Alteration to Application Form (B52)

(for MyShield/MyHealthPlus)

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.

Name of Proposer:		Contract No.:	
Name of Dependant 1:		Contract No.:	
Name of Dependant 2:		Contract No.:	
Name of Dependant 3:		Contract No.:	
Name of Dependant 4:		Contract No.:	
Name of Dependant 5:		Contract No.:	

Alteration Request

I/We hereby request that my/our Application(s) to be altered as indicated below with the understanding and agreement that the change when effected shall be an amendment to and will form part of the original Policy issued and also be binding on any person who shall have or claim any interest under the above Policy(ies).

Important Notes:

Please complete only the required fields that you wish to make amendments.

Section A: Alteration on Personal Particulars

Important Notes:

1. For alteration to personal particulars, e.g. Name, NRIC/FIN No. and Date of Birth, please submit Singapore Identity Card or an eligible Valid Pass issued by Immigration & Checkpoint Authority (ICA) Singapore.
2. 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.

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 ID Type: ☐ Singaporean ☐ Singapore PR Nationality:_____

Contact No.: ☐ Handphone:_____ ☐ Office:_____ ☐ Home:_____

Email Address:_____

Occupation:_____ Name of Employer :_____

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Section A: Alteration on Personal Particulars *(continued)*

Proposer (Assured) *(continued)*

Alteration to Address on Application Form:

☐ Residential Address:	☐ Correspondence Address: (*if different from residential address)*
_____ _____ _____ _____Postal Code:_____	_____ _____ _____ _____Postal Code:_____

For existing policyholder with Aviva Ltd:

If the correspondence address differs from our existing records, do you wish to update the correspondence address for all your other policy(ies)?

☐ Yes ☐ No

Dependant 1

Full Name as shown in Identity Card/Eligible Valid Pass:

Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr Gender: ☐ Male ☐ Female

Family Name:_____

Given Name:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Date of Birth (DD/MM/YY): _____ Nationality:_____

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others _____

Relationship to Proposer : ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent

Occupation:_____ Name of Employer :_____

Dependant 2

Full Name as shown in Identity Card/Eligible Valid Pass:

Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr Gender: ☐ Male ☐ Female

Family Name:_____

Given Name:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Date of Birth (DD/MM/YY): _____ Nationality:_____

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others _____

Relationship to Proposer : ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent

Occupation:_____ Name of Employer :_____

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Section A: Alteration on Personal Particulars *(continued)*

Dependant 3

Full Name as shown in Identity Card/Eligible Valid Pass:

Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr Gender: ☐ Male ☐ Female

Family Name:_____

Given Name:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Date of Birth (DD/MM/YY): _____ Nationality:_____

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others _____

Relationship to Proposer : ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent

Occupation:_____ Name of Employer :_____

Dependant 4

Full Name as shown in Identity Card/Eligible Valid Pass:

Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr Gender: ☐ Male ☐ Female

Family Name:_____

Given Name:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Date of Birth (DD/MM/YY): _____ Nationality:_____

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others _____

Relationship to Proposer : ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent

Occupation:_____ Name of Employer :_____

Dependant 5

Full Name as shown in Identity Card/Eligible Valid Pass:

Salutation: ☐ Mr ☐ Mrs ☐ Mdm ☐ Miss ☐ Dr Gender: ☐ Male ☐ Female

Family Name:_____

Given Name:_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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

Date of Birth (DD/MM/YY): _____ Nationality:_____

Nationality ID Type: ☐ Singaporean ☐ Singapore PR ☐ Others _____

Relationship to Proposer : ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent

Occupation:_____ Name of Employer :_____

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Section B: Alteration on Declaration of Occupation (*not applicable for MyShield Standard Plan*)

If the answer to the following question on occupation is "Yes", only MyShield will be offered and MyHealthPlus will be declined.

Does your occupation involve any of the following:
– work in heights above 15 metres (excluding those who work indoors of completed buildings, military and commercial aircrew and pilot);
– professional diving;
– use of armed weapons (excluding military personnel);
– offshore oil and gas environment;
– motorcycle dispatch;
– scaffolding; or
– welding?

