



# AIA Premier International Medical Member Enrolment 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.

## POLICY INFORMATION

Policy Number

Name of Company

## EMPLOYEE'S INFORMATION

Full Name (According to NRIC/Passport) – Please underline Surname

NRIC/Passport

Nationality

Residential Address

Gender

- ☐ Male  
☐ Female

Marital Status

- ☐ Single      ☐ Married      ☐ Separated  
☐ Divorced      ☐ Widowed

Date of Birth (DD/MM/YYYY)

Height

cm

Contact Number (Mobile)

Weight

kg

Email Address

Occupation

SPOUSE'S INFORMATION							
Full Name (According to NRIC/ Passport)	NRIC/Passport	Nationality	Occupation	Gender	Date of Birth (DD/MM/YYYY)	Height (cm)	Weight (kg)
				<input type="checkbox"/> Male <input type="checkbox"/> Female			

CHILD(REN)'S INFORMATION							
Full Name (According to NRIC/ Passport)	NRIC/Passport	Nationality	Occupation	Gender	Date of Birth (DD/MM/YYYY)	Height (cm)	Weight (kg)
1 <sup>st</sup> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female			
2 <sup>nd</sup> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female			
3 <sup>rd</sup> Child				<input type="checkbox"/> Male <input type="checkbox"/> Female			

**FAMILY HISTORY OF THE EMPLOYEE AND DEPENDANT(S) (IF APPLICABLE)**

Have any of your natural parents or sibling(s) suffered from cancer\*\*, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)?

☐ Yes    ☐ No

If Yes, please provide details below (\*\* for Cancer, please specify type of cancer)

Name of Employee/ Dependant	Relationship (to insured)	Medical Condition (Diagnosis)	Age at time of Diagnosis	Age of Death (if Deceased)	Cause of Death (if Deceased)

# MEDICAL QUESTIONNAIRE

All 11 questions must be answered		Complete ONLY IF to be insured				
		Employee	Spouse	1 <sup>st</sup> Child	2 <sup>nd</sup> Child	3 <sup>rd</sup> Child
1	<p>Do you engage in any sports(s) or occupation of a dangerous or hazardous nature such as motor racing, scuba/skin diving, parachuting, military or private flying other than as a fare paying passenger, etc.?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	<p>Has any of your application/reinstatement for life, critical illness, accident, disability income, medical insurance ever been declined, postponed, or accepted with special terms (eg: extra premium loading or exclusion imposed)?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	<p>a) Have you ever used addictive drugs, narcotics, glue sniffing or been treated for drug addiction?</p> <p>b) Have you ever had or been treated for alcoholism?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
4	<p>Do you drink wine, beer or other alcoholic beverages? If yes, please furnish details :</p> <p>a) Type of alcohol : (Beer/Wine/Others, please specify)</p> <p>b) Frequency : (number of times per week)</p> <p>c) Quantity : (mls/units per week)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____  _____  _____
5	<p>Have you ever smoked cigarettes in the last 12 months? If yes, please provide details :</p> <p>a) Number of sticks per day :</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____per day	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____per day	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____per day	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____per day	<input type="checkbox"/> Yes <input type="checkbox"/> No  _____per day
6	<p>a) Have you received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS Related Complex or any other AIDS related condition?</p> <p>b) Have you ever had HIV testing done? If yes, please state the reason and its results.</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
7	<p>In the past 3 months, have you ever had any of the following symptoms for more than one week continuously: Fatigue, weight loss, enlarged node(s) or unusual skin lesion(s)?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## MEDICAL QUESTIONNAIRE

