MyShield Standard Plan

APPLICATION FORM

* P R 0 P F *

AVIVA

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP.142), YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

This policy is underwritten by Aviva Ltd and will be entered into 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.

IMPORTANT:

1) Please attach the following documents to your application:
   - Copy of Identity Card
   - If address is not available in the Identity Card, copy of fixed line telephone, utility, tax bill or any documents issued by a local government body.

2) To be eligible for MyShield Standard Plan, the assured must be a Singapore citizen or Singapore permanent resident and have a Medisave account. The life assured must be a Singapore citizen or Singapore permanent resident.

Select the person(s) to be insured:

For Official Use Only

MyShield

☐ Proposer:	Contract No.	
☐ Dependant 1:	Contract No.	
☐ Dependant 2:	Contract No.	
☐ Dependant 3:	Contract No.	
☐ Dependant 4:	Contract No.	

Particulars of Financial Adviser Representative

Name:

Source Code:

Name of Firm:

Contact No.: (HP)

(O)

Email Address:

For Financial Adviser Representative Use Only

Referral ID:

Please complete in capital letters and tick boxes as appropriate.

SECTION A: PARTICULARS OF PROPOSER (ASSURED)

Full Name as shown in Identity Card: Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr

Family Name: Given Name:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Identity Card No.: Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others

CPF Account No.: Date of Birth (DD/MM/YY):

Nationality: *(Please list your nationalities)* Nationality ID Type: ☐ Singaporean ☐ Singapore PR

Contact No.: (HP) (O) (H) Email Address:

(Please provide at least mobile number)

Occupation: Name of Employer:

Exact Duties: Nature of Business:

Residential Address Block/Street No.: Street Name:

Unit No.: Building Name: Postal/Zip Code: Country:

Correspondence Address *(if different from address above):* Block/Street No.: Street Name:

Unit No.: Building Name: Postal/Zip Code: Country:

For existing policyholder with Aviva Ltd:
(Not applicable to MINDEF/MHA/POGIS)
If the correspondence address differs from our existing records, do you wish to update the correspondence address for all your life and health policy(ies)?

☐ Yes ☐ No

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SECTION B: PARTICULARS OF DEPENDANT(S) (LIFE ASSURED(S))

DEPENDANT 1

Full Name as shown in Identity Card/Eligible Valid Pass: Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr

Family Name: Given Name:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Identity Card/FIN No.: Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others

Date of Birth (DD/MM/YY): Nationality: *(Please list your nationalities)*

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others

Relationship to Proposer: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ***(only Singaporean/Singapore PR can apply as Grandparent/Sibling Dependant)***

Occupation: Name of Employer:

Exact Duties: Nature of Business:

DEPENDANT 2

Full Name as shown in Identity Card/Eligible Valid Pass: Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr

Family Name: Given Name:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Identity Card/FIN No.: Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others

Date of Birth (DD/MM/YY): Nationality: *(Please list your nationalities)*

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others

Relationship to Proposer: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ***(only Singaporean/Singapore PR can apply as Grandparent/Sibling Dependant)***

Occupation: Name of Employer:

Exact Duties: Nature of Business:

DEPENDANT 3

Full Name as shown in Identity Card/Eligible Valid Pass: Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr

Family Name: Given Name:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Identity Card/FIN No.: Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others

Date of Birth (DD/MM/YY): Nationality: *(Please list your nationalities)*

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others

Relationship to Proposer: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ***(only Singaporean/Singapore PR can apply as Grandparent/Sibling Dependant)***

Occupation: Name of Employer:

Exact Duties: Nature of Business:

DEPENDANT 4

Full Name as shown in Identity Card/Eligible Valid Pass: Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr

Family Name: Given Name:

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Identity Card/FIN No.: Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Others

Date of Birth (DD/MM/YY): Nationality: *(Please list your nationalities)*

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others

Relationship to Proposer: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ***(only Singaporean/Singapore PR can apply as Grandparent/Sibling Dependant)***

Occupation: Name of Employer:

Exact Duties: Nature of Business:

SECTION C: PLAN TYPE

MyShield:

If any applicant crosses the age band while the application is being processed, we will charge the higher premium according to the age next birthday.

Please tick ✓ the box according to your plan selection.

MyShield Please do not tick if you have an existing MyShield Plan. This is not applicable for upgrading/downgrading of plan.	**Proposer**	**Dependant 1**	**Dependant 2**	**Dependant 3**	**Dependant 4**
Standard Plan					

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SECTION D: PAYMENT DETAILS

Note:

1. For MyShield, please refer to the Product Summary for the Additional Withdrawal Limits (AWLs) for Singaporeans and Permanent Residents and refer to www.aviva.com.sg for the Medisave Withdrawal Limits (MWLs) for foreigners. We will attempt to deduct the maximum withdrawal amount from the designated CPF Medisave account. **Premium in excess of the applicable withdrawal limits and/or balance premium will be paid by your selected payment method(s) below.**

2. For payment by Interbank GIRO, please complete the attached Application for Interbank GIRO form. For initial premium via GIRO, **the bank account must be a DBS or POSB account**, a single or joint/or account, not a trust/minor account, belongs to the payor of the policy (who is also the policyholder) and the payer's identification number (e.g. NRIC) in our record must be the same as the bank's record.

3. For payment by Credit Card, please complete the section on Visa/Mastercard Authorisation.

MyShield Standard Plan
Payment Frequency: Yearly

Please tick ONE option for both initial and subsequent premium payments

Payment Method	☐	☐	☐	☐
Initial Premium	Credit Card	Interbank GIRO	Cash/Cheque	Cash/Cheque
Subsequent Premium	Interbank GIRO	Interbank GIRO	Interbank GIRO	Cash/Cheque

VISA/MASTERCARD AUTHORISATION

I authorise Aviva Ltd to charge the initial premium(s) to my credit card account for this insurance policy.

Name of Cardholder *(as shown in Identity Card/Eligible Valid Pass)*:

Identity Card/FIN No.:

Card Number: ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐

Card Expiry Date (MM/YY): ☐☐ / ☐☐

Signature of Cardholder:

☐ Visa ☐ Mastercard Issuing Bank:

SECTION E: SOURCE OF WEALTH/FUNDS

Source of Wealth *(Where your wealth is derived from)*

☐ Employment/Trade Income ☐ Rental Income ☐ Investment Income

☐ Others, please specify:

Source of Funds *(Origin of the funds used to pay premiums)*

☐ Employment/Trade Income ☐ Sales of Property ☐ Savings ☐ Maturity or Surrender of Policy

☐ Others, please specify:

Name of Payer *(if different from Assured/Life Assured)*:

Identity Card/Passport No.*:

Payer's Relationship to Assured:

Please provide reason for paying for this policy:

**Please provide a copy of Identity Card/Passport (whichever applicable)*

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SECTION F: REPLACEMENT OF EXISTING INTEGRATED SHIELD PLAN/DECLARATION
(Please complete this Section if you are purchasing MyShield for yourself and/or your dependant(s))

Please tick ✓ the appropriate boxes.	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Is this application to replace or intended to replace your / your dependants' existing Integrated Shield Plan? If **'Yes'**, please complete the table below and answer Question 2.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer:

Name of Plan:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer:

Name of Plan:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer:

Name of Plan:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer:

Name of Plan:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer:

Name of Plan:

2. In answering **'Yes'** to Section F Question 1 for the proposer and/or any of the dependant(s), please tick to confirm the below declaration:

☐ I confirm that my Financial Adviser Representative has explained to my satisfaction the implications associated with this switch/replacement and, based on his/her recommendation, I agree to proceed with the switch/replacement of my existing Integrated Shield Plan. I am aware that each Life Assured can only have one Integrated Shield Plan. Once this policy commences, the existing Integrated Shield Plan covering the Life Assured will be automatically terminated.

