INDIVIDUAL APPLICATION
HEALTH / MEDICAL DECLARATION 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.

SECTION 1A: INDIVIDUAL APPLICATION

All fields must be completed under Section 1A

Name (last): _____

Name (first): _____

Name (middle): _____

NRIC/FIN No.: _____ Nationality (Country of Passport): _____

Date of Birth (dd/mm/yyyy): _____ Social Security No. (If U.S. Citizen): _____

Gender: ☐ M ☐ F Smoker: ☐ Yes ☐ No Height (cm): _____ Weight (kg): _____

Marital Status: ☐ Single ☐ Married ☐ Others (please specify): _____

Occupation (specify nature of duties): _____

Usual Country of Residence: _____

Email: _____

Telephone (Home): _____ (Work): _____

Mobile: _____ Fax: _____

Residential Address: _____

Line 1: _____

Line 2: _____

Line 3: _____ City: _____

Country: _____ Postal Code: _____

Mailing Address (if different from residential address) : _____

Line 1: _____

Line 2: _____

Line 3: _____ City: _____

Country: _____ Postal Code: _____

SECTION 1B: DEPENDANTS TO BE ENROLLED

Number of eligible dependants: _____

Details	Dependant 1	Dependant 2	Dependant 3	Dependant 4
Last Name				
First, Middle Name				
Relationship to Applicant				
Marital Status				
Citizenship				
NRIC/FIN No.				
Date of Birth (dd/mm/yyyy)				
Height (cm) & Weight (kg)				
Gender	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F	☐ M ☐ F
Smoker	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Occupation (specify nature of duties)				
Country of Residence				

SECTION 2: 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

SECTION 3: HEALTH / MEDICAL DECLARATION

Important Note about filling in this form:
The answers you give to the questions contained in this Application Form will form the basis of any insurance Policy issued, and will be incorporated into the contract of insurance. It is essential that you give accurate, truthful, and complete information for all persons to be insured as inaccuracies may jeopardise coverage or invalidate a claim.

MEDICAL DECLARATION should be filled by the individual applicant and every dependant. Kindly print this Section as needed for all your dependant/s to be insured.

1. Does the occupation of any of the persons to be insured include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If "Yes", please give details. ☐ Yes ☐ No

2. Have you or any of the persons to be insured previously applied for/been rejected for or held a PROHealth policy? If "Yes", please provide policy number. ☐ Yes ☐ No

3. Do you or any of the persons to be insured have health insurance with another company? If "Yes", please attach a copy of the policy and Benefits Schedules, and indicate if the other coverage will be continued if the PROHealth application is approved. ☐ Yes ☐ No

4. Have you or any of the persons to be insured ever had a policy or application for life, sickness, Accident Disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details. ☐ Yes ☐ No

5. Have you or any of the persons to be insured experienced, been treated for, sought advice on, or had symptoms relating to any of the following conditions listed below from (a) to (q)? Please answer every question.

If the answer is "Yes" to any of the following, please write the medical condition and complete the relevant questionnaire where indicated.
For other medical conditions, please provide details in the table on page 3.

a) Cancer, leukemia, tumours, cysts or a growth of any kind? If "Yes", please complete the **Tumour & Cyst** Questionnaire. ☐ Yes ☐ No

b) Asthma, persistent cough, coughing of blood, pneumonia, chest or breathing complaints, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? If "Yes", please complete the **Respiratory System** Questionnaire. ☐ Yes ☐ No

c) Chest pain, raised blood pressure, raised cholesterol, palpitation, skipped beats, swelling of the lower extremities, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? If "Yes", please complete the **Cardiovascular & Cerebrovascular / Nervous System** Questionnaire. ☐ Yes ☐ No

d) Indigestion, gastritis, gastric or duodenal ulcer, blood in stools, fistula, hernia, haemorrhoids or any disease or recent changes in your bowel habits, unexplained weight loss, loss of apetite? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

e) Kidney stones, urinary tract infections or complaint, blood, protein or sugar in urine, or any disease or disorder of the kidney, bladder, prostate or genito-urinary tract? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

g) Diabetes, thyroid disorders or any other endocrine disorders? If "Yes", please complete the **Diabetes / Thyroid** Questionnaire. ☐ Yes ☐ No

h) Anaemia, leukemia, thalassaemia, haemophilia, or any other disease or disorder of the blood? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, seizures, numbness weakness of a limb or prolonged headache? If "Yes", please complete the **Cardiovascular & Cerebrovascular / Nervous System** Questionnaire. ☐ Yes ☐ No

j) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

k) Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or any symptoms of a muscle disorder? If "Yes", please complete the **Musculo-Skeletal** Questionnaire. ☐ Yes ☐ No

