AIA SINGAPORE
CHANGE FORM
(WITH HEALTH DECLARATION)

For the following change requests:

A. Policy Reinstatement/Others
B. Increase Face Amount of Basic Plan/Rider(s)/Supplementary Benefit(s)
C. Add Rider(s)/Supplementary Benefit(s)
D. Change Plan/Area of Cover
E. Add Dependant(s)
F. Change of Payor for Juvenile Policy

WARNING: In accordance with **Section 25(5) of the Insurance Act**, as may be amended from time to time, you are to fully disclose in this form, all facts which you know or ought to know failing which the insurance issued herein may be void.

Particulars of Insured and Policy Owner/Trustee/Assignee

Name of Insured

NRIC/Passport/FIN No.

Name of Policy Owner/Trustee/Assignee *(if different from Insured)*

NRIC/Passport/FIN/Entity Registration No.

Name of Trustee *(if any)*

NRIC/Passport/FIN No.

Policy Number(s)

Part I: Change Request

☐ A. Policy Reinstatement/Others

Please complete the POS Enhanced Due Diligence Form for reinstatement after 3 years from lapsed date

☐ Reinstatement
☐ Reinstatement with re-dating
☐ Review medical rating and/or exclusion
☐ Declaration of new medical condition(s)
☐ Others Please specify

☐ B. Increase Face Amount of Basic Plan/Rider(s)/Supplementary Benefit(s)

Increase the face amount of the basic plan/supplementary benefit(s) of the above policy(ies):

Basic Plan/Rider(s)/Supplementary Benefit(s) - Please write in full	New Sum Assured ($)

☐ C. Add Rider(s)/Supplementary Benefit(s)

Add the following supplementary benefit(s) to the above policy(ies):

Rider(s)/Supplementary Benefit(s) to be Added - Please write in full	Sum Assured ($)

AIA Singapore Private Limited (Reg No. 201106386R)
AIA Customer Service Centre, 1 Finlayson Green, Singapore 049246
Monday to Friday: 8.45am – 5.30pm
AIA Customer Care Hotline: 1800 248 8000 AIA.COM.SG

D. Change Plan/Area of Cover

Change the basic plan of the above policy(ies) to as follows:

New Basic Plan - Please write in full	New Sum Assured ($)

With this change, the supplementary benefit(s) to be changed as follows:

New Supplementary Benefit(s) - Please write in full	New Sum Assured ($)

Change the area of cover of the above policy(ies) to as follows:

New Area of Cover

Note: Change of Area of Cover can only be done on the policy anniversary date.

E. Add Dependant(s)

Add Dependant to the following plan/(s): *(Please state the HS/HB Benefit Amount &/or A&H Plan Name)*

HS ____ HB ____ A & H Plan Name ____

Particulars of Dependants

Name of **Dependant 1**

Relationship to Insured

☐ Male ☐ Female

Date of Birth (DD/MM/YYYY)

NRIC/Passport/FIN No.

Marital Status

☐ Single ☐ Married ☐ Widowed/Divorced/ Separated

Country of Residence

Residency Status

☐ Singapore ☐ Singapore PR ☐ Pass Holder ☐ Others

Citizenship *(if not Singaporean)*

Name of **Dependant 2**

Relationship to Insured

☐ Male ☐ Female

Date of Birth (DD/MM/YYYY)

NRIC/Passport/FIN No.

Marital Status

☐ Single ☐ Married ☐ Widowed/Divorced/ Separated

Country of Residence

Residency Status

☐ Singapore ☐ Singapore PR ☐ Pass Holder ☐ Others

Citizenship *(if not Singaporean)*

☐ **F. Change of Payor for Juvenile Policy (Please complete a Self Certification Form as well)**

Details of New Payor – Please submit photocopy of NEW Payor's Identity Card

Name

NRIC/Passport/FIN No.

Date of Birth (DD/MM/YYYY)

Contact No.