☐ My Financial Adviser Representative has explained to me the implications associated with this switch/replacement. I am aware that the implications that may arise from a switch/replacement could outweigh any potential benefit(s) such as:

- The new policy may offer a lower level of benefit at a higher cost or same cost, or offer the same level of benefit at higher cost and, the new policy may be less suitable for me.
- If I am switching to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may lose coverage for those conditions.

SECTION G: UNDERWRITING HISTORY

This section must be fully completed.

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. Have you had an application of a Life, Critical Illness, Health, Accident, Disability policy deferred, declined or required to pay Additional Premiums for MediShield Life? If **'Yes'**, please complete the table below. Note: If you are required to pay Additional Premiums for MediShield Life, please also provide a copy of the CPF MediShield Life Additional Premium Letter.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer: ______ Type of Policy: ______

Reason: ______

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer: ______ Type of Policy: ______

Reason: ______

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer: ______ Type of Policy: ______

Reason: ______

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer: ______ Type of Policy: ______

Reason: ______

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of Insurer: ______ Type of Policy: ______

Reason: ______

SECTION H: UNDERWRITING QUESTIONS

This section must be fully completed.

Any disease or condition of health, which existed before the date of application, will not qualify for benefit unless it is fully disclosed to and accepted by us. You must, therefore, ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the policy commencement date is declared. Should you require more space for your answers, please continue on a separate sheet, sign and date it.

If you are unsure whether any information is material or not, you are advised to disclose it.

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
1. What is your height?	☐ metres	☐ metres	☐ metres	☐ metres	☐ metres
2. What is your weight?	☐ kg	☐ kg	☐ kg	☐ kg	☐ kg
3. Have you **ever** experienced **symptoms** or received **medical advice** or had **treatment** for any of the following conditions (**whether diagnosed or not**)?					
a) Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) High blood pressure or high cholesterol?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Cancer, or malignant tumour/growth/lump/nodule/polyp/cyst of any kind including cancer screening tests that were not normal?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
d) Benign tumour/growth/lump/nodule/polyp/cyst?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e) Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
f) Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
g) Depression, anxiety, stress or any other mental or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
h) Drug or alcohol addiction or abuse?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
i) Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
j) Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
k) Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
l) Hepatitis B or C, fatty liver, jaundice, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
m) AIDS, HIV or sexually transmitted disease?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
n) Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
o) Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
p) Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
q) Any other illness, disorder, operation, physical disability, injury or hospitalisation not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. For application of life assured who is a dependant child (aged one year and below), please answer the following questions:					
a) Were there any significant events during pregnancy or delivery of the child including but not limited to difficulties during or at birth, congenital mental developmental issues, respiratory distress syndrome, prolonged neonatal jaundice, respiratory disorder?	Not Applicable	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b) Was the child a premature baby (i.e. less than 37 weeks of gestation)?	Not Applicable	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
c) Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment?	Not Applicable	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If you answered **'Yes'** to any of questions 4(a) to (c) above, please provide a full copy of the child's Health Booklet and complete the medical condition questionnaire on page 7.					

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If you answered **'Yes'** to either Question 3 or 4 above, please complete the following:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of the **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** ☐ **No** How long since your **full recovery**? ☐ 0 to 6 months ☐ 2 to 3 years ☐ 7 to 12 months ☐ 3 to 5 years ☐ 1 to 2 years ☐ 5 years or more What **treatment** or **medication** did you take?	Name: Address:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of the **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** ☐ **No** How long since your **full recovery**? ☐ 0 to 6 months ☐ 2 to 3 years ☐ 7 to 12 months ☐ 3 to 5 years ☐ 1 to 2 years ☐ 5 years or more What **treatment** or **medication** did you take?	Name: Address:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of the **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** ☐ **No** How long since your **full recovery**? ☐ 0 to 6 months ☐ 2 to 3 years ☐ 7 to 12 months ☐ 3 to 5 years ☐ 1 to 2 years ☐ 5 years or more What **treatment** or **medication** did you take?	Name: Address:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of the **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** ☐ **No** How long since your **full recovery**? ☐ 0 to 6 months ☐ 2 to 3 years ☐ 7 to 12 months ☐ 3 to 5 years ☐ 1 to 2 years ☐ 5 years or more What **treatment** or **medication** did you take?	Name: Address:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of **Condition**	Date of **first** symptoms, diagnosis or recurrence	Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of the **doctor** whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ **Yes** ☐ **No** How long since your **full recovery**? ☐ 0 to 6 months ☐ 2 to 3 years ☐ 7 to 12 months ☐ 3 to 5 years ☐ 1 to 2 years ☐ 5 years or more What **treatment** or **medication** did you take?	Name: Address:

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	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
5. In the **last 5 years**, have you had any **medical test(s) with abnormal results**, such as x-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, prostate check, pap smear or mammogram? If **'Yes'**, please complete the table below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of medical test	Date of initial test	Have you had a follow-up test? ☐ Yes ☐ No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring? ☐ Yes ☐ No	Name and address of the **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	If **'Yes'**, what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	If **'Yes'**, please provide details	Name: Address:

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

Name of medical test	Date of initial test	Have you had a follow-up test? ☐ Yes ☐ No	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring? ☐ Yes ☐ No	Name and address of the **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	If **'Yes'**, what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	If **'Yes'**, please provide details	Name: Address:

	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4
6. Are you currently experiencing **symptoms** or **considering** seeking medical advice or treatment for your health other than minor illnesses such as cold and flu? If **'Yes'**, please complete the table below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

What are the **symptoms** or conditions?	Date of **first** symptoms	Date of any planned medical consultation
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

What are the **symptoms** or conditions?	Date of **first** symptoms	Date of any planned medical consultation
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	

☐ Proposer ☐ Dependant 1 ☐ Dependant 2 ☐ Dependant 3 ☐ Dependant 4

What are the **symptoms** or conditions?	Date of **first** symptoms	Date of any planned medical consultation
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	

SECTION I: PERSONAL DATA CONSENT

Let's stay in touch!

- I agree to be contacted by Aviva (and/or Aviva group of companies or their service providers) for special marketing offers, promotions and information about Aviva's products and services which may be of interest to me. I consent to the collection, use and disclosure of my personal data by Aviva and Aviva group of companies for the above purposes.

  Please tick to provide your consent:
  ☐ By Mail or E-Mail ☐ By SMS ☐ By Telephone Call

  View your policy details anytime, anywhere. Register for MyAviva at www.aviva.com.sg/myaviva.

