GROUP (COMPANY) APPLICATION FORM

www.AIG.com.sg

PROHealth

Important Notice
Statement pursuant to Section 25(5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application Form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed. Otherwise, the Policy issued hereunder may be void. Neither this Application Form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specific terms, conditions and exclusions applicable to this insurance are set out in the Policy, a copy of which is available upon request.

COMPANY DETAILS

Company Name: __________

Specific Nature of Business: __________

LOCATION AND CONTACT DETAILS

Company Address: __________

Country: __________ Postal Code __________

Telephone (O): __________ Facsimile: __________

Email Address: __________

Mailing Address (if different from company address): __________

____

Country: __________ Postal Code: __________

PLAN SELECTION

SGD OPTION

	Select your plan	Inpatient Only Plan		Comprehensive Plan		
		☐ **Prestige A**	☐ **Prestige B**	☐ **Prestige Plus A**	☐ **Prestige Plus B**	☐ **Prestige Plus C**
1.	**Level of Cover**	Basic	Advanced	Basic	Advanced	Advanced incl. Maternity Benefit
2.	**Territory - Select your territory**	Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide	Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide
3.	**Deductible - Select your Deductible (in SGD)**	☐ NIL ☐ 1,200 ☐ 3,600 ☐ 6,000	☐ NIL ☐ 1,200 ☐ 3,600 ☐ 6,000	☐ NIL ☐ 1,200 ☐ 3,600 ☐ 6,000	☐ NIL ☐ 1,200 ☐ 3,600 ☐ 6,000	☐ NIL ☐ 1,200 ☐ 3,600 ☐ 6,000
4.	**Outpatient Coinsurance**	N/A	N/A	☐ NIL ☐ 10% ☐ 20%	☐ NIL ☐ 10% ☐ 20%	☐ NIL ☐ 10% ☐ 20%
5.	**Optional Dental Benefit**	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance

AIG

Copyright © 2017 AIG Asia Pacific Insurance Pte. Ltd.
All rights reserved

PLAN SELECTION

USD OPTION

Select your plan	Inpatient Only Plan		Comprehensive Plan		
	☐ **Prestige A**	☐ **Prestige B**	☐ **Prestige Plus A**	☐ **Prestige Plus B**	☐ **Prestige Plus C**
1. Level of Cover	Basic	Advanced	Basic	Advanced	Advanced incl. Maternity Benefit
2. Territory - Select your territory	Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide	Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide	☐ North America & the Caribbean Exclusion ☐ Worldwide
3. Deductible - Select your Deductible (in USD)	☐ NIL ☐ 1,000 ☐ 3,000 ☐ 5,000	☐ NIL ☐ 1,000 ☐ 3,000 ☐ 5,000	☐ NIL ☐ 1,000 ☐ 3,000 ☐ 5,000	☐ NIL ☐ 1,000 ☐ 3,000 ☐ 5,000	☐ NIL ☐ 1,000 ☐ 3,000 ☐ 5,000
4. Outpatient Coinsurance	N/A	N/A	☐ NIL ☐ 10% ☐ 20%	☐ NIL ☐ 10% ☐ 20%	☐ NIL ☐ 10% ☐ 20%
5. Optional Dental Benefit	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance	☐ Dental Option ☐ Dental Option with 20% Coinsurance

Requested Policy Start Date (dd/mm/yyyy): ____________________

AIG®

Copyright © 2017 AIG Asia Pacific Insurance Pte. Ltd.
All rights reserved

CONTACT PERSON OF THE COMPANY

Name (last): ____________________

Name (first): ____________________

Name (middle): ____________________

Designation: ____________________

Residential Address: ____________________

City: ____________________ Country: ____________________ Postal Code: ____________________

Telephone (H): ____________________ (O): ____________________ (F): ____________________

Email: ____________________

PAYMENT METHOD

Annual Premium Payable: SGD ____________________ **(subject to prevailing GST)**

☐ **Cheque Payment or Money Order**

Please send completed form and your cheque or money order made payable to, **AIG Asia Pacific Insurance Pte. Ltd**. AIG Building, 78 Shenton Way #07-16, Singapore 079120 and please indicate on the back of your cheque "AIG PROHealth Policy".

Cheque Number: ____________________ Bank: ____________________

☐ **Credit Card Payment Authorisation**

I/We, the undersigned, authorize you to charge to my Credit Card the payment of the AIG PROHealth Plan premium as stated below:

Please select one only: ☐

☐ Visa

Card Holder's Name: ____________________

Card Number: ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐

Expiry Date: ☐☐ / ☐☐
m m y y

____________________ ____________________

Signature of Cardholder Date

1. Card payment and Effective Date of cover is subject to credit card issuer's approval.
2. All charges will be made in Singapore dollars.
3. Where a third party Credit Card is used, I/We declare that the card holder has authorised and consented to such use.
4. We will only accept credit cards issued in Singapore.

To be completed by producer

Have you obtained Health Insurance Certification? ☐ Yes ☐ No

Producer Name: ____________________ Producer Code: ____________________

Address: ____________________

Phone No.: ____________________ Facsimile No.: ____________________

Email Address: ____________________

PROHealth Plans are underwritten by AIG Asia Pacific Insurance Pte. Ltd.

Copyright © 2017 AIG Asia Pacific Insurance Pte. Ltd.
All rights reserved