INDIVIDUAL AND FAMILY APPLICATION FORM

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 enrolment form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specified terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

PROPOSER'S DETAILS

Name (last): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Name (first): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Name (middle): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

ID/Passport No.: |___|___|___|___|___|___|___|___|___|___|___| Citizen of: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

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: |___|___|___|___|___|___|___|___| Occupation (specify nature of duties): |___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Usual Country of Residence: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

LOCATION AND CONTACT DETAILS

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: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|

PLAN SELECTION

1. Level of Cover - Select your plan	☐ Advantage 100	☐ Advantage 200	☐ Advantage 300	☐ Advantage 400	☐ Advantage 500
	Hospitalisation only coverage	Hospitalisation only coverage with option to add out-patient cover	Comprehensive hospitalisation coverage	Comprehensive hospitalisation and out-patient coverage	Comprehensive hospitalisation and out-patient coverage with Maternity cover
2. Deductible - Select your Deductible (in SG$)	☐ 600 ☐ 1,200 ☐ 2,500 ☐ 6,000	☐ NIL ☐ 600 ☐ 1,200 ☐ 2,500 ☐ 6,000	☐ NIL ☐ 600 ☐ 1,200 ☐ 2,500 ☐ 6,000	☐ NIL ☐ 600 ☐ 1,200 ☐ 2,500 ☐ 6,000	☐ NIL ☐ 600 ☐ 1,200 ☐ 2,500 ☐ 6,000

3. Area of Cover - Upgrade to a Worldwide plan	NA	NA	☐ Yes	☐ Yes	☐ Yes
4. Other Options	☐ Dental	☐ Dental ☐ Include out-patient cover	☐ Dental	☐ Dental	☐ Dental

FAMILY MEMBERS TO BE INSURED

Details	Dependant 1		Dependant 2		Dependant 3		Dependant 4	
Last Name								
First, Middle Name								
Relationship to Applicant								
Marital Status								
Citizen of								
Social Security No. (If U.S. Citizen)								
ID/Passport No.								
Date of Birth (dd/mm/yyyy)								
Gender	☐ M	☐ F	☐ M	☐ F	☐ M	☐ F	☐ M	☐ F
Height (cm) & Weight (kg)								
Smoker	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Occupation (Specify nature of duties)								

MEDICAL QUESTIONNAIRE

Important Note about filling in this form:
The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. 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.

1. Do you or any of the persons to be insured reside outside the Usual Country of Residence as shown above? If "Yes", please state which country.

☐ Yes ☐ No

2. 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

3. Have you or any of the persons to be insured previously applied for or held a GlobalHealth policy? If "Yes", please provide policy number.

☐ Yes ☐ No

4. 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 benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved.

☐ Yes ☐ No

5. 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

6. 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 each 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 4.

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** Questionnaire.

☐ Yes ☐ No

c) Chest pain, raised blood pressure, raised cholesterol, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? If "Yes", please complete the **Cardiovascular** Questionnaire.

☐ Yes ☐ No

d) Indigestion, gastritis, gastric or duodenal ulcer, blood in stools, fistula, hernia, haemorrhoids or any disease or disorder of the bowel?

☐ 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?

☐ Yes ☐ No

f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver?

☐ Yes ☐ No

g) Diabetes, thyroid disorders or any other endocrine disorders?

☐ Yes ☐ No

h) Anaemia, thalassaemia, haemophilia, or any other disease or disorder of the blood?

☐ Yes ☐ No

i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, weakness of a limb or prolonged headache? If "Yes", please complete the **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?

☐ 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 tropical 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?

☐ 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 smear test 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.

Applicant's 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)

7. Other than for those medical conditions mentioned from Q1 to Q6 (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? If "Yes", please provide full details, including the date, diagnosis and nature of treatment or surgical procedure.

☐ Yes ☐ No

8. 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

9. 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

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.

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.

Intermediary's access to online records:

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

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).

DECLARATION BY PROPOSER AND CONSENT CLAUSE

I/We hereby apply for a policy to be issued based on the statements contained herein and declare that all answers to the foregoing questions are correctly recorded and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. **I/We agree that if the health status of the above intended Insured Person changes after this application is signed and before AIG Asia Pacific Insurance Pte. Ltd. ("AIG") issues a policy I/We shall immediately notify AIG of the change.** I/We agree that the Policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium is paid in full.

Pre-existing conditions may not be covered if not declared and accepted by AIG.

If I/We are switching policy, I/We should consider whether this will result in any cost and whether the benefits under the new policy are more suitable.

I/We hereby declare that I am/We are ordinarily resident in Singapore as defined by *Insurance Act (Cap. 142) (Amendment of First Schedule) Order 2010.

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 material relating to this insurance product.