- On behalf of myself and all proposed Lives Assured, I/we consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data (whether contained in this form or obtained from other sources; existing data in Aviva's record or to be collected in future) for the following purposes:
  - to issue and administer my/our existing and/or new policy(ies) and/or account(s) with Aviva and such other purposes ancillary or related to the administering of the policy(ies) and/or account(s), including the processing of my/our personal data for underwriting purposes, payment of premiums (including, where applicable, the deduction of premiums due from the Medisave accounts of the proposed Lives Assured) and/or claims purposes;
  - for statistical, research, compliance, audit and regulatory purposes; and
  - to provide general information on product enhancements and services relevant to my/our needs or policies (including increasing benefits, adding riders/supplements and/or Lives Assured) as well as to provide financial advice or product recommendations to me/us, where applicable.

- On behalf of myself and all proposed Lives Assured, I/we also consent to Aviva (and Aviva related group of companies) disclosing and transferring my/our personal data to Aviva related group of companies and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

- For more information on Aviva's data protection policy and full details of the purpose of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

SECTION J: E-DOCUMENTS

Let's work together to save the trees.

You will receive your policy, any endorsements and communications electronically after your insurance application is approved and policy is issued. Please provide us with your mobile number and email address, and we will inform you when e-documents are ready for viewing online at www.aviva.com.sg/mydocuments. If e-documents are not available, you will receive printed documents. This will apply to all your individual life and health policies with Aviva.

☐ Please tick here if you wish to continue to receive hard copies of your policy, any endorsements and communications. This will apply to all your individual life and health policies with Aviva.

SECTION K: DECLARATION

AUTHORISATION & DECLARATION BY PROPOSER (CPF ACCOUNT HOLDER)

1. I authorise the Central Provident Fund Board (the **"CPFB"**) to deduct premium(s) due for the Life/Lives to be Insured as named under this application (the **"Life/Lives to be Insured"**) from my Medisave account (including any new Medisave account(s) which I may have arising from obtaining Singapore Permanent Resident status or otherwise) in accordance with the provisions of the Central Provident Fund Act (Chapter 36), the MediShield Life Scheme Act (Act No. 4 of 2015) and the respective subsidiary legislation made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPFB from time to time for the purposes of the Private Medical Insurance Scheme (or by such other name as it may be referred to from time to time) (PMIS).

2. I authorise the CPFB to disclose information/seek information on a confidential basis to/from any Insurer(s) for the PMIS in respect of the insurance cover issued following this application. Such information includes but is not limited to:
   (i) payment and amount of premiums due, including the deduction of premiums from my Medisave account and my Medisave account balance;
   (ii) the making of refunds under the PMIS, as the CPFB shall reasonably consider appropriate; and
   (iii) the amount of premium subsidies for the Life/Lives to be Insured and the amount of additional premium applicable to the Life/Lives to be Insured.

3. (Applicable if Life Assured is the Proposer's sibling) I confirm, warrant and represent that I am responsible for bearing the healthcare costs, including the costs to be covered in respect of the Life/Lives to be insured and I will suffer direct financial loss if any of the events to be insured under this application occurs. Accordingly, I acknowledge and agree that I have an interest in the subject matter and the events to be insured.

4. Subject to the relevant laws and terms and conditions, I understand that:
   (i) Upon the commencement of this MyShield cover, any other existing Integrated Shield Plan (if any) under the PMIS in favour of the Life/Lives to be Insured shall automatically terminate; and
   (ii) Upon the commencement of another Integrated Shield Plan in favour of the Life/Lives to be Insured, this MyShield cover of the Life/Lives to be Insured shall automatically terminate.

5. I confirm that the contents of (a) Your Guide to Health Insurance and Infographic "Evaluating My Health Insurance Coverage"; (b) Product Summary; (c) Fact Find Form have been satisfactorily explained to me and I have received a copy of (b) and (c). I have been informed and directed to view or download a copy of Your Guide to Health Insurance and Infographic "Evaluating My Health Insurance Coverage" from www.aviva.com.sg. (Applicable if you have been advised by a Financial Adviser Representative)

SECTION K: DECLARATION *(continued)*

AUTHORISATION & DECLARATION BY PROPOSER (CPF ACCOUNT HOLDER) *(continued)*

6. I am aware that I can seek advice from a qualified Financial Adviser Representative before I sign this Application Form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate for my financial needs and insurance objectives. I have read a copy and understand the contents of the Your Guide to Health Insurance and Infographic "Evaluating My Health Insurance Coverage" which are found at www.aviva.com.sg. I understand that if I decide that the Policy is not suitable for me after purchasing the Policy, I have the right to cancel the Policy and obtain a refund of any premium paid (less any expenses incurred in assessing the risk under the Policy), by giving written notice to Aviva Ltd within 21 days (free-look period) from the date of receipt of the Policy. If the Policy was sent to me by post, I will be considered to have received it seven (7) days from the date of posting. (Applicable to Direct Marketing)

7. I am aware that the product I am applying for is authorised for sale in Singapore and I acknowledge that I am responsible for ensuring that the laws and regulations applicable to my nationality and country of residence allows my purchase of this product. I understand that no liability can be accepted by Aviva Ltd for any legal consequences under the laws of any other country or any tax implications that may arise in connection with my purchase of this product. I am also responsible for my own tax affairs and hereby declare that I have not been convicted of any serious tax crimes.

8. I declare that I have not been the subject of any proceedings of a criminal nature or have been notified of any potential proceedings or of any investigation which might lead to those proceedings, or have been convicted of a criminal offence, or is being subject to any pending proceedings which may lead to such a conviction, under any law in any jurisdiction.

9. I further declare that I am not an undischarged bankrupt and that I have committed no act of bankruptcy within the last twelve months and no receiving order or adjudication order in bankruptcy has been made against me during that period.

10. I am aware and agree that I make/provide these declarations and authorisations on behalf of myself and all dependants who are below 16 years old. (where applicable)

AUTHORISATION & DECLARATION BY PROPOSER AND/OR DEPENDANTS

1. I/We, the Life/Lives to be Insured named under this application, hereby consent to the transfer and disclosure, at any time and without notice to me/us, of any medical information on me/us, in the Insurer's possession, between the Insurer and other Insurers administering or operating the PMIS, for the purpose of assessing the insurability of me/us and/or the making of a claim under the PMIS.

2. I/We, the Life/Lives to be Insured named under this application, hereby consent to the transfer and disclosure, at any time and without notice to me/us, of any medical information on me/us, in the Insurer's or the CPFB's possession, between the Insurer and the CPFB for the purpose of assessing the insurability of me/us and/or the making of a claim under the PMIS.

3. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

4. I/We declare that all the information on this Application Form is true and complete and to the best of my/our knowledge and understand that:
   (a) any misrepresentation or concealment of facts shall render the policy to be issued and any other policy which I/we have with Aviva Ltd to which the information applies null and void.
   (b) if any information disclosed to Aviva Ltd (whether on this Application Form or otherwise) disagrees with any information disclosed to Aviva Ltd on another application form or otherwise, I/we shall answer all questions and provide all documentation which Aviva Ltd may require; and if a Pre-Existing Condition is found, Aviva Ltd may, in its absolute discretion: impose conditions (including but not limited to permanent exclusion of the Pre-Existing Condition), void or terminate my/our policy or reject my/our application.

