Underwritten by:

AIG

Administered by:

Cigna

AIG Medi-Care Policy Amendment Form

AIG Medi-Care Policy Amendment Form

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

POLICY AMENDMENTS - Please ensure an answer is provided for each question

	Change?				Select new plan design Please tick all selections you would like on your plan going forward.
Product Silver / Gold / Platinum	Yes		No		Silver Gold Platinum
Area of cover Worldwide including USA / Worldwide excluding USA	Yes		No		Worldwide including USA Worldwide excluding USA
Module(s) Outpatient / Medical Evacuation / Health & Wellbeing / Vision & Dental	Yes		No		Outpatient Medical Evacuation Health & Wellbeing Vision & Dental

Please note: If you are seeking to add only the Health and Wellbeing module, there is no requirement to complete the health questionnaire. If you are seeking to add only the Vision & Dental module, please complete only Question 6 of the health questionnaire. For all other modules please complete the health questionnaire in full.

REASONS FOR CHANGING YOUR COVER?

Can you please tell us why you need to make these changes?	

DEDUCTIBLES AND COST SHARE

Deductible, cost share and out of pocket maximum amendments can only be made at renewal.

INTERNATIONAL MEDICAL INSURANCE CORE PLAN

Do you wish to change your core deductible/cost share?												**Yes**		**No**
Choose your deductible	**$0**		**$375**		**$750**		**$1,500**		**$3,000**		**$7,500**		**$10,000**	
Then, select your cost share percentage							**No cost share**		**10%**		**20%**		**30%**	
Choose your out of pocket maximum (This is the maximum amount of cost share under International Medical Insurance plan you must pay in the event of a claim or claims per period of cover)											**$2,000**		**$5,000**	

INTERNATIONAL OUTPATIENT

Do you wish to change your outpatient deductible/cost share?								**Yes**		**No**
Choose your deductible	**$0**		**$150**		**$500**		**$1,000**		**$1,500**	
Cost share after deductible (a $3,000 out of pocket maximum is applied to cost shares on International Outpatient)										
No cost share		**10%**		**20%**		**30%**				

POLICYHOLDER DETAILS

Title		First Name		Other Initials		Surname					
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					

BENEFICIARY 1 DETAILS

Title		First Name		Other Initials		Surname					
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					

BENEFICIARY 2 DETAILS

Title		First Name		Other Initials		Surname					
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					

BENEFICIARY 3 DETAILS

Title		First Name		Other Initials		Surname					
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					

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.

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 hereto 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 all beneficiaries. This includes any ongoing symptoms or conditions, any information disclosed during your initial application and any claims which you have incurred while on cover. 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.

		Yes	No
1	Has any beneficiary had symptoms of, been diagnosed with or had treatment for Cancer or Tumour, Heart Condition, Stroke, Brain or Neurological Disorders, Diabetes, Hepatitis or any Musculo-skeletal condition?		
2	Has any beneficiary had symptoms of, been diagnosed with or had treatment for any Liver, Kidney or Lung problem, Gastrointestinal problem, Urinary, Gynaecological or Prostate condition, Mental Health condition or any Drug or Alcohol misuse or dependence?		
3	Apart from what you have already told us, is any beneficiary taking any medication or receiving any treatment for a medical condition?		
4	Are any beneficiaries awaiting any test results, treatment or investigations or expect to have a review or follow up for any current or past medical problem not already mentioned?		
5	Does anyone 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.		
6	Is any beneficiary experiencing any dental problems or symptoms, receiving or expecting to undergo any dental treatment?		
7	Is anyone on the plan currently pregnant?		

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