

ElderShield / MyCare

REINSTATEMENT FORM *(for policies with Aviva lapsed not more than 180 days)*

WARNING: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CAP. 142), 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.

SECTION A: PERSONAL PARTICULARS

Name as in NRIC/Passport (in BLOCK LETTERS) Mr/Mrs/Mdm/Ms/Miss/Dr#	NRIC No.	Gender Male / Female#
Address	Date of Birth (dd/mm/yyyy)	Nationality
Contact No. (H) (O) (HP)	Email	
Occupation	Exact duties involved	

SECTION B: DETAILS OF LAPSED POLICY

I wish to reinstate the following policy(ies):

ElderShield (for policy with Aviva Ltd only)

MyCare

Policy No.:

Policy No.:

SECTION C: MEDICAL AND UNDERWRITING QUESTIONS

Q1	Please state your: Height (m) Weight (kg)																																																																
Q2	Have you ever had or been told you have or been treated for any of the conditions below? Please tick.																																																																
	<table border="1"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>If "Yes", please provide details</th> <th></th> <th>Yes</th> <th>No</th> <th>If "Yes", please provide details</th> </tr> </thead> <tbody> <tr> <td>(a) Cancer</td> <td></td> <td></td> <td></td> <td>(h) Dementia</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(b) Diabetes</td> <td></td> <td></td> <td></td> <td>(i) Parkinson's disease</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(c) Stroke</td> <td></td> <td></td> <td></td> <td>(j) Multiple sclerosis</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(d) Heart disease</td> <td></td> <td></td> <td></td> <td>(k) Motor neurone disease</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(e) Kidney disease</td> <td></td> <td></td> <td></td> <td>(l) AIDS or HIV infection</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(f) Liver disease</td> <td></td> <td></td> <td></td> <td>(m) Arthritis/Paralysis</td> <td></td> <td></td> <td></td> </tr> <tr> <td>(g) Lung disease</td> <td></td> <td></td> <td></td> <td>(n) Any other condition(s) not listed here?</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Yes	No	If "Yes", please provide details		Yes	No	If "Yes", please provide details	(a) Cancer				(h) Dementia				(b) Diabetes				(i) Parkinson's disease				(c) Stroke				(j) Multiple sclerosis				(d) Heart disease				(k) Motor neurone disease				(e) Kidney disease				(l) AIDS or HIV infection				(f) Liver disease				(m) Arthritis/Paralysis				(g) Lung disease				(n) Any other condition(s) not listed here?			
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Q3	Do you need any assistance of another person or mechanical aids such as a cane, crutches, wheelchair or walker in the performance of the activities of daily living such as washing (bathing), dressing, feeding (eating), walking, transferring from bed to chair, and maintaining continence (toileting)? If "Yes", please provide details.																																																																
Q4	Are there any day to day activities such as doing housework, preparing meals, shopping, using public transport, or any hobby which you have stopped doing in the last year due to your health or disability conditions? If "Yes", please provide details.																																																																

SECTION D: PREMIUM PAYMENT METHOD

NOTE: This authorisation shall supersede all previous payment method instructions and will be used for future premium payments unless otherwise advised in writing.

I wish to arrange for premium payment method as follows (Please tick where applicable):

- To deduct from my own CPF Medisave Account only. (Please complete Section E)
- Own / spouse's / children's / grandchildren's / parents' CPF Medisave Account (Please complete Section E)
- Interbank GIRO (Please note that GIRO will only take effect next year and a fresh GIRO form is to be completed)
- Cheque. I enclosed cheque of S\$ _____. Bank / Cheque No. _____ / _____.
(Please make the cheque payable to **Aviva Ltd** and write your Name, NRIC number and Policy number on the reverse side of your cheque.)

SECTION E: AUTHORISATION BY CPF ACCOUNT HOLDER(S) (For payment using CPF Medisave Account only)

For payment through own/spouse's/children's/grandchildren's/parent's CPF Medisave Account, please complete the following:

- I authorise the Central Provident Fund Board to deduct premium(s) due for the Policyholder to be covered under this ElderShield Policy and/or MyCare Policy from my Medisave Account in accordance with the provisions of the Central Provident Fund Act (Chapter 36), and the Central Provident Fund (Withdrawals for ElderShield Scheme) Regulations 2002 made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by Central Provident Fund Board from time to time.
- I authorise the Central Provident Fund Board to deduct the available amount in my Medisave Account in the event that the balance in my Medisave Account is not sufficient to pay for an amount up to the premium due.
- I authorise the Central Provident Fund Board to disclose/seek information on a confidential basis to/from any insurer(s) such information relating to the deduction from my Medisave Account as Central Provident Fund Board shall reasonably consider appropriate.
- I understand that for ElderShield Supplement plans, the maximum Medisave deduction is \$600.00 per life to be insured per calendar year only. Any excess over this limit has to be paid by cash.**

CPF A/C Holder's Name	Date of Birth (dd/mm/yyyy)	CPF A/C No.	Relationship	% of Premium*	Signature of A/C Holder & Date

*Total CPF contribution must add up to 100%. If there is no indication, total contribution will be taken as 100%.

SECTION F: DECLARATION

- I hereby declare that the foregoing information is true and correct and I have not withheld any material information, whether written by me or by anyone else on my behalf and I accept full responsibility for them.
- I understand that the Policy will be reinstated and the insurance cover restored only when an official letter confirming reinstatement has been issued by Aviva Ltd. Aviva Ltd will not be liable for any claims arising between the date of lapsing of the Policy and the reinstatement date of the Policy.
- I agree and authorise any medical source, insurance office or organisation to release to Aviva Ltd, and Aviva Ltd to release to any of the prior mentioned organisations relevant information concerning me at any time, irrespective of whether the proposal is accepted by Aviva Ltd. A photographic copy of this authorisation shall be as valid as the original.
- I further declare that I am not undischarged bankrupt(s) 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.
- If a material fact is not disclosed in this application, any policy issued 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 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.

Declared on _____ (Date) Signature of Policyholder _____

APPLICATION FORM FOR INTERBANK GIRO

PART 1: FOR APPLICANT'S COMPLETION

Date (dd/mm/yy) Name of billing organisation ("BO"): **Aviva Ltd**

To: Name of Financial Institution Name of Policyholder

Branch Life Insurance Policy Number

- a) I/We hereby instruct you to process the BO's instruction to debit my/our account.
- b) You are entitled to reject the BO's debit instruction if my/our account does not have sufficient funds and charge me/us a fee for this. You may also at your 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 the BO.

My/Our Name(s) My/Our NRIC Number(s)

Mr/Mdm/Ms/Mrs/Dr#

Mr/Mdm/Ms/Mrs/Dr#

My/Our Account Number My/Our Contact Number(s)

My/Our Residential Address Office Tel No.

Home Tel No.

My/Our Signature(s)/Thumbprint(s)*

(As in Financial Institution's Records)

*For thumbprints, please go to the branch with your identification

PART 2: FOR BILLING ORGANISATION'S COMPLETION

Bank Branch Billing Organisation's Account Number Billing Organisation's Customer Reference Number

Bank Branch Account Number to be debited Life Insurance Policy Number

PART 3: FOR FINANCIAL INSTITUTION'S COMPLETION

To: Billing Organisation

Signature/Thumbprint# differs from Financial Institution's records

Signature/Thumbprint# is incomplete/unclear

Wrong account number

Account operated by Signature/Thumbprint#

Amendments not countersigned by customer

Others

Name of Approving Officer Authorised Signature Date

#Please delete where applicable