5. I/We agree to inform Aviva Ltd if there is any change in state of my/our and/or any dependant's health/activities between the date of this application and the date full insurance coverage is provided by Aviva Ltd to me/us and/or any dependant. I/We understand the terms of accepting me/us and/or any dependant as a risk for insurance coverage may vary accordingly to such information received.

6. I/We authorise any medical source, insurance office, or organisation to release to Aviva Ltd and Aviva Ltd to release to any medical source, insurance office or organisation, to the extent permitted by law, all relevant information concerning me/us and/or any proposed life assured at any time, regardless of whether the application is accepted by Aviva Ltd. A photographic or electronic copy of this authorisation shall be as valid as the original.

7. I/We understand and agree that Aviva Ltd is entitled not to accept or process this application should a person connected with the relevant Policy be found to be a Prohibited Person. A Prohibited Person means a person or entity (including any director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, beneficiaries, or my/our beneficial owners or beneficiaries' beneficial owners therein) subject to any laws, regulations and/or sanctions administered by any regulatory authorities in any country, which have the effect of prohibiting Aviva Ltd from providing insurance coverage, transaction business with or otherwise offering any economic benefits to me/us or any other beneficiaries or assignees under the relevant Policy. The decision of Aviva Ltd shall be final.

8. I/We further agree that in the event that Aviva Ltd becomes aware subsequently that a person connected with the relevant Policy has become a Prohibited Person, Aviva Ltd may block and/or terminate the relevant Policy, including but not limited to, making or receiving any payments under the relevant Policy. As an ongoing obligation, I/we will immediately inform Aviva Ltd if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons. If an application is accepted or processed by Aviva Ltd despite a person connected with the relevant Policy being a Prohibited Person, Aviva Ltd shall be entitled to block/or terminate the relevant Policy at any time, whether with effect from inception of the relevant Policy or otherwise.

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SECTION K: DECLARATION *(continued)*

AUTHORISATION & DECLARATION BY PROPOSER AND/OR DEPENDANTS *(continued)*

9. I/We declare that my/our Financial Adviser Representative has advised me/us that:
   All Singapore Citizens and Permanent Residents will be covered by MediShield Life, regardless of my/our decision on an Integrated Shield Plan. An Integrated Shield Plan comprises two parts - a MediShield Life portion provided by the Central Provident Fund Board (CPFB) and an additional private insurance coverage provided by Aviva Ltd. I/We am/are aware and have considered the long-term financial commitments to pay the premiums. As Integrated Shield Plan premiums are higher than MediShield Life premiums, there should be sufficient monies in my/our Medisave account(s) or I/we should have enough cash to pay for MediShield Life premiums on an ongoing basis before I/we consider purchasing an Integrated Shield Plan.

10. If I/we opt to receive my/our policy, endorsements and communications electronically (**"e-docs"**), I/we agree that:
    (a) my/our e-docs will be made available in my/our MyAviva account; and
    (b) an e-doc is deemed to have been received by me/us upon my receipt of the SMS and/or email that it is accessible on MyAviva. The SMS or email will be sent to the last known mobile number and/or email address notified to Aviva.

11. If my/our policy, any endorsements or communications is mailed, I/we am/are deemed to have received it 7 days from the date of posting to the last known address notified to Aviva.

12. I/We represent, warrant and undertake that:
    (a) my/our mobile number, address and email address notified to Aviva is correct and complete;
    (b) I/we will notify Aviva immediately of any change to my/our mobile number, address or email address; and
    (c) I/we shall indemnify Aviva for any losses, damages or other consequences arising from or in connection with any incomplete or incorrect mobile number, address and email address.

WARNING:

Anyone who pays for, or is insured under MyShield Standard Plan is not eligible for Additional Premium Support (APS) from the Government.*

If you are currently receiving APS to pay for your MediShield Life and/or CareShield Life premiums, and you choose to be insured under this MyShield Standard Plan, you will stop receiving APS. This applies even if you are not the person paying for this MyShield Standard Plan.

In addition, if you choose to be insured under this MyShield Standard Plan, the person paying for MyShield Standard Plan will stop receiving APS, if he or she is currently receiving APS.

****APS is for families who need assistance with MediShield Life and/or CareShield Life premiums, even after receiving premium subsidies and making use of MediSave to pay for these premiums.***

Important Notes:
If a material fact is not disclosed in this application, any policy issued and any policy which you have with Aviva Ltd to which the material fact applies 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 Adviser Representative but was not included in the 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 proposal, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

Signature of Proposer:

Name:

Date of Signature (DD/MM/YY):

Signature of all Dependants who are 16 years old and above.

Signature of Dependant 1:

Signature of Dependant 2:

Signature of Dependant 3:

Signature of Dependant 4:

Signature of Financial Adviser Representative:
I confirm that I have sighted the original(s) of my customer's identification document(s) (if applicable).

Name of Financial Adviser Representative:

Date of Signature (DD/MM/YY):

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MyShield Standard Plan A Medisave-approved Integrated Shield Plan
Underwritten by Aviva Ltd

PRODUCT SUMMARY

* B I *

AVIVA

Date: ☐☐/☐☐/☐☐ **(DD/MM/YY)**

Presented to: _____
(Name of Proposer)

Name of Financial Adviser Representative: _____

Signature of Proposer: _____

Signature of Financial Adviser Representative: _____

'You/ Your' means the owner of the policy who is named as the assured in the policy schedule. 'Life assured' means the person named as the life assured in the policy schedule. 'We/ Us/ Our' means Aviva Ltd.

Warning:

Anyone who pays for, or is insured under MyShield Standard Plan is not eligible for Additional Premium Support (APS) from the Government.*

If you are currently receiving APS to pay for your MediShield Life and/or CareShield Life premiums, and you choose to be insured under this MyShield Standard Plan, you will stop receiving APS. This applies even if you are not the person paying for this MyShield Standard Plan.

In addition, if you choose to be insured under this MyShield Standard Plan, the person paying for MyShield Standard Plan will stop receiving APS, if he or she is currently receiving APS.

**APS is for families who need assistance with MediShield Life and/or CareShield Life premiums, even after receiving premium subsidies and making use of MediSave to pay for these premiums.*

DESCRIPTION OF PRODUCT

MyShield Standard Plan is a medical insurance plan which covers the life assured for costs associated with hospital stay, surgery and major outpatient treatment. Your policy will be integrated with MediShield Life. It adds to the MediShield Life tier operated by the CPF (Central Provident Fund) Board and provides higher benefits for those who would like more coverage and medical insurance protection. For more details on MediShield Life and how it works with Aviva's MyShield, you can visit https://www.medishieldlife.sg

MyShield Standard Plan is available for coverage of Singapore citizens or Singapore permanent residents only.