(Country Code) (Area Code + Telephone Number)

☐ Male ☐ Female

Marital Status

☐ Single ☐ Married ☐ Widowed/Divorced/ Separated

Relationship to Insured

Permanent Residence Address (please indicate 'Nil' if not applicable)

Occupation *(Note: This will be updated on all policies for which you are a party to)*

Exact Duties

Company Name

Nature of Business

Business Address

Please tick Declaration A or B

☐ **Declaration A** *(if PB/PBC/ECPPB is applied, Part II – Health Declaration must also be completed)*

I, the existing Payor hereby
1. declare that the Payor/Owner of the policy be changed to the new Payor as named above.
2. relinquish and transfer my right to exercise all privileges, rights and options provided under this policy to the new named Payor subject to the terms and conditions contained in the policy and the Juvenile Endorsement attached.
3. delete the Payor Benefit/Payor Benefit Comprehensive/Early Critical Protector Payor Benefit coverage under this policy.
4. Existing GIRO arrangement including Loan repayment (if any) ☐ Retain ☐ Terminate

New Payor would like to apply for ☐ Payor Benefit (PB) ☐ Payor Benefit Comprehensive (PBC) ☐ Early Critical Protector Payor Benefit (ECPPB)

Name of New Contingent Owner

NRIC/Passport/FIN No.

Relationship of Contingent Owner to Insured

☐ **Declaration B** *(applicable where the existing Payor has passed away.)*

I, the new Payor hereby declare that:
1. the existing Payor had passed away.
2. as I am the contingent beneficiary as stated in the application for assurance, I will be the new Payor of the policy. I shall pay the future premiums of this policy as and when they fall due.
3. I wish to appoint Estate as the new contingent beneficiary.
4. Existing GIRO arrangement including Loan repayment (if any) ☐ Retain ☐ Terminate

Please submit photocopy of Death Certificate.

Declaration on U.S. Person Status

☐ I, the new Payor/Owner hereby declare and agree that I am not a "U.S. person" for U.S. federal income tax purposes and that I am not acting for, or on behalf of a U.S. person. I understand that AIA Singapore, believing this statement to be true, will rely on it and act on it. In the event this statement is false, AIA Singapore reserves the right and shall be entitled to cancel or terminate this Policy/Policies and pay reasonable compensation to me in consideration of such cancellation or termination as may be required under Singapore laws.

I agree to notify AIA Singapore within 30 days of any change in my status as a U.S. person for the purposes of U.S. federal income tax. I agree to indemnify AIA Singapore in respect of any false or misleading information regarding my "U.S. person" status for U.S. federal income tax purposes.

☐ I, the new Payor/Owner hereby declare and agree that I am a "U.S. person" for U.S. federal income tax purposes.

I agree to notify AIA Singapore within 30 days of any change in my status as a U.S. person for the purposes of U.S. federal income tax. I agree to indemnify AIA Singapore in respect of any false or misleading information regarding my "U.S. person" status for U.S. federal income tax purposes.

Note: Please submit W-9 form to us.

Declaration on Common Reporting Standard (Not required to complete if the change of indices is within the same country)

I/We acknowledge that AIA Singapore Private Limited (AIA Singapore) is a reporting Singaporean financial institution as defined in the Income Tax (International Tax Compliance Agreements)(Common Reporting Standard) Regulations 2016 with reporting obligations to the Comptroller of Income Tax (Comptroller) under the Income Tax Act, Chapter 134, Singapore (Income Tax Act), and its regulations. I/We warrant that the information provided in this form is true, complete and correct and understand and agree that AIA Singapore will rely on such information given by me/us in fulfilling its reporting obligations to the Comptroller.

Where I/we have furnished information concerning a third party (including but not limited to a Controlling Person), I/we confirm that such information has been provided to me/us directly or indirectly by the third party, and I/we know or have reason to believe that such information is not false or misleading in any material particular.

I/We understand and accept that should any information furnished by me/us be known to be false or misleading in any material particular, I/we may be prosecuted under the Income Tax Act for an offence which carries a penalty of a fine of up to S$10,000 and/or imprisonment of up to two (2) years or such other penalties as may be prescribed under the Income Tax Act or its regulations, or any re-enactment or replacement thereof, at the time of commission of the offence.

(For individuals)
I/We further undertake to notify AIA Singapore within 30 days of any change to my/our country of residence for tax purposes or TIN (if any), and to complete, sign and submit to AIA Singapore my/our relevant particulars in the format prescribed by AIA Singapore in order for it to fulfil its reporting obligations under the Income Tax Act. I/we further undertake to provide AIA Singapore any documents and information that may be reasonably required in relation to the change of my/our country of residence for tax purposes.