I am aware that I can seek advice from a qualified advisor before I sign this enrolment form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

Direct Billing (Applicable only to the following plans with nil deductible: Advantage 200 with Out-patient option, Advantage 400 and Advantage 500): I/We authorise AIG/GlobalHealth to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and any records AIG/GlobalHealth may have regarding the Insured Person(s) shown on the Namelist to Hospitals, clinics, laboratories, Physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the Insured Person(s). By signing this Authority and Release Form, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by AIG for a claim which is not covered under this Policy or when the limit of liability for this insurance is exceeded, AIG reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then AIG reserves the right to suspend the direct billing service to you without further notice.

I / We are aware and acknowledge that the failure to provide all relevant details in each of the Sections of this Application Form may prejudice any claim(s) that may be made by Me / Us in the future.

I / We are aware and have been duly advised that an acceptance of an incomplete Application Form by AIG, does not amount to a waiver by AIG, of the strict requirements for a full disclosure of all relevant information requested herein.

*Insurance Act (Chapter 142) (the "Act")
This Policy is issued in Singapore and is subject to the Insurance Act (Chapter 142) (the "Act").
A policy may be regarded as a Singapore policy or an off-shore policy. For this Policy to be regarded as a Singapore policy, You should be ordinarily resident in Singapore at the date of Your application for this Policy. The Act provides that You are treated as being ordinarily resident in Singapore if

(i) You are a citizen of Singapore, unless You have resided outside Singapore continuously for 5 or more years preceding the application date of the Policy and are not currently residing in Singapore;
(ii) You are a permanent resident, unless You have resided in Singapore for less than a total of 183 days in the 12 months preceding the application date of the Policy;
(iii) You have a work pass or permit required under the Employment of Foreign Manpower Act(Cap. 91A), unless You have resided in Singapore for less than a total of 183 days in the 12 months preceding the application date of the Policy; or
(iv) You have a pass or permit required under the Immigration Act (Cap. 133) that has duration longer than 90 days and You have resided in Singapore continuously for at least 90 days in the 12 months preceding the application date of the Policy.

If You do not satisfy any one of the aforesaid definitions of being "ordinarily resident in Singapore", You must notify Us immediately.

Consent Clause: 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 and/or its service providers, 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 and/or its service providers, as set out in the contents of the consent clause contained below and the individual agrees and consents, that AIG and/or its service providers may collect, use and process my/his/her personal information (whether obtained in this application form or otherwise obtained) and disclose such information to the following, whether in or outside of Singapore: (i) AIG's group companies; (ii) AIG's, AIG's group companies', or their service providers' service providers, reinsurers, agents, distributors, business partners; (iii) brokers, my/his/her authorised agents or representatives, legal process participants and their advisors, other financial institutions; (iv) governmental / regulatory authorities, industry associations, courts, other alternative dispute resolution forums, for the purposes stated in AIG's Data Privacy Policy which include:

(a) Processing, underwriting, administering and managing my/his/her relationship with AIG;
(b) Audit, compliance, investigation and inspection purposes and handling regulatory / governmental enquiries;
(c) Compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
(d) Managing AIG's infrastructure and business operations; and
(e) 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.

Printed Name/Title	Signature	Date

PAYMENT METHOD

Annual Premium Payable: SG$_____(subject to prevailing GST)

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 "Global Health Policy". Send cheque/money order together with this duly completed form to : AIG Asia Pacific Insurance Pte. Ltd., AIG Building, 78 Shenton Way, #09-16, Singapore 079120

☐ **Credit Card (For Full Payment of Premium).**
I/We, the undersigned, authorize you to charge my Credit Card for payment of GlobalHealth Advantage Plan premium as stated below:

Please select one only: ☐ **Visa** ☐ **Mastercard** ☐ **Amex** ☐ **Diners**

Card Holder's Name: _____

Card Number: ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ Expiry Date: ☐☐ ☐☐ (m m y y)

☐ **Credit Card (For 0% Interest Installment Payment of Premium).**
I/We, the undersigned, authorize you to charge my Credit Card for payment of GlobalHealth Advantage Plan premium as stated below:

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 Installment 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 Installment Plans are not applicable for Corporate Cards, American Express Credit Cards and DBS Black Cards.
3. If Credit Card 0% interest Installment 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 Installment Plans are available only if premium exceeds SG$500.

Declarations:
1. Where a third party 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 Installments, I agree to be bound by DBS/POSB or UOB or Citibank Terms and Conditions governing Installment 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 center's approval.
2. All charges will be made in Singapore dollars.
3. Only Singapore Credit Cards are accepted.

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.
AIG Building
78 Shenton Way #07-16
Singapore 079120
Email: membercare@globalhealthasia.com
Web: www.globalhealthasia.com
www.AIG.com.sg
Co. Reg. No. 201009404M