PLAN FEATURES AND BENEFITS

1. Comparison of Benefits between MediShield Life and MyShield Standard Plan

A MyShield Standard Plan policy is made up of two parts – a MediShield Life portion provided by the CPF Board and additional private insurance coverage provided by us. The full MyShield Standard Plan premium comprises the MediShield Life premium and your MyShield's Standard Plan additional coverage premium.

In the event of hospitalisation/medical treatment, your final payout will comprise the MediShield Life payout and the MyShield Standard Plan additional coverage payout. For example,

- if the payout computed based on the full MyShield Standard Plan benefits is S$2,000, and the payout based on MediShield Life benefits is S$500, the policyholder will receive S$2,000, which comprises S$500 from the MediShield Life payout, and S$1,500 from the MyShield Standard Plan additional coverage payout.
- In the case where the payout based on MediShield Life benefits is higher than that from the MyShield Standard Plan benefits, the eventual payout will be based on the MediShield Life benefits.

Benefits Schedule in SG Dollars		
Benefit Parameters	**MyShield Standard Plan** (payout includes MediShield Life payout)	**MediShield Life** (as of March 2021)
Hospital ward type	Any 4-bed standard ward of a restructured hospital	Any 6-bed (B2) standard ward of a restructured hospital
Inpatient hospital treatment		
Daily room, board and medical related services[1]	S$1,700 per day	S$800 per day (S$1,000 per day for first 2 days)
Intensive care unit (ICU)[1]	S$2,900 per day	S$2,200 per day (S$2,400 per day for first 2 days)

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Benefits Schedule in SG Dollars *(continued)*				
Benefit Parameters	**MyShield Standard Plan** (payout includes MediShield Life payout)	**MediShield Life** (as of March 2021)		
Hospital ward type	Any 4-bed standard ward of a restructured hospital	Any 6-bed (B2) standard ward of a restructured hospital		
Inpatient hospital treatment				
Surgical benefit[2] (per surgery)		**A**	**B**	**C**
Table 1 A/B/C (less complex procedures)	S$590	S$240	S$340	S$340
Table 2 A/B/C	S$1,670	S$580	S$760	S$760
Table 3 A/B/C	S$3,290	S$1,060	S$1,160	S$1,280
Table 4 A/B/C	S$4,990	S$1,540	S$1,580	S$1,640
Table 5 A/B/C	S$8,760	S$1,800	S$2,180	S$2,180
Table 6 A/B/C	S$11,670	S$2,360	S$2,360	S$2,360
Table 7 A/B/C (more complex procedures)	S$16,720	S$2,600	S$2,600	S$2,600
Surgical implants and medical consumables[3]	S$9,800 per admission	S$7,000 per admission		
Radiosurgery[4]	S$9,600 per procedure	S$10,000 per treatment course		
Stay in a community hospital[5] (Rehab)	S$650 per day	S$350 per day		
Stay in a community hospital[5] (Sub-acute)		S$430 per day		
Inpatient psychiatric treatment	S$500 per day up to 35 days per policy year	S$160 per day up to 60 days per policy year		
Major outpatient treatment				
Outpatient kidney dialysis	S$2,750 per month	S$1,100 per month		
Outpatient erythropoietin	S$450 per month	S$200 per month		
Outpatient cancer treatment which includes:				
– Chemotherapy	S$5,200 per month	S$3,000 per month		
– External or superficial radiotherapy (hemi-body radiotherapy)	S$550 per treatment	S$900 per treatment		
– External or superficial radiotherapy (except hemi-body radiotherapy)		S$300 per treatment		
– Brachytherapy, with or without external radiotherapy	S$1,100 per treatment	S$500 per treatment		
– Stereotactic radiotherapy	S$1,800 per treatment	S$1,800 per treatment		
Major organ transplant-approved Immunosuppressant drugs	S$1,200 per month	S$550 per month		

Pro-ration factor				
		Singapore Citizen (SC) / Singapore Permanent Resident (SPR)	SC	SPR
Restructured hospital	Class C ward	100%	100%	44%
	Class B2 ward	100%	100%	58%
	Class B2+ ward	100%	70%	47%
	Class B1 ward	100%	43%	38%
	Class A ward	80%[6]	35%	35%
	Subsidised short stay ward	100%	100%	58%
	Unsubsidised short stay ward	100%	35%	35%
	Subsidised day surgery	100%	100%	58%
	Unsubsidised day surgery	100%	35%	35%
	Subsidised major outpatient treatment	100%	100%	67%
	Unsubsidised major outpatient treatment	100%	50%*	50%*
Private hospital	Inpatient	50%[6]	25%	25%
	Day surgery	65%[6]	25%	25%
	Major outpatient treatment	65%[6]	50%*	50%*

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Benefits Schedule in SG Dollars *(continued)*				
Benefit Parameters		**MyShield Standard Plan** (payout includes MediShield Life payout)	**MediShield Life** (as of March 2021)	
Hospital ward type		Any 4-bed standard ward of a restructured hospital	Any 6-bed (B2) standard ward of a restructured hospital	
Pro-ration factor				
		Singapore Citizen (SC) / Singapore Permanent Resident (SPR)	SC	SPR
Community hospital	Class C ward	100%	100%	50%
	Class B2 ward	100%	100%	50%
	Class B2+ ward	100%	100%	50%
	Class B1 ward	100%	50%	50%
	Class A ward	80%[6]	50%	50%
Annual deductible[7] for life assured age 80 years and below next birthday				
Inpatient				
Class C ward		S$1,500	S$1,500	
Class B2 / B2+ ward		S$2,000	S$2,000	
Class B1 ward		S$2,500		
Class A ward / Private hospital		S$2,500		
Subsidised day surgery / short stay ward		S$1,500	S$1,500	
Unsubsidised day surgery / short stay ward		S$2,000		
Annual deductible[7] for life assured age 81 years and above next birthday				
Inpatient				
Class C ward		S$2,000	S$2,000	
Class B2 / B2+ ward		S$3,000	S$3,000	
Class B1 ward		S$3,000		
Class A ward / Private hospital		S$3,000		
Subsidised day surgery / short stay ward		S$3,000	S$2,000	
Unsubsidised day surgery / short stay ward		S$3,000		
Co-insurance				
All ward classes and day surgery claimable amount[8]				
Inpatient (including day surgery)	S$0 - S$3,000	10% (applicable to claimable amount after deductible)	10%	
	S$3,001 - S$5,000		10%	
	S$5,001 - S$10,000		5%	
	>S$10,000		3%	
Major outpatient treatment[9]			10%	
Maximum Claim Limits				
Policy year limit		S$150,000	S$150,000	
Lifetime limit		Unlimited	Unlimited	
Age Limits (age next birthday)				
Last entry age		None	None	
Maximum coverage age		Lifetime	Lifetime	

Footnotes

1 Includes treatment fees, meals, prescriptions, medical consumables, doctor's attendance fees, medical examinations, laboratory tests and miscellaneous medical charges.

