Venus Care
Application Form

Statement pursuant to Section 25(5) of the Insurance Act (Cap 142) or any amendments thereof; You are to disclose in this application, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued may be void and you may receive nothing from the policy.

Details

Type of Plans	Annual Premium Per Person In S$ (inclusive of GST)		
Age	Plan A	Plan B	Plan C
16 - 19	☐ $119.73	☐ $107.90	☐ $99.72
20 - 24	☐ $150.34	☐ $127.97	☐ $112.67
25 - 29	☐ $167.99	☐ $139.74	☐ $120.91
30 - 34	☐ $233.90	☐ $183.29	☐ $149.16
35 - 39	☐ $358.66	☐ $265.68	☐ $203.30
40 - 44	☐ $510.50	☐ $365.37	☐ $269.21
45 - 49	☐ $843.59	☐ $587.00	☐ $415.16
50 - 54	☐ $988.36	☐ $685.87	☐ $484.60
55 - 59	☐ $1,187.27	☐ $825.93	☐ $584.65
60 - 64	☐ 1,429.73	☐ $996.60	☐ $707.06
65 - 75 Renewal	☐ $1,732.22	☐ $1,219.05	☐ $876.54

Applicant (Mrs/Mdm/Ms): _____

Address: _____

NRIC No.: _____ Date of Birth: _____ (dd) _____ (mm) _____ (yy)

Occupation: _____ Nature of Business: _____

Tel (Office): _____ Tel (Home): _____ Tel (Mobile): _____ Email: _____

Payment Mode

Authorization of premium payment through Credit Card

I / We agree to pay the premiums according to the plan chosen and I / We hereby authorize AIG Asia Pacific Insurance Pte. Ltd. to charge the stated annual premium to the following credit card. Where a third party credit card is used, I / We declare that the cardholder has authorized and consented to its use.

☐ Credit Card:
(please tick accordingly)

☐ mastercard ☐ Visa

☐ One Time Payment Only OR

☐ One Time & Recurring Payment

Cardholder's Name _____

Credit Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date (mm-yy) ☐☐ - ☐☐

NB: Policy will be issued upon receipt of approval from the respective credit card company.

Annual Premium S$ _____ (inclusive of GST)

Venus Care
Product Summary

Presented to: (Name of Applicant)	Signature of Applicant:
Presented by: (Name of Financial Advisor)	Signature of Financial Advisor:
Covered member:	Date of Birth (dd/mm/yy)
Plan:	Premium:

Please note that this is not a summary of the contract of insurance. The premium stated is not guaranteed. We may at our sole discretion increase the premium from time to time depending on the claims experience of this portfolio. The annual premium is based on your age as at the effective date of the insurance. Renewal premium rates will be determined by us based on your age at the time of renewal. This plan is available to a person between ages of 16 years to 64 years, with renewal up to age of 75 years. Application is subject to underwriting review and acceptance.

Product Information

This insurance covers certain specified female cancers including carcinoma-in-situ according to the compensation scale set out in the policy schedule of benefits.

- Choice of Plan A, B or C
- Three levels of sum insured available (S$30,000, S$50,000 and S$80,000 respectively)
- Lump sum payment upon 1st diagnosis of certain specified female cancers including carcinoma-in-situ

Schedule of Benefits - Sum Insured (S$)

Benefits Description	Plan A (S$)	Plan B (S$)	Plan C (S$)
Female Cancer Diagnosis*	S$80,000	S$50,000	S$30,000
Female Carcinoma-in-situ**	S$8,000	S$5,000	S$3,000
In-hospital Medical Reimbursement	up to S$8,000	up to S$5,000	up to S$3,000
Post-hospitalization Outpatient Reimbursement	up to S$1,000	up to S$1,000	up to S$1,000
Female Wellness Monthly Maintenance Benefit (up to 6 months)	S$1,000	S$1,000	S$1,000
Female Wellness Annual Physical Examination Reimbursement	up to S$100	up to S$100	up to S$100
Traditional Chinese Medicine	S$500	S$500	S$500
Death as a result of female cancer &/or carcinoma-in-situ	S$5,000	S$5,000	S$5,000

* Strictly restricted to Cancer of the breast, ovary, fallopian tube, cervix, uterus and vagina/vulva.

** Cover afforded under this benefit shall be part of, and not in addition to, the sum insured specified under Female Cancer Diagnosis and is restricted to breast, ovary, fallopian tube, cervix, uterus and vagina/vulva.

