Junior Advantage
Application Form

Statement pursuant to Section 25(5) of the Insurance Act (Cap 142) or any amendments thereof; You are to disclose in this application, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued may be void and you may receive nothing from the policy.

(Inclusive of GST)

☐ Junior Advantage	S$ 184.98
☐ Junior Advantage with Optional Critical Illness Cover	S$ 265.96

Name (Existing Policies, if any)[1]	Policy No.
1.	
2.	

Proposer (Mr/Mrs/Mdm/Ms): _____ NRIC No.: _____

Address: _____ Date of Birth: _____ (dd) _____ (mm) _____ (yy)

Occupation: _____ Nature of Business: _____

Tel (Office): _____ Tel (Home): _____ Tel (Mobile): _____ Email: _____

My Child's Particulars

Name:	Date of Birth:	Sex:	NRIC/Birth Certificate:

Payment Mode

I / We agree to pay the premiums according to the plan chosen and I / We hereby authorize AIG Asia Pacific Insurance Pte. Ltd. to charge the stated annual premium to the following credit card. Where a third party credit card is used, I / We declare that the cardholder has authorized and consented to its use.

☐ Credit Card: (please tick accordingly) ☐ mastercard ☐ Visa

☐ One Time Payment Only OR

☐ One Time & Recurring Payment

Cardholder's Name _____

Credit Card No. ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiry Date (mm-yy) ☐☐ - ☐☐

NB: Policy will be issued upon receipt of approval from the respective credit card company.

Annual Premium S$ _____ (inclusive of GST)

Declaration and Authorization (Kindly complete the following)

Important Information:
If you answer 'YES' to any of the below questions, you will **NOT** be eligible for cover.

Has any of your children in the last 2 years received or taken or been advised to take medicine continuously or been prescribed any diet or undergone diagnostic tests other than routine check-ups?	☐ Yes	☐ No
Has any of your children been diagnosed with or been treated for:	☐ Yes	☐ No
a. Chest or breathing complaint (eg. Asthma, Bronchitis)	☐ Yes	☐ No
b. Heart condition or other problem of the blood or vessels	☐ Yes	☐ No
c. Digestive system, kidney, liver, endocrine disease, diabetes or thyroid problem	☐ Yes	☐ No
d. Mental or brain illness or illness affecting the nervous system	☐ Yes	☐ No
e. Cancer, tumour, cyst or other growths	☐ Yes	☐ No
f. Pain or problem of the spine, muscles or joints	☐ Yes	☐ No

I understand that all pre-existing conditions are not covered.

I am aware that I can seek advice from a qualified advisor before I sign this enrolment form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

If I am switching policy, I should consider whether this will result in any cost and whether the benefits under the new policy are more suitable.

I hereby declare that I am ordinary resident in Singapore as defined by "Insurance Act (Cap, 142) (Amendment of First Schedule) Order 2010"

I/We hereby declare that I/we have received, read and understood, or have been advised of and understand, the contents of the brochure and my information material relating to this Insurance product.

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, 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, as set out in the contents of the consent clause contained below and the individual agrees and consents, that AIG may collect, use and process my/his/her personal information (whether obtained in this application form or otherwise obtained) and disclose such information to the following, whether in or outside of Singapore: (i) AIG's group companies; (ii) AIG's (or AIG's group companies') service providers, reinsurers, agents, distributors, business partners; (iii) brokers, my/his/her authorised agents or representatives, legal process participants and their advisors, other financial institutions; (iv) governmental / regulatory authorities, industry associations, courts, other alternative dispute resolution forums, for the purposes stated in AIG's Data Privacy Policy which include:

(a) Processing, underwriting, administering and managing my/his/her relationship with AIG;
(b) Audit, compliance, investigation and inspection purposes and handling regulatory / governmental enquiries;
(c) Compliance with legal or regulatory obligations, risk management procedures and AIG internal policies;
(d) Managing AIG's infrastructure and business operations; and
(e) Carrying out market research and analysis and satisfaction surveys.