2 Classified according to their level of complexity, which increases from Table 1 to Table 7.

3 Includes:
- Intravascular electrodes used for electrophysiological procedures
- Percutaneous Transluminal Coronary Angioplasty (PTCA) Balloons
- Intra-aortic balloons (or Balloon Catheters)
- Intraocular lens for cataracts

4 Radiosurgery includes Novalis radiosurgery and Gamma Knife treatments which can be performed as an inpatient or day surgery procedure. The applicable annual deductible and pro-ration factor for radiosurgery will depend on its classification as an inpatient or day surgery procedure.

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Footnotes

[5] Upon referral from the attending doctor in a restructured hospital/private hospital for immediate admission to a community hospital for continuous stay. The treatment in the community hospital must arise from the same injury or illness that resulted in the life assured's inpatient treatment in the restructured hospital or private hospital.

Rehabilitative care refers to therapy to improve the life assured's post-illness disability and functional impairment. Sub-acute care is for complicated medical conditions that require additional medical and nursing care at a lower intensity compared to that provided at the acute hospitals.

[6] Pro-ration factor is applied to reduce higher class wards/private hospital bills to Singapore restructured hospital 4-bed ward equivalent in the claims computation. This is not applicable to expenses incurred for major outpatient treatment and day surgery at a Singapore restructured hospital and for major outpatient treatment at a subsidised dialysis or cancer centre in Singapore.

[7] Annual Deductible is waived for major outpatient treatments.

[8] Claimable amount is the lower of (i) the claim limit in the table or (ii) the amount after adjusting the charges for pro-ration, if needed.

[9] Co-insurance for major outpatient treatments is 10% of a percentage of the charges incurred.

*Note: Pro-ration for unsubsidised outpatient cancer treatments will be applicable from 1 Nov 2016 onwards. Dialysis-related treatment and immunosuppressants will not be pro-rated.

PLAN FEATURES AND BENEFITS

2. Premium Rates

We calculate the premium you have to pay based on the life assured's age next birthday.

We may deduct your premium from the designated Medisave account according to the act and regulations and the CPF Act and any subsidiary legislation under the CPF Act, as may be amended, extended or re-enacted from time to time.

You must pay the premium or any part of it in cash if:

a. the premium you owe is more than the maximum Additional Withdrawal Limit set by the CPF Board;
b. there are not enough funds in your Medisave account to pay the premium due; or
c. the premium, or part of it is not taken from the designated Medisave account for any reason.

Breakdown of Standard Premiums for MyShield Standard Plan

The table below shows the breakdown of premiums for a standard life^:

For Singapore Citizens / Singapore Permanent Residents

MyShield Standard Plan Annual premium per person in SG Dollars (inclusive of 7% GST). Premium rates are non-guaranteed.				
Age Next Birthday	**MediShield Life Premiums (Fully payable by Medisave*)**	**Additional Private Insurance Coverage**		
		Premiums	**Additional Withdrawal Limits**	**Cash Outlay**
1 to 20	145.00	65.27	300.00	0.00
21 to 30	250.00	66.34	300.00	0.00
31 to 40	390.00	87.74	300.00	0.00
41 to 45	525.00	118.77	600.00	0.00
46 to 50	525.00	132.68	600.00	0.00
51 to 55	800.00	159.43	600.00	0.00
56 to 60	800.00	162.64	600.00	0.00
61 to 65	1,020.00	281.41	600.00	0.00
66 to 70	1,100.00	391.62	600.00	0.00
71 to 73	1,195.00	622.74	900.00	0.00
74 to 75	1,320.00	723.32	900.00	0.00
76 to 78	1,530.00	966.21	900.00	66.21
79 to 80	1,590.00	970.49	900.00	70.49
81 to 83	1,675.00	1,188.77	900.00	288.77
84 to 85	1,935.00	1,196.26	900.00	296.26
86 to 88	2,025.00	1,728.05	900.00	828.05
89 to 90	2,025.00	1,799.74	900.00	899.74
91 to 93	2,055.00	1,947.40	900.00	1,047.40
94 to 95	2,055.00	2,025.51	900.00	1,125.51
96 to 98	2,055.00	2,105.76	900.00	1,205.76
99 and up	2,055.00	2,188.15	900.00	1,288.15

^ *A standard life is a life assured who, at point of proposal, does not have any pre-existing conditions.*

* *Your MediShield Life premiums may differ depending on your premium subsidies, premium rebates and whether you need to pay for the Additional Premiums. The net MediShield Life Premium Payable after accounting for these is fully payable by Medisave.*

The total distribution cost of this product is 41% of additional private insurance premium for the first year and 5% of additional private insurance premium for renewal years.

PLAN FEATURES AND BENEFITS

3. Pro-ration Factor

We will apply the pro-ration factor if the life assured is admitted as an inpatient to a room or hospital above what he is entitled to under your policy or receive major outpatient treatment at a private hospital or medical institution. Pro-ration factor means the percentage shown in the benefits schedule.

4. Annual Deductible

Annual deductible applies to all claims made under your policy except for major outpatient treatment. Annual deductible means the cumulative total amount of medical expenses which you have to bear during any one policy year before any benefits are payable under your policy as shown in the benefits schedule.

5. Co-insurance

Co-insurance applies to all claims made under your policy. Co-insurance means the amount that you need to co-pay on the claimable amount after the annual deductibles have been paid. The co-insurance percentages for the benefits are shown in the benefits schedule.

6. Eligibility

To be eligible for MyShield Standard Plan, you must:
- be a Singapore citizen or Singapore permanent resident; and
- have a Medisave account;

and the life assured must be a Singapore citizen or Singapore permanent resident.

Your dependants are also eligible for cover as long as they are Singapore citizens or Singapore permanent residents. A new-born is eligible for cover 15 days after birth or after discharge from hospital, whichever is later.

7. Guaranteed renewal

We will renew your policy automatically every year. We guarantee to do this for life as long as:
a. we receive the premium before the grace period ends;
b. the cover for the life assured has not been ended.

8. When your policy ends

Your policy automatically ends on the date:
a. the life assured dies;
b. we receive your written notice requesting cancellation of your policy;
c. we do not receive your premium after the grace period;
d. you fail to give us any information or document which we require from you, which date will be determined by us;
e. you fail or refuse to refund any amount you owe us, which date will be determined by us;
f. fraud takes place;
g. you do not reveal information or misrepresent to us;
h. you or the life assured does not fulfill the eligibility requirements;
i. the cover of your policy ends; or
j. you take up another Medisave-approved integrated shield plan covering the life assured;

whichever is earlier.

ADDITIONAL INFORMATION

1. The Contract

This Product Summary provides you with an overview of the plan. The Policy Terms and Conditions provides the full terms and conditions of this plan.

2. Underwriting

Full medical underwriting only. You need to complete a medical history declaration giving details of the life assured's medical history existing before application for this policy, including any pre-existing conditions.

3. Pre-existing Conditions

'Pre-existing condition' means any illness, injury, condition or symptom:
- for which the life assured asked for or received treatment, medication, advice or diagnosis from a doctor before the cover start date, the last reinstatement date, or if you change your plan to another MyShield plan, the cover start date of the new MyShield plan, whichever is later;
- which existed or were evident before the cover start date, the last reinstatement date, or if you change your plan to another MyShield plan, the cover start date of the new MyShield plan, whichever is later, and would have led a reasonable and sensible person to seek medical advice or treatment; or
- which was foreseeable or known, by you or the life assured, to exist before the cover start date, the last reinstatement date, or if you change your plan to another MyShield plan, the cover start date of the new MyShield plan, whichever is later, whether or not the life assured asked for treatment, medication, advice or diagnosis.

All pre-existing conditions are excluded under your policy unless you have declared the pre-existing condition and it has been accepted by us in writing.

Aviva Ltd 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 • Tel: (65) 6827 7988 • Fax: (65) 6827 7900 • Website: www.aviva.com.sg
Company Reg. No.: 196900499K GST Reg. No.: MR-8500166-8

ADDITIONAL INFORMATION

4. Exclusions

The following treatment items, procedures, conditions, activities and their related or consequential expenses are not covered under your policy. However, some of these exclusions may be covered under MediShield Life. For exclusions that are covered under MediShield Life, we will deal with your claim according to the terms and conditions and benefit limits of MediShield Life. If we say that because of an exclusion or any other term or condition of your policy, any loss, damage, cost or expense is not covered by your policy, the burden is on you to prove otherwise.

a. all expenses for treatment as an inpatient, if the life assured was admitted to the hospital before the cover start date;

b. any pre-existing condition (unless we cover it);

c. overseas medical treatment;

d. transport for trips made for the purpose of obtaining medical treatment such as ambulance fees, emergency evacuation, sending home a body or ashes;

e. private nursing charges and nursing home services;

f. hospitalisation for diagnosis, diagnostic examinations, general physical or medical check-ups;

g. routine medical examinations or check-ups;

h. vaccinations, medical certificates, examinations for employment or travel, routine eye or ear examinations, hearing aids, spectacles, contact lenses and correction for refractive errors of the eye;

i. elective cosmetic treatments and plastic surgery unless such surgery is necessary for:
   - the repair of damage caused by an accident and such surgery must be done within 365 days from the date of accident; or
   - breast reconstruction after mastectomy due to breast cancer. The breast reconstruction must be done within 365 days from the date of mastectomy. Any surgery or reconstruction of the other breast to produce a symmetrical appearance will not be covered.

j. any treatment claimed to prevent illness, promote health or improve bodily function or appearance including but not limited to vitamins, supplements, scar creams, soaps and moisturisers;

k. dental treatment or oral surgery related to teeth (unless a dental or oral surgery is required as a result of an accident);

l. rest cures and services or treatment at any home, spa, hydro or aqua clinic, sanatorium, hospice or long-term care facility that is not a hospital;

m. infertility, contraception, sterilisation, impotence, sexual dysfunction or assisted conception tests or treatments or sex change operations;

n. treatment or surgical procedures done at fertility clinics or centres and reproductive medicine clinics or centres;

o. pregnancy, childbirth, miscarriage, abortion or termination of pregnancy, or any form of related hospitalisation or treatment;

p. treatment for obesity, weight reduction, weight improvement or procedure for weight management;

q. treatment for birth defects, including hereditary conditions and disorders and congenital anomalies;

r. prosthesis, corrective devices and medical appliances which are not surgically required including the buying or renting of the following for use at home or as an outpatient:
   - braces;
   - special/medical appliances which are not necessary for the completion of a surgical operation, including location, transport and associated administrative costs of such appliances;
   - durable medical equipment and machines;
   - corrective devices;
   - wheelchairs;
   - walking aids;
   - home aids;
   - kidney dialysis machines;
   - iron lungs;
   - oxygen machines;
   - hospital beds;
   - any other hospital type equipment;
   - replacement organs.

s. treatment that is not scientifically recognised by western European or North American standards, including alternative and complementary treatment;

t. costs relating to cornea, muscular, skeletal or human organ or tissue transplant (unless we cover it under surgical benefit or major organ transplant – approved immunosuppressant drugs);

u. all costs relating to the stem cell transplant such as costs of harvesting, laboratory tests, investigations, storage, transport and cell culture;

v. treatment for self-inflicted injury, attempted suicide, suicide, drug or alcohol abuse or misuse;

w. treatment for psychological, emotional or mental problems or conditions (unless we cover it under inpatient psychiatric treatment);

x. experimental or pioneering medical or surgical techniques and medical devices not approved by MOH and the Centre of Medical Device Regulation and clinical trials for medicinal products which are prescribed or recommended by the doctor even though usual and customary treatment for the condition is available;

y. injury or illness arising from or in connection with any illegal act such as imprisonment;

z. injury or illness arising directly or indirectly from or in connection with engagement or involvement in any hazardous activities or sports when remuneration or income could or would be earned or in a professional or competitive pursuit full-time, part-time, contractual or ad hoc basis other than for leisure or as a hobby;

aa. costs arising out of any litigation or dispute between the life assured and any medical personnel or establishment from whom treatment has been sought or given, or any other costs not directly and specifically related to the payment of the medical expenses covered by your policy;

bb. any loss or damage, cost or expense of whatever nature that is caused directly or indirectly by, results from or is connected to the following even if some other cause or event may contribute to the loss:

(i) ionizing radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from the burning of nuclear fuel;

(ii) radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component;

(iii) any weapon of war using atomic or nuclear fission or fusion or other reaction of radioactive force or matter;

cc. death, disability, loss, damage, destruction, legal liability, cost or expense including consequential loss which is directly or indirectly caused by, results from or is connected to the following even if some other cause or event may contribute to the loss:

(i) war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war is declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions or amounting to an uprising, military or usurped power; or

(ii) any act of terrorism including but not limited to:

- the use or threat of force or violence;
- harm or damage to life or property (or the threat of harm or damage) including nuclear radiation or contamination by chemical or biological agents or any person or group of persons, which are carried out for political, religious, ideological or similar purposes, to put the public or a section of the public in fear; or
- any action taken to control, prevent, suppress or in any way relating to (i) or (ii);

(iii) strikes and riots.

dd. sexually transmitted diseases and any treatment or test connected with human immunodeficiency virus (HIV) infection-related conditions or diseases, except:

(i) HIV infection acquired through blood transfusion in Singapore; or

(ii) HIV acquired while performing regular professional duties in a medical profession in Singapore;

ee. charges for non-medical goods or services such as telephone, television or newspapers.

ff. All outpatient medical expenses (unless we cover it under major outpatient treatment).

5. Full Disclosure

Up to the cover start date or the last reinstatement date or, if you change your plan to another MyShield plan, on the cover start date of your new MyShield plan, whichever is later, you and the life assured must disclose to us fully and truthfully, all material facts and circumstances about the life assured that may influence our decision whether or not to cover him or to impose further terms and conditions on your policy.

If you do not give us this information or misrepresent any information, we may:

- declare your policy "void" from the cover start date or the last reinstatement date (whichever is applicable); or
- end the cover for the life assured.