(For entities and other non-individuals)
I/We further undertake to notify AIA Singapore within 30 days of any change to the Policyholder's or a Controlling Person's country of residence for tax purposes or TIN (if any) and to complete, sign and submit to AIA Singapore the relevant particulars of the Policyholder or Controlling Person relating to such change in the format prescribed by AIA Singapore in order for it to fulfil its reporting obligations under the Income Tax Act. I/we further undertake to provide AIA Singapore any documents and information that may be reasonably required in relation to the change of the Policyholder's or Controlling Person's country of residence for tax purposes.

Note: The term "Controlling Person" has the meaning given to it in the Common Reporting Standard in the Schedule to the Income Tax Act (International Compliance Agreements)(Common Reporting Standard) Regulations 2016.

I/We acknowledge and accept that AIA Singapore will rely on the self-certification relating to the Policyholder's/Controlling Persons' country of tax residence contained in this form as applicable to all policies and products issued to the same person(s), and any information in any earlier self-certification inconsistent with the information provided above will be disregarded for the purposes of fulfilling its reporting obligations to the Comptroller.

Have you declared your tax residency with AIA before?

☐ No Please complete a Self-Certification Form.

☐ No Not required to submit Self-Certification Form (change of indices is within the same country).

☐ Yes, but there are changes to my tax residency. I have completed the self-certification below.

☐ Yes, but there are no change to my tax residency.

Note: Do note that a separate Self-Certification Form *is required for each Policyowner/Trustee/Assignee.*

Part II: Health Declaration

A. Details of Insured/Dependant and Policy Owner

	Insured/Dependant	Policy Owner *(applicable for PB/PBC/ECPPB)*
Occupation ^		
Monthly Income		
Exact Duties		
Company's Name		
Nature of Business		
Business Address		

^This will be updated on all policies for which you are a party to.

B. Details of Existing and Pending Insurance Coverage

	Insured/Dependant		Applicant Owner/Payor *(applicable to PB/PBC/ECPPB)*	
Insurance Company				
Death				
Total & Permanent Disability				
Critical Illness				
Personal Accident				
Disability Income				
Others				

C. Health and Lifestyle Questions

If your answer to any of the questions below is "Yes" please provide details in the space provided under Remarks.
(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
Questions for Personal Accident Plan Only	**Yes**	**No**	**Yes**	**No**
1. Do you have or have you had any physical defects, impairments, deformities, and/or any conditions affecting mobility, sight and/or hearing?	☐	☐	☐	☐
2. Do you engage or intend to engage in hazardous sports (including but not limited to motor sports, scuba diving, mountaineering) or fly other than a fare paying passenger on a licensed air service within recognized scheduled routes?	☐	☐	☐	☐
Questions for Prenatal / Baby rider Only				
3. Are you currently carrying more than one foetus? If yes, please tick the appropriate box.	☐	☐		
☐ Twins ☐ Triplets ☐ Quadruplets				
☐ Others				
4. Is your current pregnancy conceived through assisted reproductive technology (such as but not limited to IVF).	☐	☐		

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.
(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)

Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
Yes	**No**	**Yes**	**No**

5. Please provide the name and address of your main doctor/clinic consulted for pregnancy and give details of the following.

Name of Doctor/Clinic	Address of Clinic

Date of last consultation	Test(s) done during last consultation	Results of test(s) done

6. Are you aware if your spouse has any of the following medical conditions: congenital heart disorder, congenital brain and spinal cord disorder, congenital cataract, congenital deafness, cleft palate and/ or lip, renal failure, liver disease (such as haemachromotosis) or any other hereditary disease such as polycystic kidney disease, thalassaemia minor/major, haemophilia A, Huntington's disease, muscular dystrophy, cystic fibrosis, familial adenomatous polyposis?	☐	☐
7. Have you been advised by a medical doctor not to conceive?	☐	☐
8. Have you decided not to do any blood, urine or any other test or investigation that was recommended by your doctor?	☐	☐
a) First trimester prenatal screening such as OSCAR	☐	☐
b) Amniocentesis / chorionic villous sampling / Harmony Prenatal DNA Test	☐	☐
c) Detailed ultrasound and/or any other test or investigation	☐	☐
If so, please submit copies of reports for test or investigation done		

9. Has there been any history of miscarriage?
   - ☐ No
   - ☐ Yes. History of one incident during the 1st trimester. (***Note:*** Please submit the Obstetrics & Gynaecology Report).
   - ☐ Yes. History of more than one incident and/or incident(s) occur during the second or third trimester.

