Underwritten by:

Administered by:

AIG Medi-Care Application to Add Beneficiary Form

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Please complete this application and return the FULL form to us by email. See our contact information at the end of this form. Please complete this form in BLOCK CAPITALS.

APPLICANT DETAILS

Policyholder's Name	
Policy Number	

HOW WE USE YOUR INFORMATION

In relation to the personal information collected in this claim form (or otherwise provided during the course of the claim process, including by way of call recordings), I agree and consent, and if I am submitting information relating to another individual, I represent and warrant that I have the authority to provide that information to AIG Asia Pacific Insurance Pte. Ltd. ("AIG") and/or its service providers, I have informed the individual about the purposes for which his/ her personal information is collected, used and disclosed as well as the parties to whom such personal information may be disclosed by AIG and/or its service providers, as set out in the contents of the consent clause below and the individual agrees and consents, that AIG and/or its service providers may collect, use and process my/his/her personal information as follows:

a) the personal information may be collected, used and disclosed by AIG and/or its service providers to:

i. process and administer this insurance claim;
ii. assess, investigate, adjust and make a decision on this claim;
iii. administer my insurance policy (including pursuing recovery from reinsurers or other parties);
iv. deal with disputes and complaints,
v. respond to requests for information from public and governmental/ regulatory authorities, statutory boards and for audit, compliance, investigation and inspection purposes;
vi. respond to requests from the policyholder;
vii. carry out due diligence or other screening activities (including background check(s)) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by AIG;
viii. compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
ix. manage AIG's infrastructure and business operations; and
x. for other purposes stated in AIG's Data Privacy Policy.

b) AIG and/or its service providers may transfer the personal information to the following classes of persons (whether located in Singapore or elsewhere) for the purposes identified in (a) above:

i. third parties providing services related to the administration of my policy (including reinsurers) and processing of my claim;
ii. AIG's agents;
iii. brokers, my authorised agents or representatives or next-of-kin;
iv. the policyholder;
v. legal process participants and their advisors;
vi. governmental/regulatory authorities, industry associations, courts, other alternative dispute resolution forums;
vii. other financial institutions for the purpose of administering this claim, obtaining policy payments;
viii. loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers,
ix. external auditors;
x. another member of the AIG group (for all of the purposes stated in (a)) in any country; or
xi. other parties referred to in AIG's Data Privacy Policy for the purposes stated therein.

Note: The full version of AIG's Data Privacy Policy can be found at https://www.aig.sg/privacy

BENEFICIARY 1 DETAILS

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender (please tick)	Male		Female		
Date of birth (DD/MM/YYYY)		Occupation					
NRIC/FIN No.							
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							
Height: Feet		Inches		Centimetres		**Weigh**: Stones	
Pounds		Kilogrammes					
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?		Yes		No			
If **Yes**, how many per day?	Less than 20 per day		20 or more per day		Other		

If the beneficiary is less than 90 days old:					
Was the beneficiary born to a surrogate or adopted?	Yes		No		
Was the beneficiary born premature?	Yes		No		
If Yes, at how many weeks of pregnancy were they born?					

BENEFICIARY 2 DETAILS (if required)

Title		First Name		Other Initials		Surname	
Relationship to policyholder		Gender (please tick)	Male		Female		
Date of birth (DD/MM/YYYY)		Occupation					
NRIC/FIN No.							
Nationality (What is the nationality of the primary passport that you hold?)							
Location (The country in which you live/will live for the majority of your time for the period of cover)							

Height: Feet		Inches		Centimetres		**Weigh**: Stones		Pounds		Kilogrammes	
Have you smoked, or used tobacco or nicotine replacement products in the last 12 months?						Yes		No			
If **Yes**, how many per day?	Less than 20 per day		20 or more per day		Other						

If the beneficiary is less than 90 days old:					
Was the beneficiary born to a surrogate or adopted?	Yes		No		
Was the beneficiary born premature?	Yes		No		
If Yes, at how many weeks of pregnancy were they born?					

DECLARATION FOR ALL CUSTOMERS

Please note - We require you to disclose every aspect of the medical history for the beneficiary. This includes telling us about any changes to any medical conditions, treatment or medication and any outstanding, ongoing or repeat medical tests that have been suggested.

MEDICAL QUESTIONS

	Has any beneficiary received treatment, test or investigations for, or been diagnosed with, or had any symptoms of:	**Yes**	**No**
1	Diabetes and other endocrine (glandular) disorders e.g. any thyroid disorder, weight problems, gout, pituitary or adrenal gland conditions?		
2	Heart or circulatory disorders e.g. chest pain, heart attack, high blood pressure, vascular disease, coronary artery disease, angina, irregular heartbeat, aneurysm or heart murmur.		
3	Cancer, tumours or growths including polyps, cysts or breast lumps.		
4	Muscle or skeletal problems e.g. back pain, whiplash, arthritis, joint pain or problems, gout, fractures, cartilage, tendon or ligament problems.		
5	Asthma, allergies, breathing or respiratory disorders e.g. chest infections, pneumonia, bronchitis, shortness of breath, rhinitis, TB, emphysema or chronic obstructive pulmonary disease.		
6	Gall bladder, stomach, intestinal, gastric or liver problems e.g. irritable bowel disease, colitis, Crohn's disease, gastric or peptic ulcers, reflux, indigestion, heartburn, gall stones, hernia, haemorrhoids or hepatitis.		
7	Brain or neurological disorders e.g. multiple sclerosis, epilepsy or seizures, stroke, migraines, recurring or severe headaches, meningitis, shingles or nerve pain.		
8	Skin problems e.g. eczema, acne, moles, rashes, allergic reactions, cysts, dermatitis or psoriasis.		
9	Blood, infective or immune disorders e.g. high cholesterol, anaemia, malaria, HIV or systemic lupus erythematosus.		
10	Urinary or reproductive disorders e.g. urinary tract infections, kidney problems, fibroids, painful, irregular or heavy periods, fertility problems, polycystic ovarian syndrome, endometriosis, testicular or prostate problems.		
11	Anxiety, depression, psychiatric or mental health issues including eating disorders, post-traumatic stress disorder, drug or alcohol misuse or dependence.		
12	Ear, nose, throat, eye or dental problems e.g. ear infections, sinus problems, tonsils and adenoids, cataracts, glaucoma, wisdom teeth problems.		

Please also answer the following questions:		Yes	No
13	Does any beneficiary have any illness, condition or symptom not already mentioned? Please include details of any known or suspected issues whether or not medical advice has been sought or a diagnosis reached.		
14	Does any beneficiary take any medication, receive any treatment of any kind or expect to have a review or follow up for any current or past medical problem not already mentioned?		

If any beneficiary fails to inform us about a condition which we reasonably believe to have existed prior to the policy initial start date or the effective date of the change to the policy (whether the condition was already present, the beneficiary had symptoms, or taken advice from a medical practitioner); this could (subject to local law and regulation) result in us reducing the amount of any claims payment, which the beneficiary is due or in refusing to pay a claim or claims related to such condition altogether.

You warrant and represent that you have each beneficiary's consent to disclose the personal information, including the sensitive personal information (e.g. medical information) contained in this form to us. You confirm that each beneficiary is aware of their duty to take reasonable care to answer questions accurately, honestly, completely and to the best of their knowledge.

(Please note that if you are declaring the above on another person's behalf, it is your obligation to keep evidence of the consent you are providing here to of that person's actual declarations and consents.)

Consent obtained (internal use only)		Date	
Policyholder's Signature		Date	

CONFIDENTIAL HEALTH QUESTIONNAIRE

You now need to provide information about the medical history of the beneficiary. If you tick Yes to a question, please provide full details overleaf. Depending on the medical history, we might need some further information before we can finalise cover.

Please read the following questions very carefully. Please take reasonable care to answer all questions honestly and fully. Careless misrepresentation could result in us reducing the amount of any claims proportionately; whereas deliberate or reckless misrepresentation could result in us rejecting claims, and/or cancelling cover. If you need help completing your application, please contact us.

If you are unsure about the answer to any question you should make the enquiries necessary to allow you to provide an accurate answer.

ADDITIONAL HEALTH INFORMATION

If you have answered "Yes" to any of the 7 Health Questions, please provide details below. If you are unsure that any details are relevant, please include them anyway. If you run out of space, please use the Additional Information section.

Question Number	Who has suffered from this condition?	What is the name of the illness or medical problem. Where applicable state the area of the body affected? (e.g. left arm, right foot)	When did the symptoms occur and when did you last have symptoms?	What treatment was provided? (Include details of medication and dates of when treatment started and ended)	What is the current status of the illness or medical problem? (E.g. ongoing, complete recovery, recurrent or likely to recur.)

SPACE FOR ADDITIONAL INFORMATION

Please return **ALL** pages of the form to AIGCustomerCare@Cigna.com.

Need to get in touch?

If you have any questions about your policy, need to get approval for treatment, or for any other reason, please contact Cigna's Customer Care team 24 hours a day, 7 days a week, 365 days a year.

Use your Customer Area

- Live chat with us
- Message us
- Arrange a callback

Call Us

- Singapore: +65 6549 3188
- International: +44 1475 333420

Alternatively, you can email us at: AIGCustomerCare@cigna.com