If the event above happens, we will refund you all premiums paid to us only if you have not made any claim under your policy. If you have made a claim under your policy before it becomes void, we will calculate the premium to be refunded from the first policy year immediately following the policy year in which you made the last claim under your policy. If the life assured was covered under MediShield Life or a Medisave-approved Integrated Shield Plan with another insurer before, the life assured's MediShield Life cover will continue.

6. Upgrading or Switching of Plan

The life assured can only have one Integrated Shield Plan. Once this policy commences, the life assured's previous Integrated Shield Plan (if any) will be automatically terminated. Where applicable, the life assured's health will be assessed by us. If the life assured is not in good health, we may:

- decline your application; or
- not provide the life assured with certain benefits.

If the life assured is currently holding an Integrated Shield Plan with another insurer and is switching to this plan with us, and he has existing medical conditions that are currently covered by the existing plan, he may lose coverage for his existing medical conditions.

In the event that you cannot afford, or do not wish to continue paying the premiums for the life assured's Integrated Shield Plan, you can cease the life assured's Integrated Shield Plan. If you are a Singapore citizen or Singapore permanent resident, regardless of your decision, the life assured will continue to be covered by MediShield Life for life without any exclusion.

7. Change of Policy Terms or Conditions

We may change the benefits, cover, premiums or terms and conditions of your policy (as long as the changes apply to all policies of the same class). We will give you at least 30 days' written notice before we do so.

8. Cancel Your Policy

You may cancel the policy with effect from any renewal date by giving us at least 30 days' written notice of your intention not to renew your policy. The life assured's cover under your policy will end on the renewal date.

You may also cancel your policy during the policy year and after the free look period by giving us at least 30 days' written notice. We will refund you the pro-rated premium for the unexpired period of coverage.

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ADDITIONAL INFORMATION

9. Claims

Any benefits payable under the policy are made to you, your legal representative, the hospital or such other authorised parties (as the case may be). We will not make any payment in respect of any claim incurred unless full premium has been received by us.

Please contact your Financial Adviser Representative or visit the FAQs section in www.aviva.com.sg/myshield for claim procedures.

10. Other Insurance

If you or the life assured have other medical insurance policies (including medical benefits under any employment contract) which allows you or them to claim a refund for medical expenses, you or the life assured, must first claim from these policies before making any claim under your policy. Our obligations to pay under your policy will only arise after you have fully claimed under these policies.

If we have paid any benefit to you first before you make a claim under the other medical insurance policies, the other medical insurers or your employer must refund us their share. You must file your claim with the other medical insurers or your employer so that we can get back their share of the claim we have paid.

For every claim, the total reimbursement we make will not be more than the expenses actually paid.

11. Free Look

If we are issuing this policy to you for the first time, we give you a free-look period of 21 days from the date you received your policy to decide if you want to continue with your policy. If you do not want to continue with your policy, you may write to us to cancel it. As long as you have not made any claim under your policy, we will cancel your policy from its cover start date and refund all premiums paid, without interest. You are assumed to have received the policy within seven days after we have sent it by post.

12. Point-of-Sale Documents

A copy of the following documents is provided at the point-of-sale:

- Product Summary
- Fact Find
- Your Guide to Health Insurance and Infographic "Evaluating My Health Insurance Coverage" (if applicable)

13. Note

The above is merely a summary of the plan offered. The precise terms and conditions of the plan are set out in the policy contract.

You may wish to seek advice from a Financial Adviser Representative before making a commitment to purchase the plan. In the event that you choose not to seek advice from a Financial Adviser Representative, you should consider whether the plan in question is suitable for you. Buying a health insurance policy that is not suitable for you may impact your ability to finance your future healthcare needs.

14. Policy Owners' Protection Scheme

This policy is protected under the Policy Owners' Protection Scheme, and is administered by the Singapore Deposit Insurance Corporation (SDIC). Cover 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 cover, where applicable, please contact us or visit the LIA or SDIC web-sites (www.lia.org.sg or www.sdic.org.sg).

15. Details of Insurer

This plan is underwritten by Aviva Ltd, part of Aviva plc. Website: **www.aviva.com.sg**

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APPLICATION FOR INTERBANK GIRO

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Important Notes:

1. Please provide all information to avoid unnecessary delay in the processing of the application.
2. Amendments made on this form must be countersigned by Account Holder. The use of correction tape/fluid is not allowed.
3. Please provide relationship if Account Holder is different from Policy Owner and submit the Account Holder's identification together with the application.
4. The approval process for the GIRO application will take approximately one month by bank.
5. For POSB/DBS Account Holders, you can apply for GIRO via iBanking. Go to Pay (Bills and Card) ➔ Add GIRO Arrangement ➔ Select Billing Organisation as *Aviva Ltd-Life 1* (for Life policy, MyCare, MyCare Plus, MyLongTermCare, MyLongTermCare Plus) or *Aviva IND HEALTH INS* (for MyShield, MyHealthPlus).
6. Before you receive our notification on GIRO approval, please continue to pay your premium in the usual manner.

By completing this Application Form, I/We am/are instructing and authorising:

a. Aviva to debit my/our bank account to pay for my policy/policies.
b. The Bank to reject Aviva's debit instruction if my/our account does not have sufficient funds and charge me/us a fee for this. The Bank may also at Aviva's 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 Aviva.

Personal Data Consent

I/We consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Aviva.

I/We also consent to Aviva (and Aviva related group of companies) transferring my/our personal data to Aviva related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit http://www.aviva.com.sg/pdpa.html.

Please complete this form and return original form to Aviva Ltd ("Aviva")

Date (dd/mm/yyyy):

Billing Organisation: Aviva Ltd

Bank Name (please tick one bank below):

☐ POSB/DBS ☐ OCBC ☐ UOB ☐ Citibank
☐ Maybank ☐ RHB ☐ HSBC (Corporate)
☐ Standard Chartered ☐ HSBC (Personal)
☐ **Others**: _____

Signature(s) / Thumbprint(s) ^ *(as in Bank's Record)*:

Bank Account Number:

^For thumbprint, please go to any branch of your bank with identification for verification.

Bank Account Holder's Name(s): Mr/ Mdm/ Ms/ Dr	**Account Holder's NRIC(s):**	**Contact Number:**

Policy Number(s)*	**Policy Owner's NRIC No.**	**Relationship to Account Holder**

**Please write the Policy Number(s) which you wish to apply for GIRO using this bank account number only*

For Aviva's Completion

SWIFT BIC	Aviva's Bank Account No.
DBSSSGSGXXX	**0270007597**

Please use above SWIFT BIC for following reference no(s).

SWIFT BIC	Aviva's Bank Account No.
DBSSSGSGXXX	**0039001886**

Please use above SWIFT BIC for following reference no(s).

For Bank's Completion

To : Aviva Ltd

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

☐ Signature/Thumbprint# differs/irregular# from bank's records
☐ Signature/Thumbprint# is incomplete/unclear#
☐ Account operated by Signature/Thumbprint#
☐ Wrong account number
☐ Amendments not countersigned by customer
☐ Others: _____

please delete where applicable

Name of Approving Officer _____ Authorised Signature _____ Date _____

GIRO Form_May2021

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