

# APPLICATION FORM FOR IDEALMEDICAL



Adviser's Name _____	Email _____
Source Code _____	Company _____
Mobile No. _____	For Official Use : Commencement Date _____

This policy is underwritten by Aviva Ltd and will be entered in the register of Singapore Policies. The terms and conditions of this policy shall be governed by and construed in accordance with the laws of Singapore. **Payment must be submitted with this application form before any cover can be granted.**

**WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT, YOU ARE TO DISCLOSE IN THIS FORM, FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY NOT RECEIVE ANY BENEFIT FROM YOUR POLICY.**

## SECTION A: DETAILS OF PROPOSER/ MAIN APPLICANT

<b>Full Name</b> (As in NRIC/Passport. Please underline surname)	[Grid for name entry]		
<b>NRIC/Passport No.</b>	[Grid for NRIC/Passport No.]	<b>Date of Birth</b>	[Grid for Date of Birth] d d / m m / y y
<b>Gender</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Age at Last Birthday</b>	[Grid for Age]
<b>Residential Address</b>	[Grid for Residential Address]		
<b>Mailing Address</b> (If different from above)	[Grid for Mailing Address]		
<b>Contact Details</b>	Email Add.	Home/Office No.	Mobile No.
<b>Marital Status</b>	<input type="checkbox"/> Single <input type="checkbox"/> Widowed	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<b>Height &amp; Weight</b> [Grid] cm [Grid] kg (Ht) (Wt)
<b>Name of Employer</b> (if applicable)			<b>Nationality</b>
<b>Occupation</b> (Please provide a description of job nature)			<b>Usual Country of Residence</b> [S: Singapore/ A: AseanPlus (which refers to China, Korea, India, Malaysia, Indonesia, Philippines, Thailand, Brunei, Vietnam, Cambodia, Laos, Myanmar)] <input type="checkbox"/> S <input type="checkbox"/> A, please indicate country: _____
<b>Smoker</b> (In the last 12 months)	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ cigarettes per day for _____ years		<b>Are you insuring yourself?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

## SECTION B: PLAN TYPE AND DEDUCTIBLE

	Main Applicant/ Employee* (*If Proposer is his/her employer)	Spouse/Partner	Child(ren) (Plan should not be higher than Proposer or Spouse's. All children must be under the same plan with same deductible, if any)
<b>Plan</b>	<input type="checkbox"/> Classic <input type="checkbox"/> ClassicPlus <input type="checkbox"/> Supreme <input type="checkbox"/> SupremePlus	<input type="checkbox"/> Classic <input type="checkbox"/> ClassicPlus <input type="checkbox"/> Supreme <input type="checkbox"/> SupremePlus	<input type="checkbox"/> Classic <input type="checkbox"/> ClassicPlus <input type="checkbox"/> Supreme <input type="checkbox"/> SupremePlus
<b>Annual Deductible (optional) in SGD</b> (Please indicate only if applicable)	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$10,000