l) Malaria, dengue fever, typhoid or any other infectious disease? ☐ Yes ☐ No

m) HIV, AIDS (Acquired Immuno Deficiency Syndrome), AIDS related condition or had any positive blood test for HIV (also called AIDS or HTLV-III) virus? If "Yes", please complete the **General Medicine** Questionnaire. ☐ Yes ☐ No

n) Psoriasis, eczema, dermatitis, acne or any other skin condition? ☐ Yes ☐ No

o) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disease or disorder of the ear, eye, nose or throat? ☐ Yes ☐ No

p) Any other ailment, impairment, Bodily Injury, Accident, condition(s), medical investigations, or Hospital treatments not mentioned above? ☐ Yes ☐ No

q) (**Females only**) Pregnancy or any Complications of Pregnancy, abnormal PAPS smear result or any gynaecological disorder e.g. fibroid &/or cyst of the female reproductive system? If "Yes", please complete the **Gynaecological** Questionnaire. ☐ Yes ☐ No

If you answered "Yes" to any of the above questions that did not require a Medical Questionnaire, please give details of the condition in the table below.

Name	Q.No.	Date of first consultation	Details of medical condition, including nature of treatment, results and if you have fully recovered?	Name & Address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation? If so, when?

(please use an extra sheet if more space is required)

6) Other than for those medical conditions mentioned from Q1 to Q5 (a-q), have you or any of the persons to be insured been admitted to Hospital for treatment or observation or undergone any surgical procedure? ☐ Yes ☐ No
If "Yes," please provide full details, including the date, diagnosis and nature of treatment or surgical procedure.

7) Are you or any of the persons to be insured taking any medication or receiving any form of treatment at the present time? If "Yes", please provide the medical condition, name of medication and dosage, and/or treatment. ☐ Yes ☐ No

8) Have you or any of the persons to be insured been advised to have or intend to seek any medical advice, test, investigation, surgical procedure, hospitalisation, or treatment in the near future? If "Yes", please provide the medical condition, attending Physician and recommended treatment. ☐ Yes ☐ No

9) Please check if any family member has been diagnosed with or is suffering from any of the following:

Condition			If Yes, please complete. **Relation to You**
Diabetes	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Heart Attack	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Blood Disorder	☐ Yes	☐ No	
Leukemia	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	
Cancer: *Specify Type* _____	☐ Yes	☐ No	
Others _____	☐ Yes	☐ No	

10) Do you visit an usual doctor/personal Physician/medical centre or Hospital? If yes, please provide the following information. If no, please provide details of all medical providers, indicate reason and/or corresponding diagnosis/ medical conditions and dates of visits during the past two (2) years. ☐ Yes ☐ No

Name (last): _____

Name (first): _____

Name (middle): _____

Email: _____

Telephone (Home): _____ (Work): _____

Mobile: _____ Fax: _____

Address:

Line 1: _____

Line 2: _____

Line 3: _____ City: _____

Country: _____ Postal Code: _____

How long has this person been under this Physician's care:

Date of last attendance (dd/mm/yyyy): _____

Reasons and Diagnosis: _____

(please use an extra sheet if more space is required)

Important Notes regarding the medical questionnaires:

Take Note That, all information requested in this form must be completed fully and accurately. Failure to provide all information requested herein may adversely affect the acceptance of any claim(s) you may make in the future.

Our acceptance of an incomplete Application Form shall not be construed howsoever as a waiver by AIG Asia Pacific Insurance Pte. Ltd. ("AIG") of the strict requirements for full disclosure of all relevant information requested herein.

This Policy is protected under the Policy Owners' Protection Scheme which 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 AIG Asia Pacific Insurance Pte. Ltd. or visit the AIG, GIA or SDIC websites (www.AIG.com.sg or www.gia.org.sg or www.sdic.org.sg).

DECLARATION BY MAIN INSURED MEMBER AND CONSENT CLAUSE

I/We declare that:

- I/We understand that all pre-existing conditions are not covered.
- I/We am aware that I/we can seek advice from a qualified advisor before I/we sign this proposal form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.
- If I am/we are switching policies, I/we should consider whether this will result in any costs and whether the benefits under the new policy are more suitable for me/us.
- I/We hereby declare that I am/we are ordinarily resident in Singapore as defined in the First Schedule of the Insurance Act (Cap. 142).
- I/We understand that I/we must inform AIG immediately if any of the information that I/we have given AIG in this form changes or is no longer accurate.
- I/we understand and acknowledge that it is my/our duty to disclose fully and faithfully, all the facts which I/we know or ought to know in respect of this proposed insurance and to ensure that all information provided to AIG is accurate and updated. Examples of such information include, but are not limited to, a change in occupation or nature of business.
- I/We hereby declare that I/we have received, read and understood, or have been advised of and understand the contents of the brochure and any information materials relating to this insurance product.
- I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG, I have informed the individual about the purposes for which his/her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG, as set out in the contents of the consent clause contained below and the individual agrees and consents, that AIG may collect, use and process my/his/her personal information (whether obtained in this form or otherwise obtained) and disclose such information to the following, whether in or outside of Singapore:
  a) AIG's group companies;
  b) AIG's (or AIG's group companies') service providers, reinsurers, agents, distributors, business partners;
  c) brokers, my/his/her authorized agents or representatives, legal process participants and their advisors, other financial institutions;
  d) governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums, for the purposes stated in AIG's Data Privacy Policy which include:
     - Processing, underwriting, administering and managing my/his/her relationship with AIG;
     - Audit, compliance, investigation and inspection purposes and handling regulatory/governmental enquiries;
     - Compliance with legal or regulatory obligations, risk management procedures and AIG internal policies
     - Managing AIG's infrastructure and business operations; and
     - Carrying out market research and analysis and satisfaction surveys.

Note: Please refer to (and if submitting information relating to another individual, refer such individual to) the full version of AIG's Data Privacy Policy found at http://www.aig.com.sg/sg-privacy_1030_237853.html before you provide your consent, and/or the above representation and warranty.

I also consent, and if I am submitting information relating to another individual, I represent and warrant that such individual also consents, to AIG, AIGs group companies, service providers and business partners using, processing and disclosing y/his/her personal information to:

a) Enroll me/him/her in contests, prize draws and similar promotions; and

b) Contact me/him/her to market other insurance, and/or financial products and/or services of AIG, AIG's group companies and/or AIG's business partners.

If you or such individual wishes to opt out of being enrolled in contests, prize draws and similar promotions and from receiving marketing messages, please send an SMS to 76161 in the following format "optout<space>NRIC/FIN number" or call us at +65 6419 3000. Alternatively, you or such individual can opt out via our website at https://www-411.aig.com.sg/contactus/CustomerForm.aspx.

Name of Insured Member	Signature	Date

PAYMENT METHOD

Please select payment method and provide details, where relevant:

☐ **Cheque Payment or Money Order**

Please make cheque/money order payable to **AIG Asia Pacific Insurance Pte. Ltd**. and indicate at the back of your cheque/money order "PROHealth Policy", "Insured Name, NRIC No. or FIN No.". Send cheque/money order together with this duly completed form to: AIG Asia Pacific Insurance Pte. Ltd., AIG Building, 78 Shenton Way, #07-16, Singapore 079120

Cheque Number: _____ Bank: _____

☐ **Credit Card Payment Authorisation**

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

Please select one only: ☐ mastercard ☐ Visa

Card Holder's Name: _____

Card Number: ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ Expiry Date: ☐☐ / ☐☐ (m m / y y)

☐ **Credit Card (For 0% Interest Instalment Payment of Premium).**

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

Please select one only: ☐ DBS ☐ POSB ☐ UOB ☐ Citibank

Please select payment period: ☐ 6-monthly interest-free payment ☐ 12-monthly interest-free payment

Card Holder's Name: _____

Card Number: ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ — ☐☐☐☐ Expiry Date: ☐☐ / ☐☐ (m m / y y)

Notes for 0% Interest Instalment Payment:

1. Subject to the relevant bank's terms and conditions. Please note that administrative fees may be imposed by the relevant bank in accordance with its respective terms and conditions in the event of premature cancellation or termination of the IPP and/or credit card account.
2. 0% interest Instalment Plans are not applicable for Corporate Cards, American Express Credit Cards and DBS Black Cards.
3. If Credit Card 0% interest Instalment Payment of Premium option is chosen, cancellation can only be effected after the Policy has been in force for three (3) months.
4. 0% interest Instalment Plans are available only if premium exceeds SGD500.

Declarations:

1. Where a third party's Credit Card is used, I/We declare that the card holder has authorized and consented to such use.
2. If I have opted for the 0% Interest Instalments, I agree to be bound by DBS/POSB or UOB or Citibank Terms and Conditions governing Instalment Payment Plan posted at their respective websites.

Signature of Cardholder _____ Date _____

1. Credit 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. 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: _____

AIG Asia Pacific Insurance Pte. Ltd.
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78 Shenton Way #07-16
Singapore 079120
Email: aig.apac@henner.com
Web: www.henner.com/aig/apac
www.AIG.com.sg

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

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