All 11 questions must be answered		Complete ONLY IF to be insured				
		Employee	Spouse	1 <sup>st</sup> Child	2 <sup>nd</sup> Child	3 <sup>rd</sup> Child
8	<p>In the past 5 years, have you ever undergone or been advised to undergo any medical investigation(s) carried out on the recommendation of a doctor such as X-ray, Ultrasound, Heart scan, CT scan, Biopsy, Endoscopy, Gastroscopy, Colonoscopy, Surgical operation, etc.?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	<p>Have you EVER had or been told you had or been treated for:</p> <p>a) Asthma, coughing with blood, pneumonia, tuberculosis, bronchitis, breathing discomfort or breathlessness and/or any other lung disease/disorder?</p> <p>b) Rheumatic fever, high blood pressure, heart murmur, heart attack, coronary artery disease, mitral valve prolapse, or other heart valve disorder, irregular or fast heart rate, chest discomfort or chest pain, and/or any disease or disorder of the heart or blood vessels?</p> <p>c) Renal/bladder stone(s), albumin/protein in urine, blood or sugar in urine, urine infection or any other disorder of the kidney(s), bladder, urinary or genital organs?</p> <p>d) Epilepsy, fits, stroke, paralysis, dementia, Parkinson's disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, anxiety, depression, or any other nervous or mental disorder(s) or disease of the brain?</p> <p>e) Diabetes, thyroid disorder(s), or any other endocrine disorder(s)?</p> <p>f) Gastritis, ulcer, blood in stools, fistula, hernia, irritable bowel syndrome, or any other disease/disorder of the stomach or bowel?</p> <p>g) Hepatitis B carrier or any form of hepatitis, jaundice, liver disorder or gall bladder disorder?</p> <p>h) Ear discharge, nose bleeding, double vision, impaired sight, hearing or speech, or any other disorder of the ear(s), eye(s), nose, or throat?</p> <p>i) Slipped disc, back pain, gout, any form of arthritis, joint pain or deformity, and/or any disease/disorder of the muscles, spine, limbs or joints or severe injury?</p> <p>j) Anaemia, any other disorders of the blood, or advised to abstain from donating or received blood transfusion?</p> <p>k) Cancer, tumour(s), cyst(s) or growth(s) of any kind?</p> <p>l) Congenital anomalies, physical disability or any other illness, disorder, operations, hospital admission, accident or injury not mentioned above?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

# MEDICAL QUESTIONNAIRE

For Female Applicants only (including children age 12 years and above)		Complete ONLY IF to be insured				
		Employee	Spouse	1 <sup>st</sup> Child	2 <sup>nd</sup> Child	3 <sup>rd</sup> Child
10	<p>a) Have you ever been to any doctor for a Pap Smear (cervical smear)? If yes, please state result :</p> <p>(i) Result : (Normal/Abnormal)</p> <p>b) Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within 6 months?</p> <p>c) Have you ever been found to have or are you aware of any breast cyst(s)/lump(s)/ nodule(s) or any other disease or disorder of the breast(s)?</p> <p>d) Have you ever suffered from irregular, painful or unusually heavy menstruation, fibroid(s), cyst(s) or any other disorder involving the female organ(s)?</p> <p><b>If yes, please furnish details in the box on page 6</b></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No
11	<p>a) Were there any complication(s) noted during any of your pregnancy such as gestational diabetes, hypertension etc.? If yes, please provide details.</p> <p>(i) Details :</p> <p>b) Are you currently pregnant?</p> <p>If yes, please state weeks of pregnancy :</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No   	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No   	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No   	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No   	<input type="checkbox"/> Yes <input type="checkbox"/> No    <input type="checkbox"/> Yes <input type="checkbox"/> No   

If any of the answers is "Yes", please give full details in the space provided below

Qn. No.	Name of Employee/Dependant	Please provide date of consultation, details of diagnosis/exact condition, result, name and address of doctor seen

## DECLARATION AND AUTHORISATION

- 1) I/We understand that all Pre-Existing Conditions as defined in the Policy Contract before the effective date are not covered.
- 2) No statement, information or agreement made by/to or given by/to the person soliciting/taking this application or any other persons, shall be binding on AIA Singapore Private Limited, Brunei Branch ("AIA Brunei"), unless presented to me/us in writing and approved by an officer specified in the policy.
- 3) The statements and answers in this application together with any required questionnaires or amendments ("the information") are full, complete, true and correct and that no information or material has been withheld. I/We understand that AIA Brunei, believing the Information to be such, will rely and act on the Information accordingly. I/We further agree that the Information shall form the basis of the contract between the parties hereto. I/We understand that if any of the Information is not full or complete or true or correct, the coverage issued or claims incurred hereunder may be void and nothing may be received from the group policy(ies).
- 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) I understand and agree that AIA Brunei is entitled not to accept or process this form should I or any of my dependants be found to be a Prohibited Person, meaning a person/entity 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 me/my dependants or any other beneficiary under the Policy, and the decision of AIA Brunei shall be final. I/We further agree that in the event that AIA Brunei becomes aware subsequently that the Policyholder/myself/any of my dependants has become a Prohibited Person, AIA Brunei may block and/or terminate the Policy with immediate effect, remove myself or my dependants from coverage under the Policy and shall not thereafter be required to transact any business with the Policyholder and/or myself/my dependants in connection with the Policy, including but not limited to, making or receiving any payments under the Policy.
- 6) I/We further agree that this form may be signed and delivered by facsimile, electronic mail or other electronic means, including via a website or electronic portal designated by AIA Brunei. A copy of such form received via any of the above means may be stored electronically or using other means by or under the authority of AIA Brunei and such copy shall have the same legal effect and validity as if it were the original.

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

Declared in Brunei on:

D	D	M	M	Y	Y	Y	Y
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.....  
Name & Signature of Employee

.....  
Name & Signature of Spouse (if Applicable)