



AIA Premier International Medical Group Application Form

WARNING : In accordance with Section 37(4) of the Brunei Insurance Order 2006, as may be amended from time to time, you are to fully and faithfully disclose in this Application Form all facts which you know, or ought to know, failing which you may receive nothing from the policy and/or the policy issued may be void.

SUBMISSION DOCUMENTS REQUIRED

☐ Application Form

☐ Excel Template for Premier International Medical Member Census Reporting

Sole Proprietor & Partnerships

- ☐ Business Registration Certificate or equivalent (Section 16/17)
- ☐ Mandate (if authorised representative is appointed)
- ☐ Identity documents of partners, sole proprietors and/or authorised representatives

Corporations (Sdn Bhd)

- ☐ Certificate of Incorporation and Business Registration Certificate or equivalent
- ☐ Directors Listing (Form X, Form IV(F) or equivalent)
- ☐ Annual returns (and subsequent documents to verify ultimate beneficial owner)
- ☐ Board Resolution (if authorised representative is appointed)
- ☐ Identity documents of directors and authorised representatives
- ☐ Identity documents of beneficial owners

NOTE: For CS Clients

- Directors IDs not required if Directors Listing is filed within 2 years prior to policy inception
- Beneficial Owners IDs not required if latest Annual Returns are submitted

Application is hereby made for an **AIA Premier International Medical:**

1. COMPANY PARTICULARS:

Name of Company (herein the policyholder):

Company Registration No./Unique Entity No. (UEN)

Nature of Business:

Mailing Address:

Postal Code:

Total Number of Employees to be insured:

Total Number of Dependant(s) to be insured:

COMMENCEMENT OF INSURANCE COVERAGE

Effective Date:

(DD/MM/YYYY)
(Commencement Date)

CONTACT DETAILS OF AUTHORISED PERSON-IN-CHARGE

Name:

Identification Number:

(NRIC/Passport/FIN Number)

Email Address:

Office No.:

Fax No. (if applicable):

Mobile No.:

USEFUL INFORMATION

Information Library



* Visit the AIA eBenefits Information Library via <https://eben.aia.com.sg/en/my-aia/login/information-library.html> or scan the QR Code on the left, to retrieve and download the updated forms required.

- **Excel Template for Members Census Reporting:** Administration > Excel Template for Premier International Medical Member Census Reporting

2. BASIS OF COVERAGE¹

Employee Category (Management, Executive etc.)			
Covered Area	<input type="checkbox"/> Asia <input type="checkbox"/> Worldwide excluding USA <input type="checkbox"/> Worldwide ²		
Currency	<input type="checkbox"/> Brunei Dollar <input type="checkbox"/> US Dollar		
Core Module (Inpatient)	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 ¹ Co-insurance: 0%/10%/20%	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 ¹ Co-insurance: 0%/10%/20%	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 ¹ Co-insurance: 0%/10%/20%
Optional Module	Outpatient <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Dental <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Maternity <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Optical <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 Co-insurance: _____ Wellness <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____	Outpatient <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Dental <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Maternity <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Optical <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 Co-insurance: _____ Wellness <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____	Outpatient <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Dental <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Maternity <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____ Optical <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 Co-insurance: _____ Wellness <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 Co-insurance: _____
Dependant(s) Cover (On compulsory basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
MHD³ Option (applicable for 11 lives or more)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Important Notes:

¹ Both USD and BND currencies are available for all Inpatient Plans of the Core Module except for Plan 5. Optional Modules will follow the same policy currency as the selected Core Module.

² Any benefits payable in respect of eligible expenses incurred in the USA shall be subject to the 50% Coinsurance if:

- a) the Insured Person is a citizen of the USA; or
- b) the Insured Person stays in the USA for any continuous period of over 182 days.

³ MHD shall mean Medical History Disregarded.

