

Policy Number: _____
 Name of Insured: _____
 Job Title: _____
 Date of Birth (dd/mm/yyyy): _____ Gender (M/F): _____
 Height (cm): _____ Weight (kg): _____
 Upgrade to: _____

Dependants

Name	Date of Birth	Gender	Height (cm)	Weight (kg)	Relationship

- Have you or any of your dependants consulted a physician in the past 2 years? No Yes (explain)

- Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition?
 No Yes (explain)

- Have you or any of your Dependents been advised to undergo any test, treatment, special diet, medication, procedure, checkup, or hospitalisation that has not yet been completed? No Yes (explain)

- Disabilities that you and/or your Dependent(s) have suffered from prior to this upgrade application.

- Is there any current pregnancy? No Yes (provide expected due date)

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true. I agree that the answers in this form shall be incorporated into the policy and shall, along with statements made in connection with my application and any renewals, form the basis of the reinstated policy.

 Signature of the Insured / Main Applicant (Signature by Policyholder if the insured person is a Minor) _____
Date

Note: Disabilities existing prior to this Upgrade Application shall be covered according to the Terms & Conditions of the preceding medical plan unless the Company has been notified on this application of the Disabilities and said Disabilities are accepted at the higher benefit level in writing by the Company.

Arranged and administered by APRIL S.A.S.'s registered subsidiaries:
 APRIL Hong Kong Limited
 APRIL Singapore Pte Ltd
 APRIL Vietnam Company Limited
 APRIL Assistance (Thailand) Co Ltd