Note: Please refer to (and if submitting information relating to another individual, refer such individual to) the full version of AIG's Data Privacy Policy found at http://www.aig.com.sg/sg-privacy_1030_237853.html before you provide your consent, and/or the above representation and warranty.
I also consent, and if I am submitting information relating to another individual, I represent and warrant that such individual also consents, to AIG, AIG's group companies, service providers and business partners using, processing and disclosing my/his/her personal information to:

(a) enrol me/him/her in contests, prize draws and similar promotions; and
(b) contact me/him/her to market other insurance, and/or financial products and/or services of AIG, AIG's group companies and/or AIG's business partners.

If you or such individual wishes to opt out of being enrolled in contests, prize draws and similar promotions and from receiving marketing messages, please send an SMS to 76161 in the following format "optout<space>NRIC/FIN number" or call us at +65 6419 3000. Alternatively, you or such individual can opt out via our website at https://www-411.aig.com.sg/contactus/CustomerForm.aspx.

Signature of Applicant

Date

For Official Use

Have you obtained your Health Insurance Qualifications? ☐ Yes ☐ No

Producer Name: _____ Producer Code: _____

Agency: _____ Mailing Address: _____

Tel (Office): _____ Tel (Home): _____ Tel (Mobile): _____ Email: _____

This policy is protected under the Policy Owners' Protection Scheme which 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 AIG Asia Pacific Insurance Pte. Ltd. or visit the AIG, GIA or SDIC web-sites (www.AIG.sg or www.gia.org.sg or www.sdic.org.sg).

Neither this application form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

This Insurance is underwritten by: AIG Asia Pacific Insurance Pte.Ltd.

AIG Bring on tomorrow

AIG Building
78, Shenton Way #09-16
Singapore 079120
www.AIG.sg
Co. Reg. No. 201009404M

Junior Advantage
Product Summary

Presented to: (Name of Applicant)	Signature of Applicant:
Presented by: (Name of Financial Advisor)	Signature of Financial Advisor:

Insured Person(s)	Gender	Age Last Birthday (dd/mm/yy)	Plan Type

Total Premium (S$):

Please note that this is not a summary of contract and the premium is not guaranteed. AIG Asia Pacific Insurance Pte. Ltd. may at its sole discretion increase the premium from time to time depending on the claims experience of this portfolio. The annual premium is based on the Insured Person's age on the first day of the Period of Insurance and the renewal premium rates as determined by AIG at the time of renewal, based on the attained age of the Insured Person. This plan is available to a person from age 30 days to 15 years, residing in Singapore. Application is subject to underwriting review and acceptance. Benefits payable due to an Injury is only payable upon an Accident occurring.

Product Information

The Company will pay according to the limits of compensation as set out in the Schedule of Benefits:

Schedule of Benefits	Sum Insured (S$)
Accidental Disability (based on compensation scale as shown in the Policy) - Permanent Total Disablement - Loss of or the Permanent Total Loss of Use of two Limbs - Loss of or the Permanent Total Loss of Use of one Limb - Permanent total Loss of Sight of both eyes - Permanent total Loss of Sight of one eye - Loss of or the Permanent total Loss of Use of one Limb and Loss of Sight of one eye - Loss of Speech and Hearing - Permanent total Loss of Hearing - Loss of Speech - Permanent total loss of the lens of one eye - Loss of or the Permanent total Loss of Use of four fingers and thumb - Loss of or the Permanent total Loss of Use of four fingers - Loss of or the Permanent total Loss of Use of one thumb - Loss of or the Permanent total Loss of Use of fingers - Loss of or the Permanent total Loss of Use of toes - Fractured leg or patella with established non-union - Shortening of leg by at least 5 cm - Third Degree Burns	Up to S$50,000
Special Education Benefit due to specified permanent disablement arising out of injury - Loss of both limbs - Loss of sight of both eyes - Loss of speech and hearing - Total disablement - Loss of 1 limb and sight in 1 eye	Up to S$100,000
Accident Medical Reimbursement	Up to S$2,000 per injury
Daily Hospital Income due to an injury or illness	S$60 per day up to 365 days of hospitalisation
Subsidy for child care or school fees	S$200 cash benefit per injury or illness if hospitalisation is in excess of 5 days
Surgical Reimbursement per injury or illness including day surgery	Up to S$1,000 per injury or illness
Parental Allowance if child is hospitalised (based on evidence of hospitalisation of child)	S$40 per day up to a maximum of 30 days One amount payable only although both parents may stay with child
Reimbursement of A&E expenses including ambulance charges following admission of child via A&E unit	Up to S$200 per injury or illness if hospitalisation is in excess of 3 days
Accidental Death benefit	S$5,000
Emergency Medical Evacuation And Repatriation if child is abroad on an exchange/field/immersion programme	Up to S$250,000 per injury or illness
Critical Illness Cover (Optional benefit) Covers severe asthma, leukaemia, death resulting from hand, foot, mouth disease, severe epilepsy, tuberculous meningitis, haemophilia, insulin dependent diabetes mellitus, paralysis (irreversible loss of limbs), bone marrow transplant, severe encephalitis, Kawasaki disease with heart complications, still disease, irreversible aplastic anaemia, rheumatic fever with heart involvement, acquired brain damage.	S$10,000

Premium Table

Plan Type	Annual Premium Per Child (Inclusive of GST)
Junior Advantage	S$ 184.98
Junior Advantage with Optional Critical Illness Cover	S$ 265.96

Premium rates set out are level premiums. However, the rates are not guaranteed and the Company may at its sole discretion increase the premiums based on the claims experience on the entire portfolio

Note: Injury means bodily injury which is sustained during the period of insurance and is caused by an Accident (as defined in the Policy) and must occur within 365 days from the date of Accident.

Key Product Provisions

The following are key product provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the contract. Please consult your insurance advisor or AIG should you need further explanation.

- **Terms of Renewal**
  Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

- **Non-Guaranteed Premium**
  Premium payable for this coverage is not guaranteed. It may be increased at the sole discretion experience of this portfolio.

- **Waiting Period for Critical Illness Cover (Optional Benefit)**
  No benefits will be payable if the signs or symptoms of the Insured Critical Illness experience by the Insured commenced within 90 consecutive days of the date of issue or endorsement of the policy on this optional cover or the date of last reinstatement, whichever is later.

- **Survival Period for Critical Illness Cover (Optional Benefit)**
  No benefits will be payable if the Insured Person dies within 30 days of being diagnosed as suffering from a Critical Illness. Such survival period shall not apply if the Insured Person suffers death resulting from Hand, Foot and Mouth Disease.

- **Exclusions**
  There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. You are advised to read the policy contract for the full list of exclusions.

  - Any act of war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion or revolution;
  - An Insured Person engaging in air travel other than as a passenger in any properly licensed private and/or commercial aircraft;
  - An Insured Person engaging in a sport in a professional capacity or where such person would or could earn income or remuneration from engaging in such sport;
  - Suicide or attempted suicide or intentional self Injury or from deliberate exposure to exceptional danger (except in an attempt to save human life) or from an Insured Person's own criminal act, or is sustained whilst an Insured Person is in a state of insanity;
  - Pregnancy, miscarriage, abortion, childbirth, sterilisation, contraception as well as treatment for infertility;
  - Acquired Immunodeficiency Syndrome (AIDS), AIDS-related complex or, any infection by Human Immunodeficiency Virus (HIV);
  - Provoked assault, intoxication, drug abuse or insanity by natural causes;
  - General check–up, convalescence, custodial or rest cure;
  - Dental disease, dental care or surgery, cosmetic or plastic surgery or any elective surgery unless necessitated by an Accident;
  - Congenital anomalies and conditions arising out of and resulting therefrom or physical impairment;
  - Any mental, psychiatric and/or nervous disorders including anxiety or depression, sleep disorders, convalescence of rest care, alcoholism and drug related treatment;
  - Any Injury or Permanent disability directly or indirectly caused by an Illness or Critical Illness, disease, bacterial infection;
  - Pre-existing conditions as specifically defined under Part I – Definitions;
  - Any expenses incurred under Benefit 10 for services provided by another party for which the Insured Person is not liable to pay, or any expenses already included in the cost of a scheduled trip;
  - Any expenses for a service not approved and arranged by Travel Guard or an authorised representative of Travel Guard, except that this exclusion shall be waived in the event the Insured Person cannot for reasons beyond his control notify Travel Guard during an emergency medical situation. In any event, We reserve the right to reimburse the Insured Person only for those expenses incurred for service which Travel Guard would have provided under the same circumstances and up to the limits indicated under the selected plan.

