



# IFS GLOBAL HEALTH APPLICATION FORM

Adviser Name \_\_\_\_\_  
 Source Code \_\_\_\_\_  
 Mobile No. \_\_\_\_\_  
 Company \_\_\_\_\_

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.**

## 1. Your personal details

Title: Dr/Mr/Mrs/Ms \_\_\_\_\_ First Name \_\_\_\_\_  
 Other initial \_\_\_\_\_ Family Name \_\_\_\_\_  
 Gender (please circle): M/F \_\_\_\_\_ Nationality \_\_\_\_\_ Date of Birth (dd mm yy) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age last birthday \_\_\_\_\_  
 Usual Country of Residence \_\_\_\_\_ Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg Smoker:  Yes  No

## 2. Your contact details

Residential address of the country where you are to be located  
 House No. \_\_\_\_\_  
 Building Name \_\_\_\_\_  
 Street Name \_\_\_\_\_  
 City/State \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Country \_\_\_\_\_ Email Address: \_\_\_\_\_

Home contact			Work Contact		
Country Code	Area Code	Number	Country Code	Area Code	Number
Telephone					

## 3. Additional persons to be covered

### Spouse/Partner/Employee

Title: Dr/Mr/Mrs/Ms \_\_\_\_\_ First Name \_\_\_\_\_  
 Other initial \_\_\_\_\_ Family Name \_\_\_\_\_  
 Gender (please circle): M/F \_\_\_\_\_ Nationality \_\_\_\_\_ Date of Birth (dd mm yy) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age last birthday \_\_\_\_\_  
 Usual Country of Residence \_\_\_\_\_ Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg Smoker:  Yes  No

### 1st Child

Title: Dr/Mr/Mrs/Ms \_\_\_\_\_ First Name \_\_\_\_\_  
 Other initial \_\_\_\_\_ Family Name \_\_\_\_\_  
 Gender (please circle): M/F \_\_\_\_\_ Nationality \_\_\_\_\_ Date of Birth (dd mm yy) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age last birthday \_\_\_\_\_  
 Usual Country of Residence \_\_\_\_\_ Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg Smoker:  Yes  No

### 2nd Child

Title: Dr/Mr/Mrs/Ms \_\_\_\_\_ First Name \_\_\_\_\_  
 Other initial \_\_\_\_\_ Family Name \_\_\_\_\_  
 Gender (please circle): M/F \_\_\_\_\_ Nationality \_\_\_\_\_ Date of Birth (dd mm yy) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age last birthday \_\_\_\_\_  
 Usual Country of Residence \_\_\_\_\_ Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg Smoker:  Yes  No

### 3rd Child

Title: Dr/Mr/Mrs/Ms \_\_\_\_\_ First Name \_\_\_\_\_  
 Other initial \_\_\_\_\_ Family Name \_\_\_\_\_  
 Gender (please circle): M/F \_\_\_\_\_ Nationality \_\_\_\_\_ Date of Birth (dd mm yy) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Age last birthday \_\_\_\_\_  
 Usual Country of Residence \_\_\_\_\_ Height \_\_\_\_\_ cm Weight \_\_\_\_\_ kg Smoker:  Yes  No

## 4. Your choice of medical cover

Please tick one box only:

Plan:  Classic  Supreme  Elite

Area of Cover:  Area 1  Area 2 (Worldwide excluding USA & Canada)

Deductible:  (US\$500)  (US\$1,000)  (US\$2,000)  
 (£300)  (£600)  (£1,200)  
 (€400)  (€800)  (€1,600)  
 (S\$850)  (S\$1,750)  (S\$3,500)

Do you wish to purchase the optional dental cover?  Yes  No

Please indicate who you wish to purchase the optional dental cover for:

Main Applicant  Spouse/Partner/Employee  
 1st Child  2nd Child  3rd Child

5. Premiums		
	Core Premium	Optional Premium
Main Applicant		
Spouse/Partner/Employee		
1st Child		
2nd Child		
3rd Child		
Total Premiums		

Please complete this section if you opt for credit card payment.

**Card Payment Authorisation**

I authorise Aviva Ltd, until further notice in writing, to charge my card account, the premiums in respect of the IFS Global Health Plan as and when these become due. I will advise you 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

Card No. \_\_\_\_\_

Bank \_\_\_\_\_ Expiry Date (mm/yy) \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_ Date \_\_\_\_\_

## 6. Method of payment and contract details

### Contract details

Date you want cover to commence (dd/mm/yy)

(Please note this date cannot be prior to the date we receive this application form.)

### Payment details

Currency (please tick one box only)

USD  EUR  GBP  SGD

Method (please tick one box only)

Bank Cheque No. \_\_\_\_\_ Amount: \_\_\_\_\_

Please make payable to Aviva Ltd.

Bankers Draft  Credit Card (Monthly / Quarterly/Annually)\*

*\*please delete as applicable*

Telegraphic Transfer#

# Any charges made by the remitting bank and receiving bank in the course of submitting funds to Aviva Ltd must be borne by the applicants. This may mean that it is necessary to pay an amount in excess of the contribution due to the Plan to cover these charges. Please indicate your name (as in this application), Identity/Passport Number and the product name in the TT application. Please remit the amount to the currency denominated bank account of Aviva Limited as shown below:

Contract Currency	Bank	Bank Account No.	Swift Code
USD	Citibank N.A. (Singapore Branch)	0-820610-016	CITISGSG
EUR		0-820610-024	
GBP		0-820610-032	
SGD		0-820610-008	

## 7. Confidential medical history

	Main Applicant		Spouse/ Partner/ Employee		1st Child		2nd Child		3rd Child	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Name										
1 Has any person named in this form been admitted to hospital or nursing home or had any medical tests done in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Has any specialist been consulted and/or provided prescriptions for any drugs or medication in the last 4 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Has any application for life, accident, health or any other insurance been refused or had special terms applied?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Does any person named in this form anticipate the need or has been recommended to undergo any medical tests or investigations in the foreseeable future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Has any person named in this form ever suffered from or are suffering from any disease stated in note 1?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Note 1 Heart trouble, chest pain, blood pressure problems or circulatory disorders; 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, cholesterol problems or diseases or disorders of the blood; Tumour growth, cancer or glandular diseases or abnormalities; Diseases 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 illnesses, disabilities or defects present that may require treatment that have not already been disclosed

If you have answered "yes" to any of the above questions, please provide more details below by indicating the question number, the condition, dates of consultation, the treatment received and the name and address of doctor. Please attach a copy of all medical reports if applicable. If you need to use a separate sheet of paper, attach to this form and indicate you have done so by ticking this box:

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## 8. Declaration

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

I/We declare that all the information on this Application Form is true and complete. I/We am/are unaware of the existence of any medical condition or circumstance foreseeably requiring my/our hospitalization in the future, and understand that benefits will not apply to treatment or expense 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 the Policy unless such conditions are fully disclosed to and accepted by Aviva Ltd prior to the inception of the Policy. I/We consent to Aviva Ltd seeking information from any doctor who has attended to me/us or from other insurance company to which I/we have at any time made a proposal for insurance and I/we authorise the giving of such information. I/We further authorise Aviva Ltd to give such information obtained or information contained herein for the purpose of obtaining insurance cover under this Application to my insurance representative. I/We understand that Aviva Ltd may require further medical information from my doctor and I/we am/are aware that I/we am/are responsible for obtaining and paying for such information should I/we wish to continue my/our application. I/We am/are aware that I/we can seek advice from a qualified adviser before I/we 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. I/We have received Your Guide to Health Insurance and the Product Summary and they have been explained to my/our satisfaction.

I/We agree that any cover which I/we may purchase for the USA & Canada shall terminate upon informing Aviva Ltd that I/we have become a resident of the USA/ Canada. I/We agree that this application shall be the basis of the contract of insurance between me/us and Aviva Ltd. I/We understand that the insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

Signature of Main Applicant

Date

Signature of Spouse/Partner/Employee

Date