Type of Plans	Annual Premium Per Person In S$ (inclusive of GST)		
Age	Plan A	Plan B	Plan C
16 - 19	☐ $119.73	☐ $107.96	☐ $99.72
20 - 24	☐ $150.34	☐ $127.97	☐ $112.67
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Key Product Provisions

The following are key product provisions found in the contract of insurance. You are advised to refer to the actual terms and conditions and exclusions in the contract. Please consult your insurance advisor or AIG Asia Pacific Insurance Pte. Ltd. should you require further explanation.

(a) Terms of Renewal

Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium before or on the inception date.

(b) Non-Guaranteed Premium

Premium payable for this coverage is not guaranteed. It may be increased at the sole discretion of the Company depending on the claims experience of this portfolio.

(c) Exclusions

There are certain conditions for which no benefits will be payable. These are stated as exclusions in the contract. You are advised to read the policy for the full list of exclusions.

Pre-existing Conditions - This refers to any illnesses, disease or physical conditions of the Insured Person which, before Effective Date, either:-

i. became noticeable, worsened, became severe or produced symptoms as would cause an ordinary careful person to seek diagnosis, care or treatment; or
ii. require the Insured Person to take prescribed drugs or medicine or
iii. was treated by a Physician or for which treatment has been recommended by a Physician.

(d) Waiting Period

Breast Cancer & Female Carcinoma-in-situ:

Eligibility of benefits commences 180 days after you have been accepted in the plan. This will not apply for renewals.

All Other Specified Female Cancers:

Eligibility of benefits commences 90 days after you have been accepted in the plan. This will not apply for renewals.

(e) 14 Day Free-Look

Once you receive the contract of insurance, there is a 14 day free-look period for you to appreciate the benefits of the Plan. You may wish to seek the advice of a qualified advisor if you are in doubt. If you choose not to seek such advice, you must consider if the Plan is suitable for your needs. If you find it unsuitable, you may choose to return the Policy to AIG by mail before the end of the 14-day review period.

Disclosure Of Distribution Costs, Charges & Expenses

You may request for information on remuneration, including any commission, fee and other benefits that your insurance advisor has received or will be receiving for providing advice on, or arranging insurance contracts or both, in respect of any accident and health policy.

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 web-sites (www.AIG.com.sg or www.gia.org.sg or www.sdic.org.sg).

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 terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

Underwritten by: American Home Assurance Company, Singapore Branch
Incorporated in the United States with liability limited.

AIG Bring on tomorrow

AIG Building
78, Shenton Way #07-16
Singapore 079120
www.AIG.com.sg
Co. Reg. No. 201009404M

Confidential Fact-Find for:

Client's Name: _____

By Your Insurance Advisor (Advisor's Name): _____

Section 1: "Know Your Client" Form
Important Notice to Clients

For Agents

Your insurance advisor is a representative with AIG Asia Pacific Insurance Pte. Ltd. and is able to advise you on the products of :

1) AIG Asia Pacific Insurance Pte. Ltd.

2) _____

3) _____

For Insurance Brokers/Financial Advisers

Your insurance advisor is a broker with _____

As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to discolse to you the insurance companies from which he/she sources the products.

Standard Statement Applicable to all Advisors

Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs is the basis on which advice is given. A policy purchased without the proper completion of a "Know Your Client" Form may not be appropriate to your needs.

Application Type

Client's Option: [Please tick (√) in the appropriate box]

1. ☐ I/We wish to disclose all information required for this Form. (Please complete Sections 1 & 2 and sign both sections indicated with a "X")
2. ☐ I/We wish to receive product advice only. (Please complete Sections 1 & 2, except for Section 2, Part 1(a) & (b), and sign both sections indicated with a "X")
3. ☐ I/We do not wish to receive any advice from my/our advisor. (Please complete Sections 1 and sign at the place indicated with a "X")

!/We acknowledge that the insurance advisor had provided me/us with a copy of the completed "Know Your Client" Form.

Advisor's Declaration:

I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.

X _____

Signature of Client (on behalf of all Applicants)

Date (dd/mm/yyyy):

_____

Signature of Advisor

Date (dd/mm/yyyy):

Personal Information

NRIC. No: _____ Date of Birth (dd/mm/yyyy) _____

Marital Status: Single / Married / Divorced / Separated / Widowed

Gender: Male / Female

Current Occupation: _____

Monthly Income Range
- ☐ 1. Below S$2,500
- ☐ 2. S$2,501 - S$5,000
- ☐ 3. S$5,001 - above

Details of Spouse & Dependents (if family coverage is requited)

Name	Relationship	DOB	Gender	Occupation	Monthly income
			M / F		
			M / F		
			M / F		
			M / F		

Existing Health Insurance Policies

This covers all Health Insurance Policies you currently have (eg: CPF-approved Mediacal Scheme, Personal Madical, Hospital Income, Long Term Care, Employer-Sponsored Schemes etc)

Policy Type*	Insured**	Type & Amount of Benefit***	Annual Premium***	Expiry Date***

* Individual / Group policy from employer
** Y= You; S= Spouse; J= Joint
*** Please provide benefit schedule and disability definition for disability benefit, if available.