3. Has this group ever been covered by Group Insurance in another company? ☐ Yes ☐ No

If so, please provide the name of the company _____

If such insurance has been discontinued, please state date of discontinuance _____
(DD/MM/YYYY)

4. On the inception date of group policy, all eligible employees must be ACTIVELY AT WORK to participate under the coverage. With reference to this requirement:

- ☐ I hereby confirm that on the date of Declaration and to the best of my best knowledge, all employees are ACTIVELY AT WORK. Employees who are away from their jobs due to:
- Annual Leave
 - Maternity Leave
- shall be considered as being actively at work.
- ☐ I hereby confirm that as on the date of Declaration and to the best of my knowledge, the following employees listed below have been away from work due to illness or injury or on no-pay leave for whatever reasons. They are considered NOT ACTIVELY AT WORK unless they resume full time duty in good health on the inception date. Otherwise, coverage will commence on the day they resume full time duty in good health.

S/N	NRIC/Passport/FIN Number	Name of Employee	Nature of Illness/Injury

DECLARATION AND AUTHORISATION

The Applicant hereby agrees and declares, on behalf of itself and any other person or persons, firm or corporation, who may have or claim any interest in any insurance on this Application:

1. No statement, information or agreement made by/to or given by/to the person soliciting/collecting/receiving this Application or any other persons, shall be binding on AIA Singapore Private Limited, Brunei Branch ("AIA Brunei"), unless presented to AIA Brunei in writing and approved by an authorised officer of AIA Brunei.
2. The statements and answers contained in this Application, together with those contained in any required form including enrolment form, questionnaire or amendment of the Applicant, the statements and answers of the Applicant's employees and their dependants contained in any required form, or medical report, and any required supporting documents (collectively the "Information") are full, complete, true and correct and that no Information has been withheld. The Applicant further agrees that the Information shall form the basis of the contract between the parties hereto, and that the Information together with the group policy (including without limitation its riders, endorsements and any amendments thereto) shall constitute the entire contract between the parties. The Applicant understands that if any of the Information is not full or complete or true or correct, the group policy issued hereunder may be void and the Applicant/policyholder/employee/dependant as the case may be, may receive nothing from the group policy.
3. AIA Brunei shall assume no liability whatsoever and the group policy will only be effective after this Application and required forms, questionnaires or amendments have been completed by the Applicant, and its employees and their dependants, with the Application being accepted by AIA Brunei and the first premium fully paid for.
4. I/We hereby authorise, agree and consent to:
 - a) persons and organisations, whether within or outside Brunei, including but not limited to medical sources, hospitals, doctors, other healthcare professionals, laboratories, regulator, dispute resolution centres and insurers, their associated persons/organisations, my/our or the insured person's employers or financial service providers, or their third party service providers or representatives (collectively "Third Parties") disclosing and releasing to AIA Brunei, its associated persons/organisations, its and their third party service providers and its and their representatives, whether within or outside Brunei (collectively "AIA Persons"), any information concerning the policy owner and the insured person(s) at any time, including all personal data and information, medical information, medical history, consultation history and notes, prescriptions, treatments, descriptions of medical services rendered, and any employment and financial information, including the taking of copies of such records (collectively "Personal Data"), relevant for the Purpose (defined below);
 - b) the AIA Persons sharing the scope of sub-clause (a) above, along with any of the Personal Data, with any relevant Third Parties to procure their disclosure and release of additional relevant Personal Data for the Purpose;
 - c) the AIA Persons, including their approved medical examiners or laboratories, performing any necessary medical assessments and examinations and tests to determine, assess and evaluate the health of the insured person(s);
 - d) the AIA Persons collecting, using, disclosing, storing, retaining and/or processing (collectively, "Using"/"Use") the Personal Data for the Purpose; and
 - e) waive any right (on my own behalf and on behalf of the insured person(s) where applicable, in respect of which I/we represent and warrant that the insured person(s) have granted me/us authority to so waive) to bring a claim of any nature against any of the AIA Persons in respect of any above- mentioned Use and/or any Use of any Personal Data for the Purpose.

Where I/we are not the insured person, I/we represent and warrant that I/we have obtained the consent of the insured person(s), except to the extent such consent is not required under relevant laws: (i) to collect their Personal Data; (ii) to disclose their Personal Data to the AIA Persons; and (iii) for the AIA Persons and Third Parties to Use any of their Personal Data in the manner and for the purposes described in this Clause. I/We hereby agree to indemnify AIA Persons for all losses and damages that AIA Persons may suffer in the event that I/we are in breach of any representation and warranty provided by me/us herein. In this Clause, "Purpose" means any of the purposes described in the AIA Personal Data Policy, including but not limited to processing of this form, to provide subsequent advice or services to me/us or the insured person in relation to any existing or future policy/policies/programmes that I/we may hold/participate with AIA Brunei. This authorisation shall bind my/our successors and assignees, and remains valid, notwithstanding death, irrespective of whether or not my/our Application/form is accepted by AIA Brunei. A photocopy of this authorisation shall be valid and effective as the original.

5. The Applicant is not insolvent or is unable to pay its debts as they become due, or making any assignment or arrangement for the benefit of its creditors, or is ceasing or threatening to cease to carry on its business.
6. AIA Brunei is entitled not to accept or process this Application or accept an employee or dependant under the group policy should the Applicant or such employee or dependant be found to be a Prohibited Person, meaning a person/entity (including any director or direct/indirect shareholder or person having executive authority therein) subject to any laws, regulations and/or sanctions administered by any regulatory authorities in any country, which have the effect of prohibiting AIA Brunei from providing insurance coverage, transacting business with or otherwise offering any economic benefits to the Applicant/policy owner or such employee or dependant or any other beneficiary under the group policy, and the decision of AIA Brunei shall be final..
7. In the event AIA Brunei becomes aware subsequently that the Applicant/policy owner/insured employee/insured dependant has become a Prohibited Person, AIA Brunei may block and/or terminate the relevant policy, and/or remove such insured employee or insured dependant from coverage under the group policy with immediate effect, and shall not thereafter be required to transact any business with the Applicant/policy owner/insured employee/insured dependant or any other beneficiary in connection with the group policy, including but not limited to, making or receiving any payments under the group policy. The Applicant/policy owner, as an entity, also agrees as an ongoing obligation to notify AIA Brunei in writing as soon as possible of any change in its directors or direct/indirect shareholders or persons having executive authority therein.
8. By signing this Application, the Applicant confirms that the AIA Financial Services Consultant/Insurance Representative has solicited insurance business from the Applicant in the Republic of Singapore and that the signing of this Application has taken place in the Republic of Singapore.

Declared in Brunei on:

D	D	M	M	Y	Y	Y	Y
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.....
Signature of Authorised Representative & Company Stamp

.....
Signatory's Full Name as in NRIC/Passport

.....
Signatory's NRIC/Passport

.....
Designation of the Signatory

WARNING : If a material fact is not disclosed in this Application, any insurance coverage issued to you 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 AIA Financial Services Consultant(s)/Insurance Representative(s) but was not included in this Application. Please check to ensure you are fully satisfied with the information declared in this Application. Additionally and without prejudice to the parties' rights and obligations whether under law or otherwise, following the submission of this Application, you must continue to disclose any and all material facts that may arise or which have changed from the information you had provided.

AIA FINANCIAL SERVICES CONSULTANT/INSURANCE REPRESENTATIVE DETAILS**AIA Financial Services Consultant's Details**

Name of Consultant (1): _____

Contact No.: _____

Commission Share (%): _____

AIA Consultant Code: _____

Name of Agency: _____

Signature of AIA Consultant:: _____

Date: _____

Name of Consultant (2) (if applicable): _____

Contact No.: _____

Commission Share (%): _____

AIA Consultant Code: _____

Name of Agency: _____

Signature of AIA Consultant:: _____

Date: _____

AIA Financial Services Consultant Supervisor's Details

Name of Supervisor: _____

Name of Agency: BR- _____

Supervisor Code: _____

**Insurance Representative's
(Broker/Financial Advisor's) Details**

Name of Broker/Financial Advisor (FA): _____

Financial Institution: _____

Contact No.: _____

Signature of Broker/FA: _____

Date: _____