APPLICATION FOR REINSTATEMENT OF LAPSED POLICY

Pursuant to Section 25(5) of the Insurance Act (Cap 142), you are to disclose in this application form fully and faithfully all the facts which you know or ought to know, otherwise nothing may be payable under the Policy.

Contract / Policy / Certificate Number : ______________________________

Name of Assignee/Assured : ______________________________

Name of Life Assured : ______________________________

Name of Joint Life Assured : ______________________________

Amount paid with this application : $ ______________ Cheque No : ______________

I, wish to apply for reinstatement of the above Policy and confirm that the answers to the following questions are true to the best of my knowledge and no material facts have been withheld:-

Please tick if you also wish to reinstate the rider(s) that is/are pending for registration.

☐ Yes, I wish to reinstate my pending rider(s).

General Questions	Life Assured *Yes*	Life Assured *No*	Joint Life Assured *Yes*	Joint Life Assured *No*	**Details**
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.	☐	☐	☐	☐	
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.	☐	☐	☐	☐	
3. Are there any changes in your residency (from one country to another) for the past 12 months? If Yes, please provide details.	☐	☐	☐	☐	
4. 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	:	Height__________m	Weight__________kg
Joint Life Assured / Assured	:	Height__________m	Weight__________kg

	Life Assured *Yes*	Life Assured *No*	Joint Life Assured *Yes*	Joint Life Assured *No*	**Details**
3. b. Have you ever had unexplained weight loss since the commencement of the Policy?	☐	☐	☐	☐	
4. Are you currently taking medication or considering seeking medical advice from a doctor?	☐	☐	☐	☐	
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?	☐	☐	☐	☐	
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.	☐	☐	☐	☐	
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 below.	☐	☐	☐	☐	

Aviva Ltd 4 Shenton Way #01-01 SGX Centre 2 Singapore 068807 Tel: (65) 6827 7988 Fax: (65) 6827 7900 www.aviva.com.sg Company Reg. No.: 196900499K
GST Reg. No.: MR-8500166-8 Navigator Investment Services Ltd Company reg. No.: 200103470W GST Reg. No.: 20-0103470-W

Medical Questions		Life Assured Yes	Life Assured No	Joint Life/ Assured Yes	Joint Life/ Assured No	Details
8.	Have you smoked cigarettes in the past 12 months? If 'Yes', please state for how many years and how many sticks per day.	☐	☐	☐	☐	
	No. of years					
	No. of sticks per day					
9.	Do you take alcohol? If 'Yes', please state type and the average daily consumption.	☐	☐	☐	☐	
	Type					
	Quantity					
10.	Have you ever taken addictive drugs/narcotics or been treated for alcoholism or drug addiction?	☐	☐	☐	☐	
	For Female Only					
	a. Have you suffered from or are you aware of any breast lumps or any other disorders of your breasts?	☐	☐	☐	☐	
	b. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	☐	☐	☐	☐	
	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?	☐	☐	☐	☐	
	d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If 'Yes', please state type, reason, date of test done and result of test (copy to be submitted if available).	☐	☐	☐	☐	
	e. Are you now pregnant? If 'Yes', please state the number of month(s).	☐	☐	☐	☐	No. of months
	f. For females who have conceived, were there any complications during pregnancy such as gestational diabetes, hypertension, etc?	☐	☐	☐	☐	
	For Child Only Was the child born prematurely or been diagnosed to have any congenital disorder or birth defects?	☐	☐	☐	☐	
	For Male Only 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.	☐	☐	☐	☐	

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Declaration

	Assured / Assignee	Trustee / Beneficiary	Trustee / Beneficiary
Do you have one or more U.S. Indicia*? *U.S. Resident / Citizen / Place of Birth / Taxpayer ID number / Mailing or Residential Address / Contact Number If **'Yes'**, please complete the **United States of America (U.S) Person Declaration Form**.	□ Yes □ No Name:	□ Yes □ No Name: □ Yes □ No Name:	□ Yes □ No Name: □ Yes □ No Name

I/we 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/we authorise any medical source, insurance office or organisation to release to Aviva Ltd and similarly Aviva Ltd to release to any of the prior mentioned organisations, relevant information concerning me at any time, regardless of whether the application is accepted by Aviva Ltd. A photographic copy of this authorization shall be as valid as the original.

I/we further declared I/we am/are not undischarged bankrupt(s) 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 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.

On behalf of myself and all proposed insured lives, I/we consent to Aviva (and Aviva related group of companies) collecting, using and/or disclosing my/our personal data (whether contained in this form or from other sources; existing data in Aviva's record or to be collected in future) to issue and administer my existing and/or new policy(ies) and/or account(s) with Aviva, including the processing of my/our personal data for underwriting purposes, payment of premiums and/or claims purposes; for statistical, compliance, audit and regulatory purposes; to provide general information on product enhancements and services relevant to my needs or policies (including increasing benefits, adding riders / supplements and/or insured lives) as well as to provide financial advice or product recommendations to me, where applicable.

On behalf of myself and all proposed insured lives, 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 / Authorised Signatory of Assignee / Assured
* Company Stamp is required if Assignee / Assured is a Company
Name:
Mobile Number:
Email Address:

Date

Signature of Life Assured/Joint Life Assured
Name:
Mobile Number:
Email Address:

Date

Signature of trustee(s)
Name:
Mobile Number:
Email Address:

Date

Notes:
1) Both the Assured and the Life Assured above the age of 16 are to sign this Application.
2) Please note that the signatures of Assignee / Assured / Life Assured / Trustee must be consistent with our record.
3) The Assured will declare on behalf of the Life Assured below the age of 16.
4) Mobile Number and email address provided will replace our records accordingly.

*** Signature of Trustee(s) are required for Policies under Trust.**

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