## SECTION C: DETAILS OF INSURED PERSONS (SPOUSE/ PARTNER/ CHILD)

Relationship to Main Applicant/ Employee	<input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Others _____	Child 1	Child 2	Child 3
<b>Surname/Family Name</b> (As in NRIC/Passport)				
<b>Given Name</b> (As in NRIC/Passport)				
<b>NRIC/Passport No.</b>				
<b>Marital Status</b> (S: Single/ M: Married/ D: Divorced/ W: Widowed)	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W
<b>Gender</b> (M: Male/ F: Female)	<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
<b>Date of Birth</b> (Please furnish child health booklet for any child less than one year old)	<div style="display: flex; justify-content: space-around;"> <span><input type="text"/> <input type="text"/> <input type="text"/></span> <span><input type="text"/> <input type="text"/> <input type="text"/></span> <span><input type="text"/> <input type="text"/> <input type="text"/></span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>d d / m m / y y</span> <span>d d / m m / y y</span> <span>d d / m m / y y</span> </div>	<div style="display: flex; justify-content: space-around;"> <span><input type="text"/> <input type="text"/> <input type="text"/></span> <span><input type="text"/> <input type="text"/> <input type="text"/></span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>d d / m m / y y</span> <span>d d / m m / y y</span> </div>	<div style="display: flex; justify-content: space-around;"> <span><input type="text"/> <input type="text"/> <input type="text"/></span> <span><input type="text"/> <input type="text"/> <input type="text"/></span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>d d / m m / y y</span> <span>d d / m m / y y</span> </div>	<div style="display: flex; justify-content: space-around;"> <span><input type="text"/> <input type="text"/> <input type="text"/></span> <span><input type="text"/> <input type="text"/> <input type="text"/></span> </div> <div style="display: flex; justify-content: space-around; font-size: small;"> <span>d d / m m / y y</span> <span>d d / m m / y y</span> </div>
<b>Height</b>	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm	<input type="text"/> <input type="text"/> <input type="text"/> cm
<b>Weight</b>	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg	<input type="text"/> <input type="text"/> <input type="text"/> kg
<b>Occupation</b> (Please provide a description of job nature)				
<b>Nationality</b> (S: Singaporean or Singapore PR/ O: Others Please indicate details if you have selected others)	<input type="checkbox"/> S <input type="checkbox"/> O _____	<input type="checkbox"/> S <input type="checkbox"/> O _____	<input type="checkbox"/> S <input type="checkbox"/> O _____	<input type="checkbox"/> S <input type="checkbox"/> O _____
<b>Usual Country of Residence</b> [S: Singapore/ A: AseanPlus (which refers to China, Korea, India, Malaysia, Indonesia, Philippines, Thailand, Brunei, Vietnam, Cambodia, Laos, Myanmar)]	<input type="checkbox"/> S <input type="checkbox"/> A, please indicate country: _____	<input type="checkbox"/> S <input type="checkbox"/> A, please indicate country: _____	<input type="checkbox"/> S <input type="checkbox"/> A, please indicate country: _____	<input type="checkbox"/> S <input type="checkbox"/> A, please indicate country: _____
<b>Smoker</b> (In the last 12 months)	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ cigarettes per day for _____ years	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ cigarettes per day for _____ years	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ cigarettes per day for _____ years	<input type="checkbox"/> No <input type="checkbox"/> Yes, _____ cigarettes per day for _____ years

## SECTION D: DECLARATION OF HEALTH

	Main Applicant/ Employee	Spouse/Partner	Child 1	Child 2	Child 3
In the same numbering and sequence as above					
<b>1. Have you or any of the proposed insured been told or treated for any of the following conditions: Chronic obstructive lung disease/ chronic obstructive airways disease, cardio-respiratory disease (for eg, chronic cor pulmonale, pulmonary hypertension), stroke, heart attack, heart bypass, angioplasty, liver cirrhosis, paralysis, osteoporosis, HIV infection, thalassaemia intermediate/major, diabetes with complications such as protein in urine or eye problem, kidney failure, organ transplantation, systemic lupus erythematosus (SLE), muscular dystrophy, multiple sclerosis, Alzheimer's disease, dementia, cancer (other than skin cancer) or autism?</b>  If "Yes", please proceed to Section F for Authorisation & Declaration. If "No", please complete all the questions and declaration.	<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
<b>2. Have you or any of the proposed insured ever been rejected or offered on special terms for any application on life, health or any other insurance?</b> <span style="float: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No</span>					
If "Yes", please provide details in the box below					
Name	Insurance Company	Type of Policy	Reasons		

3. Have **two or more** of your natural parents or siblings ever suffered from, or are/ is suffering from the **same** conditions as follows: heart disease, kidney disease, stroke, diabetes, cancer, or any hereditary disease?  Yes  No

If "Yes", please provide details in the box below

Name	Relationship to Applicant	Attained Age	Diagnosed illness (for the living)/ Cause of Death (for the deceased)	Age of onset (For the living)	Age of Death

4. For female proposed insureds: Are you currently pregnant?  Yes  No

If "Yes", please provide details in the box below

Name	Month of Pregnancy	Name/Address/Contact No. of the Hospital/Doctor/ Clinic consulted