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section C: Alteration on Plan Type / Option (*not applicable for MyShield Standard Plan*)

Important Notes:

MyShield:
1. A dependant child up to age 20 years old at age next birthday will be eligible for Family Discount for Child(ren) (FDC) under MyShield Plan 2 if both parents are covered under MyShield Plan 1 or Plan 2. This benefit is applicable to a maximum of four (4) children, including children that enjoy existing coverage under Free Cover for Children (FCC).
2. If any applicant crosses the age band while this form is being processed, we will charge the higher premium according to the age next birthday.
3. For amendments on Plan Type from MyShield Standard Plan to Plan 1, Plan 2 or Plan 3, please submit MyShield/MyHealthPlus application form.
4. For amendments on Plan Type from MyShield Plan 1, Plan 2 or Plan 3 to MyShield Standard Plan, please submit MyShield Standard Plan application form.

Please √ tick the box according to your plan selection.

MyShield	Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
Plan 1						
Plan 2						
Plan 2 (*FDC if applicable*)	*Not Eligible*					
Plan 3 (*For Singaporean and Singapore PR only*)						

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Section C: Alteration on Plan Type / Option (*not applicable for MyShield Standard Plan*) *(continued)*

MyHealthPlus:

1. The dependant child will be eligible for FCC under MyHealthPlus Plan 2 Option A if both parents are covered under MyShield Plan 1 or Plan 2 and MyHealthPlus Option A or Option C.
2. The dependant child will be eligible for Preferred Rate under MyHealthPlus Plan 2 Option C if both parents are covered under MyShield Plan 1 or Plan 2 and MyHealthPlus Option A or Option C.
3. If any applicant crosses the age band while this form is being processed, we will charge the higher premium according to the age next birthday.
4. We will process as Option C if both Option A and Option C are ticked.

Please √ tick the box according to your plan selection.

MyHealthPlus MyHealthPlus Plan Type will follow MyShield	**Proposer**	**Dependant 1**	**Dependant 2**	**Dependant 3**	**Dependant 4**	**Dependant 5**
Option A (*Co-Insurance*)						
Option A *(Co-Insurance)* (*FCC if applicable)*	*Not Eligible*					
Option C *(Deductible and Co-Insurance)*						
Option C *(Deductible and Co-Insurance)* *(Preferred Rate for child(ren) if applicable)*	*Not Eligible*					

Section D: Alteration on Payment Details

Important Notes:

1. Credit Card payment method is applicable for initial premium(s) only.
2. If you have chosen Interbank GIRO as the initial premium payment method in the application form and wish to change the subsequent premium payment method to Interbank GIRO, please tick Interbank GIRO. However, resubmission of a new Interbank GIRO form is not required as we will deduct from the same bank account.

Change **Initial Premium Payment Method** to:	☐ Interbank GIRO ***(Please submit duly signed Interbank GIRO Form)*** ☐ Cash / Cheque ☐ Credit card ***(Please submit duly signed Credit Card Authorisation Form)***
Change **Subsequent Premium Payment Method** to:	☐ Interbank GIRO ***(Please submit duly signed Interbank GIRO Form)*** ☐ Cash / Cheque

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Section E: Alteration on replacement of existing Integrated Shield Plan/Declaration (*not applicable for MyHealthPlus*)

1. Is this application to replace or intended to replace your / your dependants' existing Integrated Shield Plan?

   If **'Yes'**, please provide the Name of Insurer, Name of Plan and answer Question 2.

Proposer	☐ Yes ☐ No	Name of Insurer: Name of Plan:
Dependant 1	☐ Yes ☐ No	Name of Insurer: Name of Plan:
Dependant 2	☐ Yes ☐ No	Name of Insurer: Name of Plan:
Dependant 3	☐ Yes ☐ No	Name of Insurer: Name of Plan:
Dependant 4	☐ Yes ☐ No	Name of Insurer: Name of Plan:
Dependant 5	☐ Yes ☐ No	Name of Insurer: Name of Plan:

2. In answering **'Yes'** to Section E 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.
   - If I am replacing my existing plan by upgrading to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may not be given the enhanced benefits for those conditions. (*Applicable for MyShield Plan 1, Plan 2 and Plan 3*)

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Section F: Alteration on Underwriting Option

Important Notes:

MyShield Standard Plan is only available under Full Medical Underwriting.

