FULL HEALTH CERTIFICATE (FOR ADULT POLICY)

AIA SINGAPORE PRIVATE LIMITED (Reg. No. 201106386R)

TO: POLICY SERVICES DEPARTMENT / CUSTOMER SERVICE *(Please tick as appropriate)*

Policy No(s): ☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

Name of Insured: _____ NRIC/FIN/Passport No: _____ Unit Name: _____

Name of Policyowner: _____ NRIC/FIN/Passport No: _____ Location: _____

FSC/IR Name: _____ FSC/IR Code: ☐☐☐☐☐ FSC/IR Tel No: _____

Warnings: In accordance with Section 25(5) of the Insurance Act and any amendments, you are to disclose in this Application Form all facts which you know, or ought to know, or the application may be void.

DETAILS OF APPLICATION

Application for:

- ◯ Reinstatement
- ◯ Reinstatement With Redating
- ◯ [1] Addition Of Rider(s)
- ◯ [1] Increase In Sum Assured
- ◯ [1] Change of Plan
- ◯ [1] Declaration of New Medical Conditions
- ◯ Revival of New Business Application
- ◯ Review Medical Rating And/Or Exclusion
- ◯ [2] Top-up For Investment Linked Policy

Payment Made With This Application _____

Important Notes:

1. Kindly submit Request For Change Form with this application.
2. Kindly submit Request For Investment Linked Transactions Form with this application.

PART 1: DETAILS OF INSURED

1.1 (a) Occupation _____ (b) Annual Income _____

(c) Please state exact duties _____

(d) Company's Name _____ (e) Nature of Business _____

(f) Business Address _____

1.2 Marital Status ◯ Single ◯ Married ◯ Widowed ◯ Divorced/Separated Since _____

1.3 (a) Do you smoke cigarettes? If yes, how many per day? _____ Yes ◯ No ◯

(b) Have you smoked any cigarettes in the past 12 months? Yes ◯ No ◯

PART 2: DETAILS OF PREVIOUS INSURANCE APPLICATIONS & PURSUIT OF INSURED

2.1 How much Life Insurance (including Accident Insurance) is in force or pending on your life?

Life: _____

Accident: _____

2.2 Have you ever been declined, postponed or rated up for life and accident insurance, or involved in military activities, private flying, hazardous sports, races or flying other than as a fare paying passenger on a regular scheduled airline. Yes ◯ No ◯

If Yes, please give details _____

2.3 Are you contemplating a trip or had been outside Singapore for more than 6 months other than for leisure or social purposes? If Yes, please give details. Yes ◯ No ◯

Country _____ Duration (months) _____ Purpose _____

PART 3: HEALTH DETAILS OF INSURED

3.1 (a) Height (m) _____ (b) Weight (kg) _____

(c) Was there any weight change in the past year? Yes ◯ No ◯

If Yes, how much and state the reason _____

PT 0011014 (10/2008 06/2009 01/2012)

(d) Name and Address of the Proposed Insured's physician

Give date, reason & result of last consultation

3.2 Do you drink alcohol? Yes ○ No ○

If Yes, how much per week? Beer ☐ cans (330ml) Wine ☐ glasses (100ml) Spirits ☐ tots (30ml)

		Yes	No
3.3	Have you EVER:		
	(a) used any habit forming drugs or narcotics or been treated for drug habits?	○	○
	(b) consumed alcohol excessively or been treated for alcoholism?	○	○
3.4	Have you had any physical defects or any health impairments?	○	○
3.5	Have you ever had or been told to have or been treated for:		
	(a) epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	○	○
	(b) diabetes, thyroid disorders or any other endocrine disorders?	○	○
	(c) ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose, or throat?	○	○
	(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/ discomfort or any other lung disorders?	○	○
	(e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	○	○
	(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	○	○
	(g) jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	○	○
	(h) blood, protein or sugar in urine, kidney stones, infection, or any other disorders of the kidney, bladder, or genital organs?	○	○
	(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	○	○
	(j) cancer, tumours, cyst or growths of any kind?	○	○
	(k) anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	○	○
	(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	○	○
3.6	Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	○	○
3.7	Have you ever had HIV testing done?	○	○
	If yes, please state reason and results		
3.8	In the last 3 months had any of the following symptoms for more than one week continuously : fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	○	○
	If yes, please state reason and results		
3.9	In the past 5 years, have you had any (other than for immunisation or vaccination)		
	(a) of the following tests done? If yes, please give details as indicated below:	○	○

Test	Date	Reason	Result	Test	Date	Reason	Result
X-Ray				Cholesterol			
Ultrasound				Liver Function			
CT Scan				Urine			
Biopsy				Others:			
ECG							

		Yes	No
3.9	(b) illness, operation, medical advice, hospital treatment or accident not mentioned in 3.9(a)?	○	○
3.10	Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If yes, please provide details below:	○	○

Relationship	Age at Onset	Current Age	Illness / Age at Death (if Deceased)

Policy No(s):

	Yes	No
3.11 **FEMALE ONLY**		
(a) Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?	◯	◯
(b) Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	◯	◯
(c) Have you ever had any abnormal pap smear test or been told by any other doctor to have a repeat pap smear within the next six months?	◯	◯
(d) Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	◯	◯
(e) For females who have conceived, were there any complications during pregnancy such as gestational diabetes and/or hypertension, etc.?	◯	◯
(f) Are you now pregnant? If Yes, please indicate number of months _____	◯	◯
(g) Have you had any test to exclude Down's Syndrome during pregnancy which showed positive results?	◯	◯
(h) Have you any child(ren) with Down's Syndrome or congenital abnormalities?	◯	◯
(i) Have you any test showing any congenital abnormalities of the baby during pregnancy?	◯	◯

3.12 **REMARKS** In connection with the above declaration, if any answer to questions 3.3 to 3.11 is "Yes", give details below, quoting the relevant question number. Please provide details of diagnosis or condition, date of consultation, name and address of doctor seen.

DECLARATION & AUTHORISATION

1. I confirm that the above answers, given by me, are full, complete and true and agree that they form part of any policy issued, reinstated or amended, where these answers are, or may be, relied upon by AIA Singapore Private Limited ("the Company").
2. I further agree that the above application stated above shall not be considered as effected by reason of any money paid or settlement made in payment of, or on account of any premium, until this Certificate shall be duly approved by an authorized Officer of the company.
3. I further agree that if my application stated above be accepted by the Company, the Incontestability and Suicide Provisions thereof shall have effect from the approval date of my application.
4. I understand and agree that the application of the Contracts (Rights of Third Parties) Act (Cap. 53B) and any subsequent revision or replacement thereof is expressly excluded insofar as this contract of insurance is concerned.
5. I/We hereby authorise, agree and consent to the Company to use and/or disclose any information collected and/or held (whether contained in this application or otherwise obtained) to enable the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, with regard to any matters pertaining to the Application/Policy and/or any other policies that I/we currently may have with the Company, including but not limited to, processing of this Application, and/or providing subsequent services to me/us and/or providing advice and/or information concerning products and/or services which the Company believes may be of interest to me/us and/or communicating with me/us for any purpose. I/We hereby specifically waive any right to bring a claim of any nature against the Company, its associated individuals/organisations and/or independent third parties, within or outside Singapore, in respect of any above-mentioned disclosure and/or any disclosure in the nature described above. This authorisation shall bind my successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application is accepted by the Company. A photocopy of this authorisation shall be effective and valid as the original.

Warnings: If a material fact is not disclosed in this application form, any application 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 Financial Services Consultant/Insurance Representative but was not included in this application. Please check to ensure you are fully satisfied with the information declared in the application.

Declared in (place) _____ on Month (e.g. Jan, Feb) ☐☐☐ / Day ☐☐ / Year ☐☐

SIGNATURE / NAME / NRIC/FIN/PASSPORT OF WITNESS

SIGNATURE OF INSURED

SIGNATURE / NAME / NRIC/FIN/PASSPORT OF WITNESS

SIGNATURE OF *OWNER/TRUSTEE(S)/ASSIGNEE(S) IF ANY
(*Delete as appropriate)

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