10. Have there been any complication(s) relating to this and/or previous pregnancies?		
a) Placental abnormalities;	☐	☐
b) Bleeding during pregnancy after first trimester;	☐	☐
c) Severe anaemia (haemoglobin level of less than 8mg/dl);	☐	☐
d) Fatty liver due to pregnancy;	☐	☐
e) Cervical incompetence or weakness of the cervix;	☐	☐
f) Repeated urinary tract infection or infection of the womb;	☐	☐
g) Premature uterine contractions;	☐	☐
h) Pre-term labour (i.e. before 32 weeks) or still birth;	☐	☐
i) Hospitalization during pregnancy;	☐	☐
j) Any pregnancy complications or abnormalities not mentioned above?	☐	☐

11. Have you ever conceived or given birth to a baby with congenital illnesses (such as but not limited to Down's Syndrome, structural heart defects, brain and spinal cord disorder, cleft palate/lip), conditions affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any other serious diseases requiring regular follow up or continuous treatment?

☐ Yes ☐ No ☐ Not Applicable. This is my first pregnancy.

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks.
(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
12. Have you been told or have you ever had any test showing any abnormality of the foetus?				
a) Abnormal foetal size in relation to gestational age	☐	☐		
b) Abnormal foetal position/ presentation	☐	☐		
c) Abnormal foetal heart rate	☐	☐		
d) Abnormal foetal movement	☐	☐		
e) Intrauterine growth retardation	☐	☐		
f) Down's Syndrome	☐	☐		
g) Any other congenital abnormality	☐	☐		

Remarks in connection with the insurance applied for, if any answer is "Yes", please give details below, quoting the relevant question number(s).

Questions for Diabetes Care Plan Only

13. Have you smoked any cigarettes in the past 12 months? If yes, please state how many cigarettes per day. ☐ ☐

	Number of cigarettes (per day)
Insured/Dependant	

14. Have you ever had any of the following: Kidney disease, Retinopathy, Gangrene, Amputation, Heart disorder or heart surgery, Stroke? ☐ ☐

15. Please indicate the condition you are suffering from

☐ Type 1 Diabetes ☐ Impaired Fasting Glucose ☐ Gestational Diabetes

☐ Type 2 Diabetes ☐ Impaired Glucose Tolerance ☐ Do not know

16. Was your condition diagnosed before you turn 25 years old? ☐ ☐

17. When was your condition diagnosed?

☐ a. Less than 10 years ago

i. Is your current HbA1c > 10.0%? ☐ ☐

☐ b. 11-15 years ago

i. Is your current HbA1c > 8.5%? ☐ ☐

☐ c. More than 15 years ago

i. Is your current HbA1c > 7.0%?
Please submit a copy of your most recent HbA1c reading (not more than 3 months ago) ☐ ☐

☐ d. Unknown ☐ ☐

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
Questions for Cancer Cover Rider Plan Only (For Diabetes Care)				
18. Have you ever had or are you currently under investigation for cancer, carcinoma in situ, tumour, lump, polyp or growth of any kind or kidney or liver disease?	☐	☐		
19. Before the age of 50, have two or more of your natural parents, brothers or sisters had cancer?	☐	☐		
20. Are you pending for any medical investigations, scans, blood or urine tests report?	☐	☐		
21. Ever had any abnormal stool test, urine test (blood in urine), ultrasound, MRI or CT scan, cervical smear, mammogram, endoscopy, colonoscopy, prostate examination or blood test (tumour markers) or a biopsy done?				
☐ i. Yes, in the last 6 months				
☐ ii. Yes, more than 6 months back				
a) Are you still following up with any doctor for the abnormal investigation?	☐	☐		
☐ iii. No				
Questions for Prime Secure Plan Only				
22. Have you ever had or are you currently under investigation for:				
a) Cancer, Malignant growth or tumour;	☐	☐		
b) Diabetes or Raised blood glucose	☐	☐		
c) Raised blood pressure	☐	☐		
d) Raised cholesterol	☐	☐		
e) Stroke or Transient ischemic attack	☐	☐		
f) Multiple sclerosis	☐	☐		
g) Parkinson's disease or motor neuron disease	☐	☐		
h) Dementia or Alzheimer's disease;	☐	☐		
i) Any condition affecting your heart	☐	☐		
**If your answer to questions (a), (b), (c) & (d) above is Yes, please complete the AIA Prime Secure Supplementary Questionnaire.*				

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
23. Many people have conditions that may affect their health. In the last 5 years, which of these conditions have you have (or are you currently under investigation for):				
a) Lung disease, emphysema or chronic bronchitis	☐	☐		
b) Any form of arthritis or osteoporosis	☐	☐		
c) Tremor, balance problems, recurrent falls, weakness of limbs or paralysis	☐	☐		
d) Blindness in both eyes (that is not corrected by glasses, lenses or laser) or macular degeneration or glaucoma in either eyes?	☐	☐		
e) Deafness in both ears (that is not successfully corrected by hearing aids)	☐	☐		
f) Urinary incontinence, enlarged prostate or bladder weakness that specifically requires treatment or medical intervention	☐	☐		

**If your answer to questions (a), (b), (d), (e) & (f) above is Yes, please complete the AIA Prime Secure Supplementary Questionnaire.*

24. Have you smoked any cigarettes in the past 12 months? If yes, please state how many cigarettes per day.	☐	☐		
25. Please provide your current height and weight (in meters and kilograms).	☐ m			
	☐ kg			
26. It's normal to get stressed from time to time, Have you specifically required medical treatment, counselling or hospitalization for any mental health disorder including anxiety and/or depression? *If Yes, please complete the AIA Prime Secure Supplementary Questionnaire	☐	☐		
27. Do you plan to travel or reside in another country for more than 6 months? If yes, please give details below.	☐	☐		
28. Before the age of 65, have any of your natural parents, brothers or sisters, ever had heart disease, stroke, diabetes, Alzheimer's disease or Parkinson's disease? If yes, please give details below.	☐	☐		

* Smoking includes cigarettes, vape or e-cigarettes

	Number of cigarettes (per day)
Insured	

	Country & Cities visited
Insured	

Relationship	Age at Onset	Current Age	Illness/Age at Death (if deceased)

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**

Additional question for Lives Age 55 & above

29. As we get older, our working situations can change. Which of the following applies to your current situation?

☐ In full time employment ☐ Retired ☐ Living with assisted facilities/home help

☐ Receiving any disability income ☐ Retired on medical grounds ☐ Confined to a hospital or medical facility

☐ On reduced working capacity due to medical condition or disability

Question For Child Critical Cover Only

30. Any developmental abnormalities like attention-deficit hyperactivity disorder (ADHD), autistic disorder and/or dyslexia? ☐ ☐

Questions for All Other Policies (Including Life, Critical Illness, Health and Disability Plans)

31. Please provide your current height and weight (in meters and kilograms).

	Insured/Dependant	Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*
Height	m	m
Weight	kg	kg

32. Was there any weight change in the past year? If yes, how much and state the reason:

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
	☐	☐	☐	☐

Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)	
Insured/Dependant	

33. Please indicate the following

	Name and Address of the doctor	Date, reason and result of the last consultation
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)		
Insured/Dependant		

34. Are you contemplating a trip or had been outside Singapore for a total of more than 90 days in a year, other than for leisure or social purposes? ☐ ☐ ☐ ☐

If yes, please give details.

	Country & Cities visited	Frequency per year	Duration per trip (in months)
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)			
Insured/Dependant			

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
35. Are you now a member of a military force (except NS men) or are you engaged in any private flying or hazardous sports (including but not limited to motor sports, scuba diving, mountaineering)or races other than as a fare-paying passenger on a regular scheduled airline?	☐	☐	☐	☐
36. Is any application for or reinstatement of your life, critical life, accidental, medical, disability or health related insurance policy pending or has it ever been declined, postponed, rated or modified in any way? (If yes, please indicate Company and provide details).	☐	☐	☐	☐
37. Have you smoked any cigarettes in the past 12 months? If yes, please state how many cigarettes per day.	☐	☐	☐	☐

	Number of cigarettes (per day)
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)	
Insured/Dependant	

38. Do you drink? If yes, how many glasses if alcohol do you consume every week?	☐	☐	☐	☐

	Beer (330ml per can)	Wine (100ml per glass)	Spirits (30 ml per tots)
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)			
Insured/Dependant			

39. Have you ever used any habit forming drugs or narcotics or been treated for drug habits or consumed alcohol excessively or been treated for alcoholism?	☐	☐	☐	☐

Additional Health Details of Juvenile Insured/Dependant – Only for Insured/Dependant below Age 16 years (Attained Age)

40. Has the Insured/Dependant received medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any other AIDS related condition, been told the Insured/Dependant has any of these; or that the Insured/Dependant had HIV testing done OR in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	☐	☐
41. To the best of your knowledge and belief, has any member of the Insured/Dependant's immediate family ever had tuberculosis, diabetes, cancer, cardiomyopathy, polycystic disease, mental disease or any AIDS related condition?	☐	☐

Relationship	Age at Onset	Current Age	Illness/Age at Death (if deceased)

42. Has the Insured/Dependant ever had, or have been told or been treated for:		
i. any respiratory disease, prolonged cough, bronchitis, asthma, heart problems, fits, epilepsy or disorder affecting the nervous system?	☐	☐
ii. any heart disorder, blood disorder, diabetes, endocrine disorder, liver disease or any gastrointestinal disorder, kidney problems, nephritis or abnormality of the genitourinary system?	☐	☐
iii. condition affecting the sight, hearing or speech, physical or developmental defects, abnormal or premature birth or any cancer, growth, tumor?	☐	☐

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**
43. In the past 5 years, has the Insured/Dependant had any (other than for immunization or vaccination)				
i. of the following tests done? If yes, please give details as indicated below	☐	☐		

Test	Date	Reason	Results	Test	Date	Reason	Results
a. Blood Test				g. Liver Function Tests			
b. Biopsy				h. PAP Smear			
c. Chest X-Ray				i. Ultrasound			
d. CT Scan				j. Urine			
e. ECGs				k. Others. Please specify			
f. Cholesterol				_____			

ii. illness, operation, medical advice, investigations or hospital treatment not mentioned above?	☐	☐		

Additional Health Details Of Applicant Owner/Payor/Insured – Adult Age 16 years and above (Attained Age)

44. Have you ever had or been told to have or been treated for:				
i. epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	☐	☐	☐	☐
ii. diabetes, thyroid disorders or any other endocrine disorders?	☐	☐	☐	☐
iii. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose or throat?	☐	☐	☐	☐
iv. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	☐	☐	☐	☐
v. raised cholesterol, high blood pressure, heart attack, heart murmur, cardiomyopathy, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels?	☐	☐	☐	☐
vi. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	☐	☐	☐	☐
vii. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	☐	☐	☐	☐
viii. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐	☐	☐	☐
ix. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐	☐	☐	☐
x. cancer, tumours, cysts or growths of any kind?	☐	☐	☐	☐
xi. anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	☐	☐	☐	☐
xii. any other illness, disorder, operation, physical disability, neurological (e.g Tourette Syndrome) or accident not mentioned above?	☐	☐	☐	☐
45. Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	☐	☐	☐	☐

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***

	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPPB)*	
	Yes	**No**	**Yes**	**No**

Additional Health Details Of Applicant Owner/Payor/Insured – Adult Age 16 years and above (Attained Age)

46. Have you ever had HIV testing done? ☐ ☐ ☐ ☐

If yes, please state reason, date and results:

	Reason	Date	Results
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)			
Insured/Dependant			

47. In the last 3 months have you had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions? ☐ ☐ ☐ ☐

If yes, please state reason, date and results:

	Reason	Date	Results
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)			
Insured/Dependant			

48. In the past 5 years, have you had any (other than for immunization or vaccination)

I. of the following tests done? If yes, please give details as indicated below ☐ ☐ ☐ ☐

Test	Date	Reason	Results	Test	Date	Reason	Results
a. Blood Test				g. Liver Function Tests			
b. Biopsy				h. PAP Smear			
c. Chest X-Ray				i. Ultrasound			
d. CT Scan				j. Urine			
e. ECGs				k. Others. Please specify			
f. Cholesterol				_____			

II. illness, operation, medical advice or hospital treatment not mentioned above? ☐ ☐ ☐ ☐

49. Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, cardiomyopathy, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If yes, please provide details below. ☐ ☐ ☐ ☐

	Relationship	Age at Onset	Current Age	Illness/Age at Death (if deceased)
Applicant Owner/Payor (applicable for PB/PBC/*ECPPB*)				
Insured/Dependant				