- **14 Day Free-Look**
  Once you receive the contract of insurance, there is a 14 day free-look period for you to appreciate the benefits of the Plan. You may wish to seek the advice of a qualified advisor if you are in doubt. If you choose not to seek such advice, you must consider if the Plan is suitable for your needs. If you find it unsuitable, you may choose to return the Policy to AIG by mail before the end of the 14-day review period.

AIG Bring on tomorrow

AIG Building
78, Shenton Way #09-16
Singapore 079120
www.AIG.sg
Co. Reg. No. 201009404M

Confidential Fact-Find for:

Client's Name: _____

By Your Insurance Advisor (Advisor's Name): _____

Section 1: "Know Your Client" Form
Important Notice to Clients

For Agents

Your insurance advisor is a representative with AIG Asia Pacific Insurance Pte. Ltd. and is able to advise you on the products of :

1) AIG Asia Pacific Insurance Pte. Ltd.

2) _____

3) _____

For Insurance Brokers/Financial Advisers

Your insurance advisor is a broker with _____

As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to discolse to you the insurance companies from which he/she sources the products.

Standard Statement Applicable to all Advisors

Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs is the basis on which advice is given. A policy purchased without the proper completion of a "Know Your Client" Form may not be appropriate to your needs.

Application Type

Client's Option: [Please tick (√) in the appropriate box]

1. ☐ I/We wish to disclose all information required for this Form. (Please complete Sections 1 & 2 and sign both sections indicated with a "X")
2. ☐ I/We wish to receive product advice only. (Please complete Sections 1 & 2, except for Section 2, Part 1(a) & (b), and sign both sections indicated with a "X")
3. ☐ I/We do not wish to receive any advice from my/our advisor. (Please complete Sections 1 and sign at the place indicated with a "X")

!/We acknowledge that the insurance advisor had provided me/us with a copy of the completed "Know Your Client" Form.

Advisor's Declaration:

I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.

X _____

Signature of Client (on behalf of all Applicants)

Date (dd/mm/yyyy):

_____

Signature of Advisor

Date (dd/mm/yyyy):

Personal Information

NRIC. No: _____ Date of Birth (dd/mm/yyyy) _____

Marital Status: Single / Married / Divorced / Separated / Widowed Gender: Male / Female

Current Occupation: _____ Monthly Income Range ☐ 1. Below S$2,500

☐ 2. S$2,501 - S$5,000

☐ 3. S$5,001 - above

Details of Spouse & Dependents (if family coverage is requited)

Name	Relationship	DOB	Gender	Occupation	Monthly income
			M / F		
			M / F		
			M / F		
			M / F		

Existing Health Insurance Policies

This covers all Health Insurance Policies you currently have (eg: CPF-approved Mediacal Scheme, Personal Madical, Hospital Income, Long Term Care, Employer-Sponsored Schemes etc)

Policy Type*	Insured**	Type & Amount of Benefit***	Annual Premium***	Expiry Date***

* Individual / Group policy from employer
** Y= You; S= Spouse; J= Joint
*** Please provide benefit schedule and disability definition for disability benefit, if available.

