

Company Name: _____

Name of Insured: _____

Job Title: _____

Date of Birth (dd/mm/yyyy): _____ Gender (M/F): _____

Height (cm): _____ Weight (kg): _____

Email Address: _____

Dependants

Name	Date of Birth (dd/mm/yy)	Gender (M/F)	Height (cm) / Weight (kg)	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

1. Have you or any of your dependants consulted a physician in the past 2 years?

Yes (please explain): _____

No

2. Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition?

Yes (please explain): _____

No

3. Have you or any of your dependants been advised to undergo any test, treatment, special diet, medication, procedure, check-up, or hospitalisation?

Yes (please explain): _____

No

4. Do you have any pending claims?

Yes (please explain and state amount): _____

No

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are complete and true.

Signature of the Insured Person / Main Applicant
(Signature by Policyholder if the Insured Person is a Minor)

Date

AIG Asia Pacific Insurance Pte. Ltd.

AIG Building

78 Shenton Way #07-16

Singapore 079120

Email: aig.apac@henner.com

Web: www.henner.com/aig/apac

www.AIG.com.sg

Co. Reg. No. 201009404M

