MyBenefits Plus

APPLICATION FORM

* P R O P F *

AVIVA

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

Particulars of Adviser

Name:

Source Code:

Name of Firm:

Contact No.: (HP) (O)

Email Address:

For Official Use Only

Group Policy No.:

Date:

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.

Checklist of required documents:

☐ 1. Application Form

☐ 2. Business Profile from the Accounting & Corporate Regulatory Authority (ACRA) website **OR** copy of Certificate of Incorporation **AND** list of directors with executive authority within the company

☐ 3. List of names & identification no. of authorised personnel to sign on the insurance acceptance (Customer Due Diligence Form)

☐ 4. Cheque Payment

☐ 5. Health Declaration Form if Sum Assured is in excess of S$100,000 for Group Term Life/Group Living Care

Please complete in capital letters and tick boxes as appropriate.

SECTION A: PARTICULARS OF GROUP POLICYHOLDER

Completed as a condition to the granting of insurance under Group Policy proposed by:

Name of Company:

Company Address:

Nature of Business:

No. of Employees in the Company: No. of Employees to be Insured:

Period of Insurance: to

Name of Authorised Personnel:

Designation: NRIC/Passport No.:

Email Address: Contact No.: Fax No.:

SECTION B: BASIS OF COVERAGE

Please **circle the selected plan** in each product line:

Category of Employee	Benefit							Dependant Cover
	Basic Plan			Supplementary Plan				
						Group Outpatient		
	Group Term Life (Plan)	Group Personal Accident (Plan)	Group Basic Medical (Plan)	Group Living Care	Group Major Medical	GP Benefit (Plan)	SP/DXL Benefit (Plan)	
	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5	Yes / No	Yes / No	1 / 2	1 / 2	Yes / No
	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5	Yes / No	Yes / No	1 / 2	1 / 2	Yes / No
	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5	Yes / No	Yes / No	1 / 2	1 / 2	Yes / No
	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5	Yes / No	Yes / No	1 / 2	1 / 2	Yes / No
	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5 / 6	1 / 2 / 3 / 4 / 5	Yes / No	Yes / No	1 / 2	1 / 2	Yes / No

Important Notes
- Please indicate the category of employees to be insured, e.g. Management Staff, Executives & above, All Others
- Eligible dependants include spouse, unmarried or unemployed children who are between the ages of 15 days and 25 years of age.
  A dependant's cover shall be the same as the employee's cover. Once taken up, it will apply to all eligible employees in the same category
- If insured is covered under Plan 6 for Group Term Life, Group Living Care will only be covered up to S$300,000

MyBenefits Plus_AF_April2014

SECTION C: PARTICULARS OF EXISTING COVERAGE

Do you currently have an existing employee benefit plan?

If 'Yes', please state the insurance company and benefits provided.

SECTION D: PARTICULARS OF INSURED (If more than 2 members, please fill the details in the MyBenefits Plus Premium Calculator)

Full Name as shown in NRIC/Passport (Please underline surname)	**NRIC/FIN No.**	**Gender**	**Nationality**	**Date of Birth** (dd/mm/yyyy)	**Marital Status**	**Date of Employment** (dd/mm/yyyy)	**Category of Employment**	**Occupation Class** (1/2/3) **& Exact Duties**	**Relationship** (Employee/Spouse/Child) If Spouse/Child, please state Name of Employee	**Premium Rate (incl. GST)**	**Bank Account Details** (Bank Name, Branch Code & Account No.) *Note: For claims reimbursement. Applicable for Medical Benefit only.*

SECTION E: ANNUAL PREMIUM AMOUNT

Total Annual Premium S$ **Payment** Cheque No. Date

SECTION F: DECLARATION

I declare that the information given above is true and complete. I agree that this application shall be the basis of the contract of insurance to be issued under the said Group Insurance Policy. I understand that the contract of insurance shall not become effective until it is accepted and confirmed in writing by Aviva Ltd.

We hereby declare that we have read and understood the Personal Data Protection Compliance Undertakings (For Corporate Prospect/Policyholder) and agreed to be bound by it. (You may request for a copy of the Personal Data Protection Compliance Undertaking (For Corporate Prospect/Policyholder) from us or view it at http://www.aviva.com.sg/pdpa.html.

Name & Signature of Employer	Company Stamp & Date	Name & Signature of Witness	Date

SECTION G: FOR OFFICIAL USE ONLY

Group Sales Staff:

Group Operations Staff:

Industry Code:
(Rating SIC Code)

LOG:

Client No.:

New Business (NB) Correspondence Arrangement:

Claims Correspondence Arrangement:

Cons. Outpatient Payment Advice Arrangement:

Billing Set Up:

Claims Set Up: