



PRODUCT SUMMARY

Date: / / (DD/MM/YY)

Presented to:
(Name of Proposer)

Name of Financial Adviser:

Signature of Proposer*:

Signature of Financial Adviser:

* The Proposer is also the Life Assured under this Policy.

Please fill/tick boxes as appropriate for the applicable plan. If you are purchasing both MyCare and MyCare Plus, please fill in the details for both the plans.

Plan Name <i>(Please tick accordingly)</i>	Monthly Benefit <i>(This sum is inclusive of your Basic ElderShield benefit. The minimum monthly benefit allowed is \$600/month and the maximum benefit allowed is \$3,500/month in multiples of \$100.)</i>	Benefit Payout Duration	Premium Term	Annual Premium (including GST)
MyCare <input type="checkbox"/> for Basic ElderShield300 <input type="checkbox"/> for Basic ElderShield400	\$	<input type="checkbox"/> 12 years <input type="checkbox"/> Lifetime	<input type="checkbox"/> Limited (No. of years: _____) <input type="checkbox"/> Lifetime	\$
MyCare Plus <input type="checkbox"/> for Basic ElderShield300 <input type="checkbox"/> for Basic ElderShield400	\$	<input type="checkbox"/> 12 years <input type="checkbox"/> Lifetime	<input type="checkbox"/> Lifetime	\$

PRODUCT INFORMATION

MyCare and MyCare Plus provide ElderShield policyholders supplemental lifetime protection against severe disability, which renders the Life Assured incapable of performing simple daily activities. They provide a monthly benefit when the Life Assured is unable to perform the minimum number of activities of daily living – washing, dressing, feeding, toileting, mobility and transferring. There are other benefits payable under these two plans, which include a Lump Sum Benefit, a Dependant Care Benefit, a Waiver of Premium Benefit and a Death Benefit. For MyCare, there is also a Rehabilitation Benefit payable.

For both plans, you can either choose a lifetime Benefit Payout Duration or a 12-year (144 months) Benefit Payout Duration.

BENEFITS

A. Severe Disability Benefit

A monthly benefit will be payable when the Life Assured suffers Severe Disability. Severe Disability means the inability to perform the minimum number of Activities of Daily Living (ADL), out of 6 ADL, even with the aid of special equipment, and always to require the physical assistance of another person throughout the entire activity.

The minimum number of ADL which the Life Assured is unable to perform for the 2 plans are:

MyCare	3
MyCare Plus	2

NEW

The 6 Activities of Daily Living are as follows:

(i) Washing	The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.
(ii) Dressing	The ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical or medical appliances.
(iii) Feeding	The ability to feed oneself food after it has been prepared and made available.
(iv) Toileting	The ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate.
(v) Mobility	The ability to move indoors from room to room on level surfaces.
(vi) Transferring	The ability to move from a bed to an upright chair or wheelchair, and vice versa.

This benefit will be payable immediately after the Deferment Period for a Benefit Payout Duration of either lifetime or up to 12 years, whichever is chosen under the Policy and as long as disability persists.

Termination of Severe Disability Benefit

The monthly Severe Disability Benefit payments shall cease upon the earliest of:

- (a) the Life Assured ceases to suffer from the Severe Disability;
- (b) the death of the Life Assured; or
- (c) the expiry of the Benefit Payout Duration.

B. Lump Sum Benefit

An additional lump sum benefit will be payable when the Life Assured is severely disabled. The Lump Sum Benefit payment will amount to 3 times the first monthly benefit payable under MyCare or MyCare Plus. This benefit will be payable once in the Policy lifetime.

This benefit will be payable immediately after the Deferment Period.

C. Rehabilitation Benefit (Applicable to MyCare only)

A monthly Rehabilitation Benefit will be payable when the Life Assured recovers from a Severe Disability but is still unable to perform 2 of the 6 Activities of Daily Living, even with the aid of special equipment, and always to require the physical assistance of another person throughout the entire activity. The Rehabilitation Benefit will amount to 50% of the monthly benefit payable under MyCare.

This benefit will be payable for the same Benefit Payout Duration as the Severe Disability Benefit.

Termination of Rehabilitation Benefit

The monthly Rehabilitation Benefit payments shall cease upon the earliest of:

- (a) the Life Assured no longer meets the requirement for the Rehabilitation Benefit;
- (b) the death of the Life Assured; or
- (c) the expiry of the Benefit Payout Duration.

D. Dependant Care Benefit

An additional monthly benefit will be payable when either the Severe Disability Benefit or the Rehabilitation Benefit (applicable to MyCare), is payable and the Life Assured has a child aged 21 years and below at the point of claim. The Dependant Care Benefit is a \$200 per month payable up to 36 months.

This benefit will be payable immediately after the Deferment Period.

Termination of Dependant Care Benefit

The monthly Dependant Care Benefit payments shall cease upon the earliest of:

- (a) the cessation of the Severe Disability Benefit or the Rehabilitation Benefit, as applicable;
- (b) the death of the Life Assured; or
- (c) the expiry of the Benefit Payout Duration.

E. Waiver of Premium

No premium will be payable during the period when the Life Assured is receiving either the Severe Disability Benefit or the Rehabilitation Benefit (applicable to MyCare).

Premium payment will resume when the Life Assured no longer suffers from the Severe Disability or no longer meets the requirements for the Rehabilitation Benefit.

F. Death Benefit

A lump sum benefit will be payable if the Life Assured dies due to any accident or sickness while receiving either the Severe Disability Benefit or the Rehabilitation Benefit. The Death Benefit will amount to 3 times the last monthly benefit payable under MyCare or MyCare Plus for the Severe Disability Benefit or the Rehabilitation Benefit, whichever is applicable.

The Policy will terminate upon the death of the Life Assured.

ILLUSTRATION ON SEVERE DISABILITY BENEFIT

The monthly benefit payouts under MyCare and MyCare Plus[#] are illustrated below:

(a) If the Basic ElderShield300 Policy is to provide for a monthly payout of \$300 for up to 5 years,

Benefit Payout Period	Monthly Benefit Payable
1st 5 years	Severe Disability Benefit selected less \$300
Subsequent years (up to 12 years or a lifetime)	Severe Disability Benefit selected

For example if Monthly Benefit selected is \$1,000 and the Benefit Payout Duration is 12 years,

Benefit Payout Period	Monthly Benefit Payable
1st 5 years	\$700/month
Subsequent years (up to 12 years)	\$1,000/month

(b) If the Basic ElderShield400 Policy is to provide for a monthly payout of \$400 for up to 6 years,

Benefit Payout Period	Monthly Benefit Payable
1st 6 years	Severe Disability Benefit selected less \$400
Subsequent years (up to 12 years or a lifetime)	Severe Disability Benefit selected

For example if the Monthly Benefit selected is \$1,000 and the Benefit Payout Duration is 12 years,

Benefit Payout Period	Monthly Benefit Payable
1st 6 years	\$600/month
Subsequent years (up to 12 years)	\$1,000/month

The monthly benefit payout under MyCare Plus will be computed and payable as shown above, whether or not there is any actual payout payable to you from the Basic ElderShield300/400 Policy. For example, if Life Assured is unable to perform 2 out of 6 ADL, the Life Assured will be receiving the difference between the MyCare Plus Severe Disability Benefit and the Basic ElderShield monthly benefit amount though there is no payout from Basic ElderShield Policy.

KEY PRODUCT PROVISIONS

1. Monthly Severe Disability Benefit

You have the option to select a monthly benefit (inclusive of your Basic ElderShield benefit) from \$600 to \$3,500, in increments of \$100.

2. Benefit Payout Duration

- (a) Lifetime Benefit Payout Duration; or
(b) 12-year Benefit Payout Duration.

3. Lifetime Coverage

The coverage is for a lifetime. Aviva undertakes not to terminate the cover under this Policy for any reason unless earlier terminated as provided under the Policy.

4. Premium Term

- (a) limited (applicable for MyCare only)

Entry Age (Age Next Birthday)	41	42	43	44	45	46	47 onwards
Premium Term	26	25	24	23	22	21	20

Note: Last premium payment is till 66 age next birthday or for 20 years from entry age, whichever is later.

- (b) lifetime.

5. Premiums

Premiums are payable by Medisave or cash. You may withdraw up to \$600 per calendar year per Life Assured, from your or any other allowed Medisave account to pay the premiums. Any premium in excess of \$600 has to be paid by cash. This \$600 limit is applicable on the aggregate premiums of all ElderShield Supplement Policies, if you have more than one ElderShield Supplement Policy.

The premiums for this plan are level. However, they are not guaranteed and these rates may be adjusted, by giving you 30 days advance notice, based on future experience.

NEW Premiums are subjected to GST.

6. Guaranteed Renewability

This Policy is guaranteed to be renewable annually as long as premium is paid, unless terminated as provided under the Policy.

7. Deferment Period

This is a period of 90 days from the Claim Date (inclusive).

The Deferment Period shall be waived if the Life Assured again suffers from a Severe Disability arising from the same cause within 180 days from ceasing to suffer from the Severe Disability.

8. Exclusions

There are certain conditions whereby benefits under this plan will not be payable. These are stated as exclusions in the contract. You are advised to read the policy contract for the full list of exclusions.

Benefits under the Policy are not payable in the event of any one of the following occurrences in whole or in part:

- (a) intentionally self-inflicted injury, or attempted suicide whether the Life Assured is sane or insane;
(b) war, whether declared or undeclared;
(c) alcohol abuse; or
(d) drug addiction or abuse

No benefit payments shall be made for a Pre-Existing Disability or a disability arising from Pre-Existing Conditions.

9. Waiting Period (Applicable to MyCare Plus only)

No benefit shall be payable if the Life Assured suffers from a Severe Disability within 90 days from the Policy Issue Date, Policy Commencement Date or reinstatement date of the Policy, whichever is latest. This waiting period does not apply if the Severe Disability is caused by an Accident or the Severe Disability is such that the Life Assured is unable to perform more than 2 ADLs, even with the aid of special equipment, and always to require the physical assistance of another person throughout the entire activity.

"Accident" means an event caused solely and independently of all other causes and directly by violent, unexpected, external and visible means.

10. Paid-Up

After a minimum number of premium payments have been made, this Policy shall not terminate due to non-payment of premiums. Instead, this Policy will become paid-up with a reduced monthly Severe Disability Benefit. The other benefits under this Policy, where applicable, shall be reduced accordingly, based on the reduced monthly Severe Disability Benefit.

11. Basic ElderShield Policy

You need to have a Basic ElderShield Policy with any of the ElderShield insurers appointed by MOH before purchasing this Policy.

If the ElderShield Policy has lapsed due to non-payment of premiums or is terminated by you, Aviva Ltd shall also lapse this MyCare Policy.

This Policy will continue to remain in force on the following events:

- (a) if the premium has already been paid for this Policy before your request to terminate the Basic ElderShield Policy, this Policy shall be lapsed only at the next premium due date and cover under this Policy will continue then.
- (b) notwithstanding clause (a) above, a claim for the Severe Disability Benefit or the Rehabilitation Benefit is still being paid at the time the Basic ElderShield Policy is lapsed due to non-payment of premiums or is terminated by you, the Policy will not lapse and your claim will continue to be payable. When the claim payout subsequently ceases under this Policy and the Basic ElderShield Policy is no longer in force, this Policy shall lapse.
- (c) the Basic ElderShield Policy is terminated due to full payment of benefits.