Section 2: "Our Advice and Reasons Why" Form

Part 1(a) – Personal Priorities [Please tick (√) in the appropriate box]

	Client			Spouse		
Your Health Insurance Concerns	Level of Concerns			Level of Concerns		
	Low	Medium	High	Low	Medium	High
Cover for Hospitalisation Expenses	☐	☐	☐	☐	☐	☐
Cover for Outpatient Medical Expenses	☐	☐	☐	☐	☐	☐
Cover for Major Illnesses (eg. cancer, kidney dialysis, etc)	☐	☐	☐	☐	☐	☐
Cover for Maternity Expenses	☐	☐	☐	☐	☐	☐
Cover for Dental Expenses	☐	☐	☐	☐	☐	☐
Cover for Old Age Disabilities	☐	☐	☐	☐	☐	☐
Cover for Loss of Income due to Illness or Sickness	☐	☐	☐	☐	☐	☐

Part 1(b) - Analysis and Calculation Worksheet [Please tick (√) in the appropriate box]

Hospital/Surgical/Mediacal Expenses	Client	Spouse
1. Which type of hospital do you or your family members prefer in the event of hospitalisation?	☐ Private ☐ Public	☐ Private ☐ Public
2. Which type of hospital ward do you or your family members prefer in the event of hospitalisation?	☐ Single Bed ☐ 2 Bed ☐ 4 Bed ☐ 6 Bed	☐ Single Bed ☐ 2 Bed ☐ 4 Bed ☐ 6 Bed
3a. Do you have an existing hospitalisation insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No

3b. If yes,please state the name of existing insurer: _____ Monthly Income: S$ _____

Type of cover: ☐ Hospital & Surgery ☐ Maternity ☐ Hospital Income ☐ Outpatient ☐ Dental

Critical Illnesses	Client	Spouse
1. Total lump sum benefit to be covered.		
2. Existing lump sum benefit covered.		

Hospital Cash Income	Client	Spouse
1. Existing amount covered.		
2. Total Amount of Cash Income to be covered.		
3. Total Amount of Cash Income needed (Amount 2 less Amount 1)		

Part 2 - Advisor Analysis and Recommendations

Total Insurance Budget (S$) per year	Advisor's Recommendations	Reasons for Recommendation	Remarks
	☐ **Medical Expenses** (also known as Hospital/ Surgical / Medical Expense Protection)		Replacement ☐ Yes ☐ No
	☐ **Critical Illness Protection**		Replacement ☐ Yes ☐ No
	☐ **Hospital Cash Protection**		Replacement ☐ Yes ☐ No
	☐ **Others**		Replacement ☐ Yes ☐ No

Note: If this product is intended to replace any existing health insurance policy, the Advisor should state the reason for recommending a replacement.

Part 3 - Acknowledgement [Please tick (√) in the appropriate box]

Client's Declaration:

I/We understand that the above recommendation(s) is/are on the facts furnished in the "Know Your Client" Form; and
[Please tick (√) in the appropriate box]

☐ I/We agree with the proposed recommendation(s) ☐ I/We do not agree with the proposed recommendation(s)

If !/We should decide to switch from one insurance product to another insurance product, !/We understand that:
1. !/We may not be insurable at standard terms;
2. !/We may have to pay a different premium;
3. Terms and conditions may differ.

Statement by Advisor:
The recommendations in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliale and accurate to the best of my knowledge. If there has been any change in your circumstances since you completed that Form, please notify your Advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of thr "Know Your Client" Form.

X

Signature of Client (on behalf of all Applicants)

Date (dd/mm/yyyy):

Signature of Advisor

Date (dd/mm/yyyy):

For Office Use Only
To be completed by a qualified staff of the Insurer or Principal Firm of the Advisor

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and

☐ I agree with the proposed recommendation(s) ☐ I do not agree with the proposed recommendation(s).

Comments (necessary if in disagreement with the proposed recommendation)

Remedial Action

Signature | Name | Position | Date (dd/mm/yyyy)