5. In the last 5 years, have you or any of the proposed insured had medical test or investigation such as X-ray, ultrasound, electrocardiogram (ECG), Barium Meal Examination, CT Scan, Biopsy, blood & urine test etc (excluding routine health screening that shows no abnormalities), or ever been refused an offer to donate blood? Any intention to undergo any of such tests/investigation in foreseeable future?  Yes  No

If "Yes", please provide details in the box below

Name	Diagnosis/ Underlying Cause	Date of Tests	Details of Tests and Results	Name/Address/Contact No. of the Hospital/ Doctor/ Clinic consulted

6. Have you or any of the proposed insured consulted a doctor or had been provided prescriptions for any drugs or medication in the last 5 years? (excluding common flu)  Yes  No

If "Yes", please provide details in the box below

Name	Date of last visit/ Period of Medication	Name of Medicine/Drugs Prescribed	Dosage	Name/Address/Contact No. of the Hospital/ Doctor/ Clinic consulted

7. Have you or any of the proposed insured ever had, been told to have or been treated for any conditions stated in Note 1?  Yes  No

If "Yes", please provide details in the box below

Name	Details of Condition/ Treatment/ Operation	Test Done/ Results (Is the result normal or abnormal?)	Consultation/ Treatment received	Name/Address/Contact No. of the Hospital/ Doctor/ Clinic consulted

**Note 1:** Heart trouble, chest pain, blood pressure problems or circulatory disorder; Fainting blackouts, dizziness, seizures, fits, stroke or paralysis; Asthma, persistent cough, breathlessness or other respiratory disorders; Stomach ulcer, liver, hepatitis, gall bladder, intestinal or bowel disorders, kidney, bladder, prostate or genito-urinary disorder; Gynaecological or hormonal disorders or irregularity; Diabetes or disorders of the eyes, ears, nose or throat; Diseases or disorders of the back bones, joints, muscles or skin; Mental or nervous disorders; AIDS, HIV or venereal diseases; Any diseases, disorders or conditions which are long lasting or recurrent; Treatment for drug or alcohol addiction or abuse; Any other illness, disabilities or defects present that may require treatment that have not already been disclosed.

## SECTION E: PAYMENT METHOD

**Payment Frequency**

Monthly  Quarterly  Annually

**Payment Mode**

Cheque (Applicable for annual mode only. Please make payable to Aviva Ltd)

Bank/ Cheque No \_\_\_\_\_ Amount paid \_\_\_\_\_

Giro (Please complete a separate Giro form)

(Please pay 2 months premium upfront by cash/cheque if monthly Giro mode is selected;

Please pay 3 months premium upfront by cash/cheque if quarterly Giro is selected;

Please pay 1<sup>st</sup> year premium upfront by cash/cheque if annual Giro is selected as Giro deduction is upon renewal only.)

Credit Card (please complete the Card Payment Authorisation below)

Card Payment Authorisation

I authorize Aviva Ltd, until further notice in writing, to charge my card account, the premiums in respect of this insurance policy as and when these become due. I will advise in writing immediately if the card becomes stolen or if I wish to close my card account or cancel the authorisation.

Cardholder's Name (as it appears on credit card) \_\_\_\_\_

Visa

MasterCard

\_\_\_\_\_ Bank \_\_\_\_\_

Card No. \_\_\_\_\_ Expiry Date (mm/yy) \_\_\_\_\_

Cardholder Security Value (CSV) No. \_\_\_\_\_  
(last 3-digit number at the back of your credit card)

Cardholder's signature \_\_\_\_\_ Date \_\_\_\_\_

## SECTION F: AUTHORISATION AND DECLARATION

**Benefit may not be payable if you do not fully disclose any material facts which could influence our assessment and acceptance of this application. If you are in any doubt as to whether any facts are materials, you should disclose them.**

1. I/We declare that all the information on this Application Form is true and complete and that I/we am/are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalisation in the future.
2. I/We understand that benefits will not apply to treatment or expenses arising from medical conditions which originated or were known to exist or for which treatment, medication, advice or diagnosis was sought or received prior to my/our enrolment in this policy unless such conditions are fully disclosed to and accepted by Aviva Ltd prior to the inception of the policy.
3. I authorise any medical source, insurance office, or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organisations, relevant information concerning me at any time, regardless of whether the application is accepted by Aviva Ltd. A photographic copy of this authorization shall be as valid as the original.
4. I/We are aware that I/we can seek advice from a qualified adviser before I sign this Application 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.
5. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd and the premium has been received by Aviva Ltd.