50. **For Adult Female ONLY**

i. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts? ☐ ☐ ☐ ☐

ii. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs? ☐ ☐ ☐ ☐

iii. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months? ☐ ☐ ☐ ☐

iv. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available). ☐ ☐ ☐ ☐

v. Are you now pregnant? If yes, please indicate: ☐ ☐ ☐ ☐

Expected delivery date: dd mm yyyy

When was the last time you visited the doctor: dd mm yyyy

Has there been any complication(s) relating to this and/or previous pregnancies? Please tick:

☐ No Complication ☐ Gestational diabetes ☐ Caesarian section ☐ Eclampsia ☐ Hypertension

☐ Diabetes ☐ Thrombosis ☐ Miscarriage ☐ Others (please specify): _____

If your answer to any of the questions below is "Yes" please give details in the space provided under Remarks. ***(For review of change in smoker status, the new status will apply to all policies for which you are a party to.)***	Insured/Dependant		Applicant Owner/Payor *(applicable for PB/PBC/ECPP)*	
	Yes	**No**	**Yes**	**No**
Additional Question for Platinum Legacy, Platinum Heritage and Platinum Wealth Elite				
51. Since the date of the application of the policy, has your pattern or frequency of travel changed? If yes, please provide details on countries and cities visited, frequency per year, duration per trip and purpose of travel.	☐	☐	☐	☐
Questions for AIA MultiStage Cancer Cover				
52. Have you ever had: i. Cancer, malignant growth / lump, leukaemia, bone marrow disease, carcinoma in situ or precancerous conditions* *Precancerous, or premalignant conditions, are medical conditions which could develop into cancer if left untreated. Examples are liver cirrhosis, atrophic gastritis, colon polyposis, prostate intraepithelial neoplasia, cervical intraepithelial neoplasia (CIN), cervical dysplasia and atypical changes of breast.	☐	☐	☐	☐
ii. Non-malignant / benign growth or lump or polyp.	☐	☐	☐	☐
If Yes for (ii), please answer the following: a. Has it been removed?	☐	☐	☐	☐
b. Has there been any recurrence?	☐	☐	☐	☐
53. In the past 2 years, have you undergone any pap smear, mammogram, breast ultrasound, tumor marker test, endoscopy and/or prostate examination where results are pending, abnormal or not within the normal range?	☐	☐	☐	☐
54. In the past 3 months, have you experienced unexplained weight loss of 5 kg or more, blood in urine (other than caused by kidney stones), persistent coughing, bleeding from the bowels or in the stools (other than piles / haemorrhoids), diarrhea or constipation for 30 days or more?	☐	☐	☐	☐
Question for Quit Smoking Benefit for Platinum Heritage Wealth (II)				
55. Please provide details under *Remarks* on the below questions. ***Please also submit urine cotinine test***. a) The reason(s) to quit smoking. b) Was the reason given under advice? If (b) is Yes, was it due to medical reason/concern and/or doctor's advice? c) Please confirm when is the last time you have smoked or used tobacco in any form (mm/yy)? d) Type of tobacco : cigarettes/cigars/pipe/sisha/paan/e-cigarettes/others. Please provide details.	☐	☐	☐	☐

Remarks

Declaration and Authorisation

1. I/We hereby authorise, agree and consent to AIA Singapore, its associated persons/organisations, its and their third party service providers and its and their representatives, whether within or outside Singapore (collectively "**AIA Persons**") to collect, use, disclose, store, retain and/or process (collectively, "**Use**") all personal data and information ("**Personal Data**") that had/has been provided to AIA Persons and/or that AIA Persons possess about me/us (whether from me/us or a third party), in the manner and for the purposes described in the AIA Personal Data Policy ("**PD Policy**"), including but not limited to, processing of this Application/form and/or to provide subsequent advice or services to me/us in relation to this Application/Policy/form/AIA Vitality Programme and/or any other existing or future policy/policies/programmes that I/we may hold/participate with AIA Singapore. Without prejudice to the foregoing, I/we agree to comply with the terms of the PD Policy, including where such PD Policy is amended from time to time by AIA Singapore in accordance with its terms. Where Personal Data of another person is disclosed by me/us, I/we represent and warrant that I/we have obtained the consent of the individual concerned, except to the extent such consent is not required under relevant laws: (i) to collect such Personal Data; (ii) to disclose such Personal Data to the AIA Persons; and (iii) for the AIA Persons to Use such Personal Data in the manner and for the purposes described in the PD Policy. I/We hereby specifically waive (on our own behalf and on behalf of each such other person, and I/we represent and warrant that such other person has granted me/us authority to so waive) any right to bring a claim of any nature against any of the AIA Persons in respect of any above-mentioned Use and/or any Use of Personal Data in the nature of or for any of the purposes described above or in the PD Policy. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application/form is accepted by AIA Singapore. A photocopy of this authorisation shall be valid and effective as the original.