1. Have you had an **application**, **reinstatement or renewal** of a Life, Critical Illness, Health, Accident or Disability policy **deferred** or **declined**?

   If '**Yes'**, please provide Name of Insurer, Reason, Type of Policy and submit duly completed New Business Health Declaration Form (for Health Products).

Proposer	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:
Dependant 1	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:
Dependant 2	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:
Dependant 3	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:
Dependant 4	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:
Dependant 5	☐ Yes ☐ No	Name of Insurer: Reason: Type of Policy:

2. Have you **ever** experienced **symptoms** or received **medical advice** or had **treatment** for any of the following conditions **(whether diagnosed or not)**? (*Not applicable for MyShield Standard Plan*)

   If '**Yes'**, please submit duly completed New Business Health Declaration Form (for Health Products).

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

- AIDS or HIV infection
- Alzheimer's disease
- Angioplasty
- Any form of Cancer
- Atherosclerosis
- Autism
- Bipolar Disorder
- Chronic cor pulmonale
- Chronic Kidney disease
- Chronic Obstructive lung disease
- Coronary Artery Disease (CAD)
- Dementia
- Diabetes Mellitus /Impaired Glucose tolerance
- Down syndrome
- Heart attack
- Heart bypass
- Hepatitis C/D
- Ischaemic Heart Disease (IHD)
- Kidney failure
- Liver cirrhosis
- Multiple sclerosis
- Muscular Dystrophy
- Organ transplant
- Osteoporosis
- Paralysis
- Polycystic Kidney disease
- Pulmonary hypertension
- Schizophrenia
- Stroke
- Systemic Lupus Erythematosus (SLE)
- Thalassaemia intermediate/major

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Section F: Alteration on Underwriting Option *(continued)*

3. Are you required to pay Additional Premiums for MediShield Life?

   If **'Yes'**, please either submit a duly completed New Business Health Declaration Form (for Health Products) or provide a copy of the **CPF MediShield Life Additional Premium Letter** to us for underwriting purposes.

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

4. Please select an underwriting option:
   (Not applicable for MyShield Standard Plan)

   In answering 'Yes' to the above Question 1,2 and/or 3, please tick **"Full Medical Underwriting"** option and submit a duly completed New Business Health Declaration Form (for Health Products).

   I/We confirm that I/we have read and understood the Product Summary, which includes the exclusions and pre-existing conditions that shall be permanently excluded under Moratorium Underwriting.

Proposer	Dependant 1	Dependant 2	Dependant 3	Dependant 4	Dependant 5
☐ Moratorium Underwriting or ☐ Full Medical Underwriting	☐ Moratorium Underwriting or ☐ Full Medical Underwriting	☐ Moratorium Underwriting or ☐ Full Medical Underwriting	☐ Moratorium Underwriting or ☐ Full Medical Underwriting	☐ Moratorium Underwriting or ☐ Full Medical Underwriting	☐ Moratorium Underwriting or ☐ Full Medical Underwriting

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Section G: Declaration

I/We agree to inform Aviva Ltd if there is any change in my/our financial and/or health status between the date of this Declaration and the date the full insurance coverage is provided by Aviva Ltd to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We agree that the above alteration(s) and declaration(s) shall form part of my/our Application for the Insurance. I/We understand that any alteration is subject to the acceptance of Aviva at its sole discretion. Except as amended by this Alteration to Application Form, all other information in my MyShield/MyHealthPlus Application Form remains valid and unchanged.

This Application will not be valid until I/We have been informed in writing that Aviva has accepted this Application or issued the Policy Documents.

_____
Signature of Proposer & Sign Date (DD/MM/YYYY)

_____
Signature of Dependant 1 & Sign Date (DD/MM/YYYY)
(who is 16 years old and above)

_____
Signature of Dependant 2 & Sign Date (DD/MM/YYYY)
(who is 16 years old and above)

_____
Signature of Dependant 3 & Sign Date (DD/MM/YYYY)
(who is 16 years old and above)

_____
Signature of Dependant 4 & Sign Date (DD/MM/YYYY)
(who is 16 years old and above)

_____
Signature of Dependant 5 & Sign Date (DD/MM/YYYY)
(who is 16 years old and above)

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