingly <input type="checkbox"/> Type 1 Diabetes Mellitus <input type="checkbox"/> Type 2 Diabetes Mellitus Year your condition was first diagnosed _____ <input type="checkbox"/> Pre-diabetes: Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT) <input type="checkbox"/> Gestational Diabetes Mellitus (GDM) </td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HbA1c value <input type="text"/> %</td> </tr> <tr> <td>High Blood Pressure</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Systolic : <input type="text"/> Diastolic : <input type="text"/></td> </tr> <tr> <td>Raised Total Cholesterol</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Total Cholesterol <input type="text"/> mg/dL</td> </tr> <tr> <td>Raised Triglycerides</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td> Tick the range that your latest Triglycerides reading fall under: <input type="checkbox"/> < 501 mg/dL <input type="checkbox"/> 501 – 750 mg/dL <input type="checkbox"/> 751 – 1000 mg/dL <input type="checkbox"/> 1001 – 1250mg/dL <input type="checkbox"/> > 1250 mg/dL </td> </tr> </tbody> </table>	Conditions	Life Assured		Latest reading within the last 12 months as provided by a doctor	Yes	No	Diabetes Mellitus/ Pre-diabetes/ Gestational Diabetes Please tick accordingly <input type="checkbox"/> Type 1 Diabetes Mellitus <input type="checkbox"/> Type 2 Diabetes Mellitus Year your condition was first diagnosed _____ <input type="checkbox"/> Pre-diabetes: Impaired Fasting Glucose (IFG) or Impaired Glucose Tolerance (IGT) <input type="checkbox"/> Gestational Diabetes Mellitus (GDM)	<input type="checkbox"/>	<input type="checkbox"/>	HbA1c value <input type="text"/> %	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Systolic : <input type="text"/> Diastolic : <input type="text"/>	Raised Total Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Total Cholesterol <input type="text"/> mg/dL	Raised Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	Tick the range that your latest Triglycerides reading fall under: <input type="checkbox"/> < 501 mg/dL <input type="checkbox"/> 501 – 750 mg/dL <input type="checkbox"/> 751 – 1000 mg/dL <input type="checkbox"/> 1001 – 1250mg/dL <input type="checkbox"/> > 1250 mg/dL		
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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?	<input type="checkbox"/>	<input type="checkbox"/>																						

FOR MYCORECI PLAN (CONTINUED)				Life Assured		
				Yes	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 <input type="checkbox"/> 0 – 6 mths <input type="checkbox"/> 7 – 12 mths <input type="checkbox"/> 1 – 2 yrs <input type="checkbox"/> 2 – 3 yrs <input type="checkbox"/> 3 – 5 yrs <input type="checkbox"/> > 5 yrs	Details of tests, dates and results			
<input type="checkbox"/> Assured/ Life Assured	Have you made a full recovery with no further treatment, symptoms or complications? <input type="checkbox"/> Yes <i>(to provide duration since full recovery)</i> <input type="checkbox"/> 0 – 6 mths <input type="checkbox"/> 7 – 12 mths <input type="checkbox"/> 1 – 2 yrs <input type="checkbox"/> 2 – 3 yrs <input type="checkbox"/> 3 – 5 yrs <input type="checkbox"/> > 5 yrs		<input type="checkbox"/> No <i>(to provide treatment and medication given)</i> Name and address of doctor consulted			
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?				<input type="checkbox"/>	<input type="checkbox"/>
	(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?				<input type="checkbox"/>	<input type="checkbox"/>
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 <input type="checkbox"/> 0 – 6 mths <input type="checkbox"/> 7 – 12 mths <input type="checkbox"/> 1 – 2 yrs <input type="checkbox"/> 2 – 3 yrs <input type="checkbox"/> 3 – 5 yrs <input type="checkbox"/> > 5 yrs	Details of tests, dates and results			
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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:				<input type="checkbox"/>	<input type="checkbox"/>
Assured/Life Assured						
Type of cancer		Relationship	Age at diagnosis	Age at death (if deceased)		

DECLARATION

Section A: Declaration of US Indicia

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

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

	Assured / Assignee	Joint Assured	Trustee / Beneficiary	Trustee / Beneficiary
	Name: _____ _____	Name: _____ _____	Name: _____ _____	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/mailling/in-care of address, telephone number)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>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.</p>				

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.

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 ▶ For age next birthday 17 years and above ▶ Your signature must be consistent with our record	Signature of Assured / Joint Life Assured ▶ Your signature must be consistent with our record	Signature of Assignee/ Trustee(s)* ▶ Your signature must be consistent with our record	Signature of Financial Adviser Representative	Date ▶ DD/MM/YYYY
Name ▶ As in NRIC / Passport	Name ▶ As in NRIC / Passport	Name ▶ As in NRIC / Passport	Name ▶ 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:

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