2. I hereby request that the policy(ies) stated in this form be changed in accordance with the above application.

3. I understand and agree that no application is valid until this change form is received by AIA Singapore Private Limited ("AIA Singapore") during the life time of the Insured and is finally accepted by AIA Singapore.

4. I understand and agree that application shall not be considered as effected by reason of any money paid or settlement made in payment of, or no account of any premium, until this form has been duly approved by the authorised Officer of AIA Singapore.

5. I understand and agree that my application is subject to the terms and conditions as stated in the Policy Contract and is effective only when it has been officially accepted and notified to me by AIA Singapore.

6. I confirm that the above answers, given by me, are full, complete and true and agree that they form part of any policy issued, reinstated or amended, where these answers are, or may be, relied upon by AIA Singapore.

7. I understand and agree that the application of the Contracts (Rights of Third Parties) Act (Cap. 53B) and any subsequent revision or replacement thereof is expressly excluded insofar as this contract of insurance is concerned.
8. For Increase Face Amount of Basic Plan/Rider(s)/Supplementary Benefit(s), Add Rider(s)/Supplementary Benefit(s), Change Plan/Area of Cover, Add Dependant(s), I have received a copy of (1) Benefit Illustration (applicable to riders with cash value or unit linked riders), (2) Product Summary, (3) "Your Guide to Life Insurance" and (4) "Your Guide to Health Insurance" (applicable only to accident and health insurance products), the contents of which have been explained to me to my satisfaction.

9. I understand and agree that if AIA Singapore accepts my application, the Incontestability and Suicide Provisions (if any) thereof shall have effect from the approval date of my application.

10. In relation to my application to increase the Face Amount of the Basic Plan/Rider(s)/Supplementary Benefit(s), I understand and agree that if AIA Singapore accepts my application, AIA Singapore shall have the right to impose or vary any terms and conditions of the Policy in relation to the increased portion of such Face Amount.

WARNING: If a material fact is not disclosed in this application form, any application may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Financial Services Consultant(s)/Insurance Representative(s) but was not included in this application. Please check to ensure you are fully satisfied with the information declared in this application. Additionally and without prejudice to the parties' rights and obligations whether under law or otherwise, following the submission of your application, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

Your Declaration Type

Acknowledgment of Receipt of Product Summary
Applicable for Addition of Supplementary Benefit(s), Increase in Sum Assured and Add Dependent

Declaration
1. I have received all pages of the Product Summary/Policy Illustration for the coverage(s) indicated either under Section B: Increase Face Amount of Basic Plan/Rider(s)/Supplementary Benefit(s), Section C: Add rider(s)/supplementary benefits and/or Section E: Add Dependent, and I have read and understood its contents.
2. I understand that this Product Summary/Policy Illustration contains simplified description of the product features of the plan and it does not form a part of any contract of insurance. I am aware that I have to refer to the actual policy contracts for all terms and conditions, including exclusions whereby benefits may not be paid out.
3. I understand that it is the precise terms and conditions as appeared in the policy contract which bind the parties.

Signature of Insured	Signature of Policy Owner*/Trustee/Assignee
Date	Date
	*Contact Number

** If different from Insured*

Signature of Trustee *(if any)*
Date
*Contact Number

*** We will call you at this number if we need any clarifications regarding your request. This contact number will not be updated into our records. If you wish to update your contact details, please complete the Update of Address & Contact Details form.**

Please note that Signature of Witness/FSC/IR is required only if Change of Payor for Juvenile Policy is requested.

Signature of New Policy Owner *(if applicable)*	Signature of Witness/FSC/IR
Date	Date

Name of Witness	NRIC/Passport/FIN No.

Address of Witness	Contact No.

FSC/IR's Name	FSC/IR's Code	FSC/IR Unit Name	Mobile No.