

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: EMPLOYEE APPLICATION

Name of Company: _____

Name of Employee (last): _____

Name of Employee (first): _____

Name of Employee (middle): _____

ID/Passport No.: _____ Citizenship: _____

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: _____

(NOTE: When applying for dependants, the eligible spouse and all eligible children MUST be enrolled.)

Details	Dependant 1		Dependant 2		Dependant 3		Dependant 4	
Last Name								
First, Middle Name								
Relationship to Applicant								
Marital Status								
Citizenship								
ID/Passport No.								
Date of Birth (dd/mm/yyyy)								
Height (cm) & Weight (kg)								
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Smoker	<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	<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
Occupation (specify nature of duties)								
Country of Residence								



SECTION 2: 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 individual applicant, each and every employees and/or dependants. Kindly print as needed for all your employees and/or dependants 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 appetite? 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
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- 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:

If Yes, please complete.

Condition

- | | | |
|----------------------------|------------------------------|-----------------------------|
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart Attack | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Leukemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer: Specify Type _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Others _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Relation to You

10) Please provide the following information about this person's usual doctor/personal Physician/medical centre or Hospital. If none, 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)

Intermediary's access to online records (Please tick this box if applicable)

In the event that our family is represented by an insurance intermediary, we hereby accept that our intermediary will gain access to our PROHealth policy documents online on his/her personal and password protected Producer Corner.

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, AIG's 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