(Applicable only if you have seen an adviser)

I/We confirm that I/we have received a copy of Your Guide to Health Insurance and the Product Summary which were explained to my/our satisfaction.

**Please check to ensure that you are fully satisfied with the information declared in this Application Form before signing.**

<b>Signature of Main Applicant/ Employee</b>		<b>Signature &amp; Name of all Insured Persons who are above 16 years old</b>		<b>Signature of Witness, Financial Adviser</b>	
<b>Name of Company &amp; Company Stamp (if Proposer is the Employer)</b>					
<b>Date</b>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> d d / m m / y y	<b>Date</b>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> d d / m m / y y	<b>Date</b>	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> d d / m m / y y

**TO BE COMPLETED BY FINANCIAL ADVISER**

Premium Calculation

Premium calculated to 2 decimal places

If annual mode is not selected, please indicate modal premium accordingly

Quarterly premium = Total Premium Payable X 0.2548

Monthly premium = Total Premium Payable X 0.0853

Insured Persons	Sex M/F	Age	Gross Premium (A)	Discount (%) (Please indicate only if applicable)			Loading (%) (Please indicate only if applicable)			Total Premium Payable = (Sub-Total (I) + Sub-Total (II))
				Deductible Discount (B)	Family Discount (C)	Sub-Total (I) = (A) X (1 - B) X (1 - C)	Occupational Loading (D)	Health Extra (E)	Sub-Total (II) = [(A) X (D)] + [(A) X (E)]	
IP #1			\$ _____	_____ %	_____ %	\$ _____	_____ %	_____ %	\$ _____	\$ _____
IP #2			\$ _____	_____ %	_____ %	\$ _____	_____ %	_____ %	\$ _____	\$ _____
IP #3			\$ _____	_____ %	_____ %	\$ _____	_____ %	_____ %	\$ _____	\$ _____
IP #4			\$ _____	_____ %	_____ %	\$ _____	_____ %	_____ %	\$ _____	\$ _____
IP #5			\$ _____	_____ %	_____ %	\$ _____	_____ %	_____ %	\$ _____	\$ _____
<b>Total Premium Payable</b>							<b>\$ _____</b>			

1. Are you aware of any factor (medical or otherwise) which you feel is not apparent from the application form and which could affect the underwriting of this Policy? If yes, please give details.  Yes  No

2. Does any of the Insured Persons looked ill in any way or appear to have physical defect?  Yes  No  
If yes, please give details \_\_\_\_\_

**Financial Adviser's Declaration**

I hereby certify that I have personally seen the Proposer/Insured Persons and explained the terms of the insurance policy to him/her and I have not given any statement to the Proposer contrary to the provisions as contained in the referant policy contract.

I declare that all the answers provided to me by the Proposer/ Insured Persons are declared in the application form. I have not withheld any other information which may influence the acceptance of this application by the Aviva Ltd.

Signature of Adviser \_\_\_\_\_ Date \_\_\_\_\_

Name of Adviser \_\_\_\_\_

Name of Company \_\_\_\_\_

Submission of Payment with application	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has any of the Insured Persons submitted any application for life or health insurance to AVIVA Ltd other than IdealMedical recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", have they furnished any test result/medical report or other supporting documents together with the application for life cover, which will help in our review of the application for IdealMedical?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Submission of other documents	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, kindly indicate accordingly <input type="checkbox"/> Product Summary <input type="checkbox"/> Fact Find Form <input type="checkbox"/> Giro Form <input type="checkbox"/> Others (please specify) _____

## Product Summary

### IdealMedical – A Medical Expense Insurance Underwritten By Aviva Ltd

Presented to: \_\_\_\_\_  
(Name of Proposer)

Signature of Proposer: \_\_\_\_\_

\_\_\_\_\_  
Name & Signature of Insurance Adviser

Date: \_\_\_\_\_

#### 1. Product Information

IdealMedical is a comprehensive medical expense insurance plan that covers eligible in-patient expenses as a result of an illness or accident subject to the limits set out in the Benefit Schedule shown below. Outpatient expenses are also covered under selected plans.

Plans	SupremePlus	Supreme	ClassicPlus	Classic
Type of hospital	All	All	All	Restructured Hospital (1)
Area of Cover	Asean Plus (2)	Asean Plus (2)	Singapore	Singapore
<b>1) Hospital &amp; Related Services</b>				
Daily Room & Board				S\$160 (4)
Daily Intensive Care Unit	As Charged	As Charged	As Charged	As charged (5)
Hospital Miscellaneous Services				
Surgical Benefits (including day surgery)				
Daily In-Hospital Doctor's Visit				
Pre-Hospital Specialist Consultation				
Pre-Hospital Diagnostic & Laboratory Services				
Post-Hospital Follow-up Treatment (max 90 days after discharge)				
Home Nursing following hospital discharge (max. 26 weeks per policy year)				
Parent Accommodation as companion for insured child (below age 18)				
In-Hospital Psychiatric Treatment (after 10 months of coverage)				
Emergency Outpatient Treatment due to accident (payable up to 30 days from date of accident)	As Charged	As charged	As charged	As charged
Local Ambulance Services				
Accident Dental Treatment				
<b>2) Emergency Medical Evacuation and Repatriation</b>				
Emergency Medical Evacuation	As charged	As charged	As charged	Not Applicable
Emergency Repatriation				
Repatriation or Local Burial of Mortal Remains				
Emergency Medical Advice and Assistance				
<b>Annual Limit Per Person</b>	<b>S\$1,000,000</b>	<b>S\$300,000</b>	<b>S\$150,000</b>	<b>S\$50,000</b>
<b>3) Organ Transplant, Kidney Dialysis &amp; Cancer Treatment (annual limits)</b>				
Organ Transplant	S\$600,000	S\$300,000	S\$150,000	S\$50,000
Outpatient Kidney Dialysis	S\$300,000	S\$150,000	S\$50,000	S\$25,000
Outpatient Cancer Treatment	S\$300,000	S\$150,000	S\$50,000	S\$25,000
<b>4) Outpatient Benefits</b>				
Deductible per visit	S\$50	S\$50		
General Practitioner services	S\$10,000 per policy year	S\$10,000 per policy year	Not Applicable	Not Applicable
Specialist services				
Diagnostic and Laboratory services (include Outpatient MRI / CT Scan / PET scans)				
Prescription Drugs				
Prescribed Outpatient Therapy by Physiotherapy, Speech & Oculomotor Therapist				
Prescribed Medical Aids (such as artificial limbs, hearing aids)				
Prescribed Alternative Medicine (chiropractor, homeopath, acupuncturist, Chinese physician). Benefit for Chinese physician is limited to \$500 per insured person per policy year				
<b>5) Hospital Cash, Get Well &amp; Preventive Health Benefits</b>				
Daily Hospital Cash for admission in Singapore Restructured Hospitals (max 30 days per disability) (3)	S\$300	S\$200	S\$100	S\$150 if warded in B2 & below
Get-Well benefit for stay in Singapore Restructured Hospitals ( which exceeds 10 consecutive days )	S\$3,000	S\$2,000	S\$1,000	S\$1,000
Complimentary Annual Health Screen	SupremePlus Package	Supreme Package	Not provided	Not provided
Renewal Gift Voucher (annually)	Not provided	Not provided	S\$20	S\$20
<b>Lifetime limit per person</b>	<b>S\$3,000,000</b>	<b>S\$1,500,000</b>	<b>S\$750,000</b>	<b>S\$250,000</b>
<b>6) Death Benefit (due to any cause)</b>	<b>S\$1,000</b>	<b>S\$1,000</b>	<b>S\$1,000</b>	<b>S\$1,000</b>

(1) refers to privatised government hospitals and medical centres in Singapore such as Singapore General Hospital, Tan Tock Seng Hospital, Alexandra Hospital, Changi General Hospital, KK Women's and Children's Hospital, National Heart Centre and National Cancer Centre

(2) refers to Singapore, Malaysia, Indonesia, Philippines, Thailand, Brunei, China (excluding Hong Kong), Korea, India, Vietnam, Myanmar, Cambodia and Laos.