Section 2: "Our Advice and Reasons Why" Form

Part 1(a) – Personal Priorities [Please tick (√) in the appropriate box]

	Client			Spouse		
Your Health Insurance Concerns	Level of Concerns			Level of Concerns		
	Low	Medium	High	Low	Medium	High
Cover for Hospitalisation Expenses	☐	☐	☐	☐	☐	☐
Cover for Outpatient Medical Expenses	☐	☐	☐	☐	☐	☐
Cover for Major Illnesses (eg. cancer, kidney dialysis, etc)	☐	☐	☐	☐	☐	☐
Cover for Maternity Expenses	☐	☐	☐	☐	☐	☐
Cover for Dental Expenses	☐	☐	☐	☐	☐	☐
Cover for Old Age Disabilities	☐	☐	☐	☐	☐	☐
Cover for Loss of Income due to Illness or Sickness	☐	☐	☐	☐	☐	☐

Part 1(b) - Analysis and Calculation Worksheet [Please tick (√) in the appropriate box]

Hospital/Surgical/Mediacal Expenses	Client	Spouse
1. Which type of hospital do you or your family members prefer in the event of hospitalisation?	☐ Private ☐ Public	☐ Private ☐ Public
2. Which type of hospital ward do you or your family members prefer in the event of hospitalisation?	☐ Single Bed ☐ 2 Bed ☐ 4 Bed ☐ 6 Bed	☐ Single Bed ☐ 2 Bed ☐ 4 Bed ☐ 6 Bed
3a. Do you have an existing hospitalisation insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No

3b. If yes,please state the name of existing insurer: _____ Monthly Income: S$ _____

Type of cover: ☐ Hospital & Surgery ☐ Maternity ☐ Hospital Income ☐ Outpatient ☐ Dental

Critical Illnesses	Client	Spouse
1. Total lump sum benefit to be covered.		
2. Existing lump sum benefit covered.		

Hospital Cash Income	Client	Spouse
1. Existing amount covered.		
2. Total Amount of Cash Income to be covered.		
3. Total Amount of Cash Income needed (Amount 2 less Amount 1)		

Part 2 - Advisor Analysis and Recommendations

Total Insurance Budget (S$) per year	Advisor's Recommendations	Reasons for Recommendation	Remarks
	☐ **Medical Expenses** (also known as Hospital/ Surgical / Medical Expense Protection)		Replacement ☐ Yes ☐ No
	☐ **Critical Illness Protection**		Replacement ☐ Yes ☐ No
	☐ **Hospital Cash Protection**		Replacement ☐ Yes ☐ No
	☐ **Others**		Replacement ☐ Yes ☐ No

Note: If this product is intended to replace any existing health insurance policy, the Advisor should state the reason for recommending a replacement.

Part 3 - Acknowledgement [Please tick (√) in the appropriate box]

Client's Declaration:

I/We understand that the above recommendation(s) is/are on the facts furnished in the "Know Your Client" Form; and
[Please tick (√) in the appropriate box]

☐ I/We agree with the proposed recommendation(s) ☐ I/We do not agree with the proposed recommendation(s)

If !/We should decide to switch from one insurance product to another insurance product, !/We understand that:
1. !/We may not be insurable at standard terms;
2. !/We may have to pay a different premium;
3. Terms and conditions may differ.

Statement by Advisor:
The recommendations in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliale and accurate to the best of my knowledge. If there has been any change in your circumstances since you completed that Form, please notify your Advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of thr "Know Your Client" Form.

X

Signature of Client (on behalf of all Applicants)

Date (dd/mm/yyyy):

Signature of Advisor

Date (dd/mm/yyyy):

For Office Use Only
To be completed by a qualified staff of the Insurer or Principal Firm of the Advisor

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and

☐ I agree with the proposed recommendation(s) ☐ I do not agree with the proposed recommendation(s).

Comments (necessary if in disagreement with the proposed recommendation)

Remedial Action

Signature | Name | Position | Date (dd/mm/yyyy)