



Policy Servicing Health Declaration (for Life Products)

AVIVA

Policy Details	
Policy Number :	<input type="text"/>
Name of Assignee/Assured :	<input type="text"/> NRIC/Passport No. : <input type="text"/>
Name of Joint Assured :	<input type="text"/> NRIC/Passport No. : <input type="text"/>
Name of Life Assured :	<input type="text"/> NRIC/Passport No. : <input type="text"/>
Name of Joint Life Assured :	<input type="text"/> NRIC/Passport No. : <input type="text"/>

Important Notes:
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. 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 licensed 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.

Regulations based on the Singapore Income Tax Act (Chapter 134), Foreign Account Tax Compliance Act ("FATCA"), OECD Common Reporting Standard for Common Exchange of Financial Account Information ("CRS") require Aviva Ltd to collect certain information about an Account Holder's tax residence. We may be legally obliged to give the Internal Revenue Authority of Singapore (IRAS) this information, along with information relating to your policies, which may be shared between different countries' tax authorities.

To help us collect this information, we need you to complete the questions in Section A and Section B in the Declaration portion.

Please tick (✓) the appropriate box

General Questions	Life Assured		Joint Life Assured		Details	
	Yes	No	Yes	No		
1. Are you currently engaged in or have you any intention of engaging in any form of aviation other than as a passenger travelling solely for transport, or engaging in any hazardous pursuits such as scuba diving, motor racing, mountain/rock climbing, free fall parachuting, sky diving, etc? If 'Yes', please state activity and provide details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Has any application, renewal or reinstatement of a life, accident, health policy on your life been deferred, declined or accepted at special rates or terms? If 'Yes', please state the name of the company and provide details.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Please state your current occupation and exact nature of work.						
Medical Questions	Details					
1. What is the name and address of your regular doctor?						
2. When did you last consult a doctor and for what reason?						
3. a. Please state your height and weight. Life Assured Joint Life Assured/ Assured	Height	<input type="text"/>	m	Weight	<input type="text"/>	kg
	Height	<input type="text"/>	m	Weight	<input type="text"/>	kg
b. Have you ever had unexplained weight loss since the commencement of the Policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Are you currently taking medication or considering seeking medical advice from a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Have you ever had or been advised to undergo surgery or any diagnostic tests such as X-ray, ultrasound, biopsy, electrocardiogram, blood or urine tests?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Medical Questions (Continued)		Life Assured		Joint Life Assured		Details
		Yes	No	Yes	No	
6.	Have you ever had or been told to have or been treated for asthma, cancer, tumour, growth, cyst, disease or disorder of the heart (including high blood pressure, heart attack, heart murmur, heart valve disorder, chest pain), diabetes, epilepsy, fits, Hepatitis, liver disease, raised cholesterol, kidney or urinary disorder, stroke, blood disorder, mental disorder, respiratory disorder, endocrine disorder, musculo-skeletal disorder, gastrointestinal disorder, autoimmune disease, disease and disorder of the eye, ear, nose or throat, HIV infection, sexually transmitted disease or any other illness / physical deformity not listed above? If 'Yes', please give full details including name of the condition(s), date of diagnosis, investigations, result and treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Have any of your natural parents or siblings ever had or been treated for cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder or any hereditary disease? If 'Yes', please state condition, age of onset and relationship in the space provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Have you smoked cigarettes in the past 12 months? If 'Yes', please state for how many years and how many sticks per day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	No. of years	<input type="text"/>		<input type="text"/>		
	No. of sticks per day	<input type="text"/>		<input type="text"/>		
9.	Do you take alcohol? If 'Yes', please state type and the average daily consumption.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Type	<input type="text"/>		<input type="text"/>		
	Quantity	<input type="text"/>		<input type="text"/>		
10.	Have you ever taken addictive drugs/narcotics or been treated for alcoholism or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11.	<i>For Female Only</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	a. Have you ever suffered from or are you aware of any breast lumps or any other disorders of your breasts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	c. Have you had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynecological investigations? If 'Yes', please state type, reason, date of test done and result of test (copy to be submitted if available).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Medical Questions (Continued)	Life Assured		Joint Life Assured		Details
	Yes	No	Yes	No	
e. Are you now pregnant? If 'Yes', please state the number of month(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No. of months: _____
f. For females who have conceived, were there any complications during pregnancy such as gestational diabetes, hypertension, etc?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. <i>For Child Only</i> Was the child born prematurely or been diagnosed to have any congenital disorder or birth defects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. <i>For Male Only</i> Have you ever had or been told to have or been treated for prostate enlargement, disease or disorder of the male reproductive organs? If 'Yes', please furnish details in the space provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Declaration
Section A: Declaration of US Indicia

	Assured / Assignee	Joint Assured	Trustee / Beneficiary	Trustee / Beneficiary
	Name: _____ _____	Name: _____ _____	Name: _____ _____	Name: _____ _____
Do you have one or more US Indicia*?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you give standing instructions to transfer funds to an account maintained in the US?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you give effective power of attorney or signatory granted to a person with a US address?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have ticked 'Yes', please complete the **United States of America (US) Person Declaration form** that is available at <http://www.aviva.com.sg/fatca/resources-downloads.html> and return to Aviva.

**US Resident / Citizen / Place of Birth / Taxpayer ID number / Mailing or Residential Address / Contact Number/US "in-care-of" or "hold mail" address*

Declaration (Continued)
Section B: Declaration of Tax Residency under the Common Reporting Standard (CRS)

	Assured / Assignee	Joint Assured	Trustee / Beneficiary	Trustee / Beneficiary
	Name: _____ _____	Name: _____ _____	Name: _____ _____	Name: _____ _____
Is there any change in the information that you have provided to Aviva Ltd that would result in a change in your tax residency status (for e.g. change in your residence/ mailing/ in-care of address, telephone number)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you have ticked 'Yes', please complete the CRS Self-Certification Form for Individual/Entity/Controlling Person (whichever is applicable) that is available at http://www.aviva.com.sg/CRS/resources-downloads.html and return to Aviva.				

I/We understand that the insurance shall not take effect until this application is accepted, the full premium is received and the endorsement of the benefit(s) is issued by Aviva Ltd.

I/We declare that no material fact, that is, any fact likely to influence the assessment and acceptance of this application has been withheld and to the best of my/our knowledge and belief, the information furnished is true and complete. I/We agree to inform Aviva Ltd if there is any change in the state of my/our and/or any life assured's health or activities between the date of this application and the date the benefit(s) is issued by Aviva Ltd to me/us.

I/We agree that all medical examination reports done for the purpose of this application are properties of Aviva Ltd to be used solely for insurance purposes.

I/We authorise any medical source, insurance office or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any medical source, insurance office or organisation, to the extent permitted by law, relevant information concerning me/us and/or any 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.

I/We understand that any payment made at the time of signing this application or thereafter shall be held as a deposit placed with the Company until acceptance of this application by the Company, subject to the terms and conditions contained in the receipt issued in respect of the said payment. I/We agree to pay to the Company the medical fees incurred in assessing the risk under this application (if any) should I/we decide not to accept at the standard rates or revised terms offered by the Company. Should the Company decline the application, then I/we shall be entitled to a full refund of the amount tendered for this application. I/We further understand that the assurance granted shall be subject to the conditions in and endorsed on the Policy issued.

I/We also understand that if this application is submitted for reinstatement of Policy, the Policy will be reinstated and the insurance cover restored only when an official letter confirming the reinstatement has been issued by the Company. The Company will not be liable for any claims arising between the date of lapsing of the Policy and the reinstatement date of the Policy.

I am/We are aware that insurance is a long term commitment and I am/we are aware that I/we can seek advice from a licensed Financial Adviser Representative before I/we sign this application. Should I/we choose not to, I/we take sole responsibility to ensure that this application is appropriate to meet my/our financial needs and insurance objectives.

I/We further declared that I am/we are not an undischarged bankrupt and that I/we 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/us during that period.

Declaration (Continued)

I/We acknowledge that the Company may reject any of my/our instructions including, but not limited to, those that, in the Company's sole and absolute discretion, are deemed incomplete, unclear or ambiguous, or if my/our signature(s) differ(s) from what was originally provided as a specimen to the Company, and the Company will not be responsible for any losses that may be incurred by me/us due to such rejection of any of my/our instructions.

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/policies, 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>.

Signature of Main Life Assured ▶ For age next birthday 17 years and above ▶ Your signature must be consistent with our record	Signature of Assured / Joint Life Assured ▶ Your signature must be consistent with our record	Signature of Assignee/ Trustee(s)* ▶ Your signature must be consistent with our record	Signature of Financial Adviser Representative	Date ▶ DD/MM/YYYY
Name ▶ As in NRIC / Passport	Name ▶ As in NRIC / Passport	Name ▶ As in NRIC / Passport	Name ▶ As in NRIC / Passport	
NRIC / Passport Number	NRIC / Passport Number	NRIC / Passport Number	NRIC / Passport Number	
Mobile Number	Mobile Number	Mobile Number	Mobile Number	
Email address	Email address	Email address	Email address	

Note:

- *Signature of Trustee(s)/Assignee are required for policies under Trust/Assignment.
- Mobile number and email address provided will replace our records accordingly.
- Both the Assured and Life Assured above the age of 16 are to sign on this Application.
- The Assured will declare on behalf of the Life Assured below the age of 16.