(3) This benefit is not applicable to day surgery cases.

(4) refers to a fixed dollar limit which is based on a standard 4-bed ward in a Singapore Restructured Hospital.

(5) For the Classic Plan, we will reimburse the eligible expenses incurred as an inpatient (excluding the room and board charges) at :

- a) 85% of the eligible expenses if admitted in class higher than a 4-bed ward in a Singapore Restructured Hospital; or
- b) 50% of the eligible expenses if admitted to any ward in a private hospital.

## 2. Premium Rates

The premium payable is based on the age last birthday of each insured person at the date of underwriting approval and will increase when the insured person enters the next age band.

### Annual Premium per person in SG Dollars (inclusive of 7% Goods and Services Tax)

Plan	Supreme Plus		Supreme		Classic Plus		Classic		
	Age Last Birthday	Male	Female	Male	Female	Male	Female	Male	Female
0 to 17		1,623.19	1,623.19	737.23	737.23	420.51	420.51	207.58	207.58
18 to 24		1,759.08	1,907.81	916.99	1,134.20	525.37	631.30	284.62	349.89
25 to 29		1,917.44	2,302.64	1,086.05	1,277.58	623.81	847.44	321.00	426.93
30 to 34		2,177.45	2,625.78	1,188.77	1,385.65	707.27	945.88	363.80	472.94
35 to 39		2,544.46	2,805.54	1,310.75	1,510.84	761.84	967.28	391.62	497.55
40 to 44		2,956.41	3,032.38	1,611.42	1,704.51	913.78	1,092.47	450.47	518.95
45 to 49		3,580.22	3,495.69	1,807.23	1,921.72	1,065.72	1,247.62	570.31	606.69
50 to 54		4,392.35	4,275.72	2,171.03	2,215.97	1,485.16	1,496.93	785.38	742.58
55 to 59		5,309.34	4,597.79	2,862.25	2,477.05	2,140.00	1,917.44	1,053.95	894.52
60 to 64		6,432.84	5,477.33	3,602.69	3,098.72	2,869.74	2,396.80	1,388.86	1,203.75
*65 to 69		8,003.60	7,066.28	4,751.87	4,152.67	3,946.16	3,161.85	1,890.69	1,630.68
*70 to 74		9,989.52	9,032.94	6,198.51	5,517.99	5,308.27	4,529.31	2,480.26	2,382.89

For monthly payment, multiply the rate by 0.0853

For quarterly payment, multiply the rate by 0.2548

Annual Deductible (optional)	1000	2000	3000	5000	8000	10000
Premium Discount	10%	15%	20%	25%	40%	50%

Rates updated as at June 2007

### Who is eligible to apply?

- 1) Adult between the ages of 18 and 65 years old.
- 2) Newborn child from 15 days old or the date of discharge from the hospital after birth, whichever is later.
- 3) ClassicPlus and Classic Plans are available to Singapore Citizen, Singapore PR, and Holders of Employment Pass, Work Permit, Dependant Pass and Student Pass only.
- 4) SupremePlus and Supreme plans are available to any nationalities residing in AseanPlus countries.

## 3. Key Product Provisions

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the policy contract. Please consult your insurance adviser should you require further explanation.

### a) Exclusions

There are certain conditions under which no benefit will be payable. These are stated as exclusions in the policy contract. The following is a list of some of the exclusions applicable under this plan. **You are advised to read the policy contract for the full list of exclusions.** These exclusions include but are not limited, to the following.

- Pre-existing condition unless otherwise declared on the application form and expressly confirmed acceptance by us
  - refer to any condition for which treatment or medication or advice or diagnosis has been sought or received or was foreseeable prior to the commencement date of the insurance cover, or
  - which originated or was known to exist by you or any insured person prior to the commencement date of the insurance cover, whether or not treatment or medication or advice or diagnosis was sought or received.
- Routine medical examination or check-ups, cosmetic treatments;
- Congenital anomalies or birth defects, hereditary conditions;
- Pregnancy or childbirth, self-inflicted injuries, suicide, abuse of alcohol, drug addiction, sexually transmitted diseases and AIDS or any AIDS-related conditions or diseases;
- Injury or illness arising out of or in connection with active military and police duties while serving National Service or reservist duty or training;

- Hazardous sports or activity;
- War and terrorism
- Injury or illness sustained by the insured person while outside the selected area of cover

- (a) for more than 180 consecutive days during the policy year if the insured person is insured under the SupremePlus Plan; or
- (b) for more than 90 consecutive days during the policy year if the insured person is insured under the Supreme, ClassicPlus or Classic Plan.

b) **Accuracy of Information**

You must provide us with complete and accurate information when applying for this plan or when making any claim, otherwise your rights under the policy may be reduced or lost.

c) **Non-Guaranteed Premium**

Premium rates payable under the policy are not guaranteed and may be increased on the policy renewal date based on the claims experience of the portfolio.

d) **Geographical Scope**

This policy covers you in the Area of Cover as stated in the policy on a 24-hour basis. If you are insured under the SupremePlus Plan, you will not be covered if you remain outside of your Area of Cover for a period exceeding 180 consecutive days during the policy year. If you are insured under the Supreme, Classic Plus or Classic Plan, you will not be covered if you remain outside of your Area of Cover for a period exceeding 90 consecutive days during the Policy Year.

The insured person shall, wherever possible, seek treatment in the specified Area of Cover except for any treatment of an Emergency Medical Complaint occurring while outside the specified Area of Cover for not more than 180 consecutive days per trip for SupremePlus Plan or 90 consecutive days per trip for Supreme, ClassicPlus or Classic Plan.

If any insured person chooses to be treated outside the specified Area of Cover although it is available in the specified Area of Cover, this policy will reimburse the cost of covered treatment subject always to the limits specified in the policy, and subject to the following conditions:

- i. If you are covered under the Classic or ClassicPlus Plan, we will pay the actual incurred charges or the charges for equivalent medical treatment in the Singapore General Hospital, whichever is lower ;
- ii. If you are covered under the Supreme or SupremePlus Plan, we will pay up to an amount not exceeding the Reasonable and Customary Charges (as defined in the policy) for equivalent medical treatment rendered in the relevant AseanPlus country as defined above.

The Supreme and SupremePlus Plans also provides transportability where your cover can continue even if you relocate within the relevant AseanPlus countries as defined above.

e) **Terms of Renewal**

The policy is automatically renewed for a further period by payment of the renewal premium before the renewal date. On the renewal date, we may vary the benefits, cover and /or premium or even cancel all policies in a particular age group or of a plan type by giving you 30 days' advance notice in writing but we will not cancel any individual policy.

f) **Termination Clause**

The cover of an insured person under this policy will automatically terminate on the date any one of the following events first occurs:

- (i) upon death of an insured person;
- (ii) on the expiry of the policy year during which the insured person attains the age of 75;
- (iii) the insured person's entry into full-time military, naval or police service excluding National Service and reservist duty or training;
- (iv) upon request for cancellation by the insured;
- (v) non payment of premium after the premium due date; or
- (vi) the lifetime limit of the insured person as stated in the policy has been exhausted.

g) **Reinstatement**

If the policy terminates due to non payment of premium, you may apply to reinstate this policy within 30 days of its termination by providing us with satisfactory evidence of insurability for each insured person at your expense, provided the insured person for whom reinstatement is requested is not older than age 60 on the date of reinstatement. All outstanding premiums must be received by us before the policy can be reinstated.

Treatment provided to the insured person commencing before or within 30 days of the reinstatement date will not be covered unless the treatment is provided for injuries caused by an accident occurring after the reinstatement date.

h) **Cancellation Clause**

The policy may be cancelled with effect from any renewal date if the insured person gives 30 days' notice in writing of his intention not to renew the insurance. If the policy is cancelled and the premium is paid annually, we will make a 50% refund of premium if the unexpired period of insurance is more than 6 months.

If a claim has arisen in respect of that policy period or the unexpired period of insurance is less than 6 months, no refund of premium will be made. If the policy is cancelled and premium is made on either a monthly or other regular basis, we will reserve the right to deduct the premiums for the remaining policy period from the amount of claim payment.

i) **Material Change**

You must advise us in writing as soon as you are aware of any change in:

- the occupation or business
- country of residence of any insured person (that is when you intend to live in another country for more than 90 days),
- any other material change such as change in hobbies or pursuits of an insured person.