12. Termination

This Policy shall terminate on the earliest of the following events:

- (a) the expiration of the grace period and outstanding premiums remain unpaid;
- (b) the death of the Life Assured;
- (c) if a claim has been admitted, on the expiry of the Benefit Payout Duration of the Severe Disability Benefit or the Rehabilitation Benefit, as applicable;
- (d) revocation, surrender or cancellation of the Policy; or
- (e) subject to clause 11(a) and 11(b) of this Product Summary, the Basic ElderShield Policy is lapsed due to non-payment of premiums or is terminated by you.

13. Free Look

Within sixty (60) days of the receipt of the Policy, you may write to us to cancel your Policy. We will refund the premiums you have paid (without interest).

The refund will be made after we receive the original Policy for cancellation. If the Policy was sent to you by post, you are considered to have received it seven (7) days from the date of posting.

14. Point-of-Sale Documents

A copy of the following documents are given at the point-of-sale:

- (a) Product Summary
- (b) Your Guide to Health Insurance

15. Policy Owners' Protection Scheme

This Policy is protected under the Policy Owners' Protection Scheme, and is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for Your Policy is automatic and no further action is required from You. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Us or visit the LIA or SDIC web-sites (www.lia.org.sg or www.sdic.org.sg).

Note: This plan is underwritten by Aviva Ltd. This is only product information provided by Aviva Ltd. You may wish to seek advice from a financial adviser before making a commitment to purchase the Policy. In the event that you choose not to seek advice from a financial adviser, you should consider whether the Policy in question is suitable for you. Buying health insurance products that are not suitable for you may impact your ability to finance your future healthcare needs. This is not a contract of insurance. Full details of the standard terms and conditions of this Policy can be found in the relevant Policy contract which will be sent to you upon acceptance by Aviva Ltd.



APPLICATION FORM

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.

<p>Particulars of Adviser</p> <p>Name: <input type="text"/></p> <p>Source Code: <input type="text"/></p> <p>Name of Firm: <input type="text"/></p> <p>Contact No.: <input type="text"/> (HP) <input type="text"/> (O)</p> <p>Email Address: <input type="text"/></p>	<p>Select the plan(s) applied for:</p> <p><input type="checkbox"/> ElderShield:</p> <p><input type="checkbox"/> MyCare:</p> <p><input type="checkbox"/> MyCare Plus:</p>	<p>For Official Use Only</p> <p>Contract No.: <input type="text"/></p> <p><input type="text"/></p> <p><input type="text"/></p> <p>Client No.: <input type="text"/></p>
<p>For Adviser Use Only</p> <p>Backdated to (DD/MM/YY): <input type="text"/> Referral ID: <input type="text"/></p>		

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.

Please complete in capital letters and tick boxes as appropriate.

SECTION A: PARTICULARS OF PROPOSER (LIFE ASSURED UNDER THE POLICY)

Full Name as shown in Identity Card/Passport: Salutation: Mr Mrs Mdm Miss Dr

Family Name: Given Name:

Gender: Male Female Marital Status: Single Married Widowed Divorced Others

Identity Card/Passport No.: Race: Chinese Malay Indian Others

Date of Birth (DD/MM/YY): Country of Birth: Nationality: (Please list your nationalities)

Usual Country of Residence:

Contact No.: (HP) (O) (H) Email Address:

Residential Address Block/Street No.: Street Name:

Unit No.: Building Name: Postal/Zip Code: Country:

Correspondence Address (if different from address above): Block/Street No.: Street Name:

Unit No.: Building Name: Postal/Zip Code: Country:

For existing policyholder with Aviva Ltd: Employment Status: Employed Self-employed Unemployed

If correspondence address differs from our records, Occupation:

do you wish to update the above address in all your Name of Employer:

other policy(ies)? Yes No Address of Employer:

SECTION B: DETAILS OF YOUR BASIC ELDERSHIELD PLAN

Please complete this section if you have an existing basic ElderShield policy.

Insurance Company: Aviva Great Eastern NTUC Income

SECTION C: DECLARATION OF FACT FIND OPTION

Please indicate the type of fact find that was carried out before the sale of this plan.

Full Fact Find Product Advice Only No Advice

SECTION D: DECLARATION OF BENEFICIAL OWNERSHIP

If there is any Beneficial Owner(s) in relation to the policy, we are required by regulation to request the details of such Beneficial Owner(s). Please provide the details such as Name and Identity Card/Passport No. of the Beneficial Owner(s) and your personal relationship(s) with them and submit a copy of their Identity Card/Passport to us.

Please provide relevant details here:

"Beneficial Owner" as defined in the MAS Notice on Prevention of Money Laundering and Countering the Financing of Terrorism means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over a body corporate or unincorporate.

For the avoidance of doubt, completion of this section is not a nomination of beneficiary(ies) under the policy.

SECTION E: PLAN DETAILS (ONLY APPLICABLE IF YOU PURCHASE AVIVA MYCARE OR MYCARE PLUS PLAN)

Please refer to Page 1 of Product Summary for details of the plan chosen.

Note: The maximum allowable monthly benefit is S\$3,500 per Life Assured, aggregated on all ElderShield Supplement Policies purchased from Aviva.

SECTION F: PAYMENT DETAILS

Note:

1. Current & future premium payment method must be the same. Please choose ONE premium payment method and tick the relevant boxes.
2. If your premium amount is within Medisave deduction limit of S\$600.00, the premium amount will be deducted fully from the Medisave Account(s) as stated in Section H.

ElderShield Plan Premium:

Interbank GIRO

Please complete the attached Application for Interbank GIRO form.

Cheque / Credit Advice (Deposit slip must be submitted)

CPF Medisave Account

Please complete Section H.

Combined Payment Methods

CPF Medisave Account for amount of S\$ (Please complete Section H), AND

Balance premium by (please tick ONE only):

Interbank GIRO for amount of S\$ (Please complete attached Application for Interbank GIRO form), OR

Cheque / Credit Advice for amount of S\$ (Deposit slip must be submitted)

MyCare Plan Premium:

Interbank GIRO

Please complete the attached Application for Interbank GIRO form.

Cheque / Credit Advice (Deposit slip must be submitted)

CPF Medisave Account (for premium amount up to S\$600.00 per Life Assured per calendar year)

Please complete Section H.

Combined Payment Methods

Maximum of S\$600.00 (per life to be insured per calendar year) via **CPF Medisave Account** (Please complete Section H), and

Balance premium by (please tick ONE only):

Interbank GIRO for amount of S\$ (Please complete attached Application for Interbank GIRO form), OR

Cheque / Credit Advice for amount of S\$ (Deposit slip must be submitted)

MyCare Plus Plan Premium:

Interbank GIRO

Please complete the attached Application for Interbank GIRO form.

Cheque / Credit Advice (Deposit slip must be submitted)

CPF Medisave Account (for premium amount up to S\$600.00 per Life Assured per calendar year)

Please complete Section H.

Combined Payment Methods

Maximum of S\$600.00 (per life to be insured per calendar year) via **CPF Medisave Account** (Please complete Section H), and

Balance premium by (please tick ONE only):

Interbank GIRO for amount of S\$ (Please complete attached Application for Interbank GIRO form), OR

Cheque / Credit Advice for amount of S\$ (Deposit slip must be submitted)

SECTION G: HEALTH QUESTIONS

1. What is your height and weight? Height: metres Weight: kg
2. Have you **ever** been **diagnosed** or have you been **treated** for any of the **conditions** below?
- | | | | | | |
|-------------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| a) hypertension or high cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | i) Dementia or Alzheimer's disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b) cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | j) Parkinson's disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | k) Multiple Sclerosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d) stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | l) Motor neuron disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e) heart disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | m) AIDS or HIV infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f) kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | n) arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g) liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | o) paralysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h) lung disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | p) Any other condition(s) not listed above: | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered 'Yes' to any of the above Questions 2(a) to 2(p), please complete the following:

Name of Condition	Date of first symptoms or diagnosis	Have you made a full recovery with no further treatment, ongoing symptoms or complications?	Name and address of the doctor who you consulted
Question () Condition: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/>
Question () Condition: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/>
Question () Condition: <input type="text"/>	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> No What treatment or medication did you take? <input type="text"/> <input type="text"/> <input type="text"/>

3. Do you need any **assistance** from another person or mechanical aids such as a cane, crutches, wheelchair or walker to enable you to go about your **activities of daily living*** (washing, dressing, feeding, toileting, moving from one place to another)?
- Yes No
- If 'Yes', what assistance do you need?
- Cane Wheelchair Crutches or walker Others, please describe _____
4. In the last **12 months**, has your ability to carry out your daily activities (such as housework, preparing meals, shopping, using public transport or a hobby) been **reduced** or **restricted** in anyway due to your **health** or **disablement**?
- Yes No
- If 'Yes', please provide details. _____

* Please refer to Product Summary for its definitions.

SECTION H: AUTHORISATION BY CPF ACCOUNT HOLDER(S) (FOR PAYMENT USING CPF MEDISAVE ACCOUNT ONLY)

- I authorise the Central Provident Fund Board to deduct premium(s) due from the Policyholder to be covered under this Policy from my Medisave account in accordance with the provisions of the Central Provident Fund Act (Chapter 36), and the regulations made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the 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 any 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 S\$600.00 per life to be insured per calendar year only. Any excess over this limit has to be paid in cash.
- I authorise Aviva Ltd to deduct any extra premiums from Medisave Account(s) in accordance to the proportion as stated.

SECTION H: AUTHORISATION BY CPF ACCOUNT HOLDER(S) (FOR PAYMENT USING CPF MEDISAVE ACCOUNT ONLY) (continued)

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

ELDERSHIELD PLAN					
CPF Account Holder's Name	Date of Birth (DD/MM/YY)	CPF Account No.	Relationship to Applicant	% of Premium ⁺	Signature of Account Holder & Date

MyCare Plan - For payment through own/ spouse's/ children's/ grandchildren's/ parent's CPF Medisave Account, please complete the following:
If payment details are the same as ElderShield Plan, please tick here

MYCARE PLAN					
CPF Account Holder's Name	Date of Birth (DD/MM/YY)	CPF Account No.	Relationship to Applicant	% of Premium ⁺	Signature of Account Holder & Date

MyCare Plus Plan - For payment through own/ spouse's/ children's/ grandchildren's/ parent's CPF Medisave Account, please complete the following:
If payment details are the same as ElderShield Plan, please tick here

MYCARE PLUS PLAN					
CPF Account Holder's Name	Date of Birth (DD/MM/YY)	CPF Account No.	Relationship to Applicant	% of Premium ⁺	Signature of Account Holder & Date

⁺ Total CPF contribution must add up to 100% for each plan applied. If there is no indication, the percentage of premium will be distributed equally among the CPF account holder and the total contribution will be taken.

SECTION I: DECLARATION

- I understand that the insurance shall not take effect until this application is accepted, the full premium is received and the policy is issued by Aviva Ltd. (Applicable to MyCare and MyCare Plus plans only)
- I understand that I need to have a basic ElderShield policy with any of the Medisave-approved ElderShield insurers to qualify for MyCare or MyCare Plus application.
- I agree to purchase only one ElderShield policy using Medisave with any insurer. (Applicable to ElderShield plan only)
- I agree to take sole responsibility to ensure this product is appropriate to my financial needs and insurance objectives. (Applicable to ElderShield plan only)
- I declare that I have been given a copy of the Product Summary, Fact Find, Your Guide to Health Insurance, and the contents of these documents have been explained to my satisfaction. (Applicable to MyCare or MyCare Plus plans only)
- I 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 knowledge and belief, the information furnished is true and complete. I agree to inform Aviva Ltd if there is any change in the state of my health or activities between the date of this application and the date full insurance coverage is provided by Aviva Ltd to me.
- I 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 am aware that the product that I am applying for is authorised for sale in Singapore and I acknowledge that I am responsible for ensuring that the laws and regulations applicable to my nationality and country of residence allows my purchase of this product. I understand that no liability can be accepted by Aviva Ltd for any legal consequences under the laws of any other country or any tax implications that may arise in connection with my purchase of this product.
- I further declare that I am not an undischarged bankrupt 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.
- I agree that in addition to the release of information to any medical source, insurance office or other organisation mentioned in this section, Aviva Ltd is authorised to use and/or disclose as it reasonably deems fit, any information obtained from any source in respect of me, that is held by Aviva Ltd to employees, representatives and relevant third parties (including but not limited to companies within the Aviva Group, reinsurers, my financial advisers, financial institutions, credit agencies, direct marketing service providers, investigators, regulatory, governmental and statutory authorities) whether within or outside Singapore. As far as possible, Aviva Ltd will release such information to such parties on the understanding that the information will be kept strictly confidential.

SECTION I: DECLARATION

11. I 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 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.

Important Notes:

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 adviser but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.

Signature of Proposer:

Name:

Identity Card/Passport No.:

Date (DD/MM/YY):

Signature of Witness/Adviser:

Name of Witness/Adviser:

Identity Card/Passport No.:

Date (DD/MM/YY):

Intentionally Left Blank

For E-GIRO Use

I have verified that the Account holder, Account number, NRIC number & signature as stated under the Application for Interbank GIRO* form are identical to the records maintained in DBS/POSB.

(*Only if nominated account is a DBS/POSB account).



Verified By:

Name, Signature & Specimen Signature No.

APPLICATION FOR INTERBANK GIRO (Please submit original form to Aviva)

FOR APPLICANT'S COMPLETION

Date (DD/MM/YY): Name of Billing Organisation ("BO"): **Aviva Ltd**
To: Name of Bank: Bank Branch:

Plan	Policy Number*:	Name of Policy Owner:	NRIC Number:
<input type="checkbox"/> ElderShield			
<input type="checkbox"/> MyCare			
<input type="checkbox"/> MyCare Plus			

* Please write the Policy Number which you wish to apply for GIRO using this bank account number only.

- a) I hereby instruct you to process Aviva's instruction to debit my account.
- b) You are entitled to reject Aviva's debit instruction if my account does not have sufficient funds and charge me 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 address last known to you or upon receipt of my written revocation through Aviva.
- d) The use of correction tape is not allowed. Amendments made on this form must be countersigned by applicant.

My Bank Account Name: Mr/Mdm/Ms/Dr

My NRIC Number:

My Bank Account Number:

My Contact Number (Home/Handphone):

My Signature(s)/Thumbprint^ (as in Bank's Record):

My Residential Address:
(if address differs from Section A)

^ If your account is operated by thumbprint, your thumbprint needs to be witnessed and verified by the bank's staff.

FOR BILLING ORGANISATION'S COMPLETION

Bank 7 1 7 1	Branch 0 2 7	Aviva's Bank Account Number 0 2 7 0 0 0 7 5 9 7	Aviva's Customer Reference No.:
Bank <input type="text"/>	Branch <input type="text"/>	Account Number to be Debited <input type="text"/>	<input type="text"/>

FOR BANK'S COMPLETION

To: Aviva Ltd
This Application is hereby **REJECTED** (please tick) for the following reason(s):

- Signature/Thumbprint# differs/irregular# from bank's records
- Signature/Thumbprint# is incomplete/unclear#
- Account operated by Signature/Thumbprint#
- Wrong account number
- Amendments not countersigned by customer
- Others _____

Name of Approving Officer:

Authorised Signature: Date:

Please delete where applicable