We may adjust the premium rates or decline to cover you as a result of such change.

j) **Payment Guarantee**

We will provide you with a card, which lists a 24-hour hotline number. Prior to any admission in any hospital anywhere, you just need to call the hotline and provide the relevant information. We will provide a Payment Guarantee, which is direct settlement with the hospital if the treatments are covered under the policy and for the following benefits only:

- In-patient treatment;
- Organ Transplantation;
- Home nursing care;
- Emergency Medical Evacuation and Repatriation

If we make any payment under the Payment Guarantee or direct settlements which payment should have been made by you, you shall reimburse the amount(s) paid by us within 30 days of being notified.

k) **Continuity of Benefits**

Cover will continue for a maximum period of 30 days after the policy comes to an end provided:

- (a) the claim was reported and accepted by us before the policy ends;
- (b) the insured person was within the stated Area of Cover; and
- (c) the claim relates to a covered treatment under the policy.

l) **Co-ordination of Benefits**

If at the time of claim, the insured person has other medical insurance which makes provision for reimbursement of medical expenses, you shall advise us of the details of such other policies and we shall not be liable to contribute more than the rateable proportion of such reimbursement.

m) **Deductible**

You may opt to pay a lower premium on the basis that you will first pay a pre-determined amount called the Annual Deductible before a claim for In-Hospital benefits under the policy can be made.

n) **Aviva's Promise of Service**

The policy issued to you will contain Aviva Ltd's promise of service. You can contact Aviva Ltd if you have any concern about the terms of your policy or any claim you may make. Information on the distribution costs will be available at your request.

**Note: This is only product information provided by us. Full details of the terms, conditions and exceptions of this insurance are provided in the policy and will be sent to you upon acceptance by Aviva Ltd. You have a "Free Look" period of 14 working days from the date you receive the policy. Please inform Aviva Ltd within 14 working days if you do not want the policy. It will be cancelled from its commencement date and any premium that you may have paid will be refunded in full, so long as no claim has arisen. This policy is governed by and shall be construed according to the laws of Singapore.**

# APPLICATION FORM FOR INTERBANK GIRO

## Part 1: For applicant's completion

Date (dd / mm / yyyy):

Name of Billing Organisation (BO):

**Aviva Ltd**

To: Name of Financial Institution

Name of Policyowner:

Branch:

Policy Number:

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- a) I/We hereby instruct you to process the BO's instruction to debit my/our account.  
b) You are entitled to reject the BO's debit instruction if my/our account does not have sufficient funds and charge me/us a fee for this. You may also at your discretion allow the debit even if this results in an overdraft on the account and impose charges accordingly.  
c) This authorisation will remain in force until terminated by your written notice sent to my/our address last known to you or upon receipt of my/our written revocation through the BO.

My/Our Name(s):

My/Our NRIC Number(s):

Mr/Mdm/Ms/Dr

Mr/Mdm/Ms/Dr

My/Our Account Number:

My/Our Contact Number(s):

Office Tel. No.:

My/Our Signature(s)/Thumbprint(s)\*:

Home Tel. No.:

## Part 2: For billing organisation's completion

Bank Branch Billing Organisation's Account Number

Billing Organisation's Customer Reference Number:

**7 1 7 1 0 0 3 0 0 3 9 0 0 1 8 8 6**

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Bank

Branch

Account Number to be Debited

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## Part 3: For financial institution's completion

To: Employee Benefits and Healthcare, Aviva Limited, 4 Shenton Way, #01-01 SGX Centre 2, Singapore 068807

This Application is hereby REJECTED for the following reason(s) (please tick):

\* Please delete where applicable

- Signature/Thumbprint# differs from Financial Institution's records       Wrong account number  
 Signature/Thumbprint# is incomplete/unclear       Amendments not countersigned by customer  
 Account operated by Signature/Thumbprint#       Others: \_\_\_\_\_

Name of Approving Officer:

Authorised Signature:

Date: