

## APPLICATION FOR INVESTMENT-LINKED PLAN

### STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP. 142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You must disclose all facts as you know or ought to know which may affect the insurance cover being applied for. Otherwise, the insurance policy issued may not be valid.

#### For Official Use

Adviser's Name	Adviser's Code	Source Code	Delivery Mode <input type="checkbox"/> Mail <input type="checkbox"/> Hand
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#### Particulars of Proposer/Insured

Name (as shown in NRIC)			NRIC No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (dd/mm/yyyy)	Height (m)	Weight (kg)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Residential Address				Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR <input type="checkbox"/> Others (Please specify)
Contact No. (O) _____ (H) _____ (Hp) _____			Email	
Name of Company/School		Occupation/Position	Annual Income (S\$)	
Exact Nature of Work				

#### Particulars of Insured (if different from Proposer)

Relationship with Proposer <input type="checkbox"/> Child (Below age 18) <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please specify)				
Name (as shown in NRIC)			NRIC No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (dd/mm/yyyy)	Height (m)	Weight (kg)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Residential Address				Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR <input type="checkbox"/> Others (Please specify)
Contact No. (O) _____ (H) _____ (Hp) _____			Email	
Name of Company/School		Occupation/Position	Annual Income (S\$)	
Exact Nature of Work				

#### Details of Plan

<input type="checkbox"/> Own Life	<input type="checkbox"/> Single Premium: GrowthLink (GL1)	Premium Payable (\$)	Source of Single Premium (For investment of \$200,000 and above)
<input type="checkbox"/> Third Party	<input type="checkbox"/> Regular Premium: Vivolink (VL1)		
Please specify fund allocation		<b>Reinvestment of distribution for Aim Now Fund</b> The default option is to reinvest the distribution from Aim Now fund into the fund. Please select the option below only if you have selected Aim Now fund and wish to encash future distribution when they are available. <input type="checkbox"/> I wish to encash all future distribution from Aim Now fund when they are available.	

#### Regular Single Premium Top-up

Amount of Premium	Premium Payment Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly <input type="checkbox"/> Yearly	Period From year _____ to year _____
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## Additional Questions on Health

Additional Questions on Health	
	Insured
1. Have you ever had or been told to have or been treated for i. Hypertension? ii. High Cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you suffered from physical or mental impairment or deformity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had or been advised or planned to go for any appointment for surgery or any investigation or tests such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine tests, etc or have you had or been advised for any hospital admissions? If "Yes", please give details of condition(s) and any abnormalities.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Additional Health Questions for Female only (For age 10 and above)</b>	
4. (a) Have you had or received any treatment for or intend to be treated for any disease or disorder of the breast including breast lump, cyst, fibroadenoma, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ, cancer or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Have you had or received any treatment for or intend to be treated for any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, abnormal enlargement of the abdomen, carcinoma in situ or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Have you at any time undergone a PAP smear, mammogram or ultrasound of the breasts or pelvis, cone biopsy or colposcopy for which the results were abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Have you had any complications during your pregnancy or as a result of your pregnancy? (E.g. ectopic pregnancy, diabetes, high blood pressure or protein in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Have any of your children suffered from hereditary disorders? (E.g. Spina bifida or Down's Syndrome)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) Have any of your children suffered from congenital disorders? (E.g. Club foot, Hole-in-heart or Cleft lip/palate)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) Are you now pregnant? If "Yes", how many months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If you answered "Yes" to Questions 1-4, please provide details below:</b> <ul style="list-style-type: none"> <li>• Name of condition and date of diagnosis;</li> <li>• Name and address of each doctor/hospital;</li> <li>• Duration of illness/injury and date of recovery as appropriate; and</li> <li>• Nature of tests done, dates, results and reasons for tests</li> <li>• Copy of the above test(s), if any</li> </ul>	

## Declaration/Replacement of Existing Policy(ies)

						Proposer	Insured
1. Do you have any existing policy(ies)? If "Yes", please provide details below.						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Proposer</b>							
Name of Company	Year Issued	Sum Assured			Total & Permanent Disability	Accident & Hospitalisation	Others
		Life	Critical Illness	Term			
<b>Insured</b>							
Name of Company	Year Issued	Sum Assured			Total & Permanent Disability	Accident & Hospitalisation	Others
		Life	Critical Illness	Term			
2. Has any proposal or application for a Life or Accident or Hospital Assurance Policy ever been declined, postponed and accepted at special rates or terms with this or any other office? If yes, please provide details of company(ies) and why.						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you making or have you made any claims, including hospitalization claims, or any policy with this or any other office?						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the assurance now applied for intended to replace any existing policy(ies) with this or any other office?						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Warning: It is disadvantageous to replace an existing life insurance policy with a new one. Some of the disadvantages are:</p> <p>i. Insurance may not be granted on standard terms;</p> <p>ii. A higher premium may have to be paid in view of increased age;</p> <p>iii. The financial benefits accumulated over the years may be lost.</p> <p>In your own interest, we would advise that you consult your present insurer (s) before making a final decision. Do hear out both sides and make a careful comparison so that you can be sure that you are making a decision that is in your best interest.</p>							
<b>If your answer is "Yes" to Questions 2-4, please provide details below:</b>							
<b>Proposer</b>							
Question No.	Details						
<b>Insured</b>							
Question No.	Details						

## Declaration of Beneficial Ownership

If you are not the beneficial owner\*, please provide the details such as Name and NRIC/Passport No. of the beneficial owner(s) and your personal relationship(s) with them and submit a copy of their NRIC/Passport to us.

Please provide relevant details here : \_\_\_\_\_

\* "Beneficial Owner" as defined in the MAS Notice on Prevention of Money Laundering and countering the Financing of Terrorism means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over a body corporate or unincorporate.

For the avoidance of doubt, completion of this section is not a nomination of beneficiary (ies) under the policy.

## Declaration and Authorisation

I/We agree to inform NTUC Income as soon as possible if there is any change in the state of my health and/or Insured's health or if I and/or Insured plan to seek any medical consultation, investigation or treatment between the date of this application and before the date the policy is issued by NTUC Income. I/We understand that NTUC Income may impose special terms according to the information provided by me/us.

I/We declare and warrant that the answers given in this application are true, correct and complete and I/We accept full responsibility for them, whether written by me/us or by anyone else on my/our behalf. I/We have not withheld any information. I/We agree that this application and other written answers, statements, information or declarations made by me/us or on my/our behalf shall form the basis of the contract of insurance between me/us and NTUC Income and if anything untrue, incorrect or incomplete is stated, the insurance policy issued shall not be valid.

I/We agree that there shall be no liability upon NTUC Income until a policy has been issued and delivered to me and the first premium has been paid in full. And I/We agree and authorise:

(a) Any medical source, insurance office, or organisation to release to NTUC Income, and

(b) NTUC Income to release to any medical source or insurance office,

any relevant information concerning me/us at the time, irrespective of whether the application is accepted by NTUC Income or not. A photocopy is valid as an original copy.

I/We understand that it is usually disadvantageous to replace an existing investment product e.g. unit trust, with a new investment product, whether from the same/different financial institution.

I/We have been given the following documents, the contents of which were explained to my satisfaction:

(a) Your Guide to Life Insurance or Your Guide to Health Insurance or both, (b) Products Summary, and (c) Benefit Illustration.

I/We confirm that the entire marketing and selling process in respect of my/our proposed insurance application has been conducted in Singapore.

I/We agree that the policy will be entered in the Register of the Singapore policies.

I/We further declare that I/we am/are not (an) undischarged bankrupt and that I/we have committed no act of bankruptcy within the last twelve months and that no receiving order or adjudication in bankruptcy has been made against me/us during that period.

I/We also wish to apply for admission as a member of NTUC Income and if accepted, I/We agree to be bound by the By-Laws of NTUC Income.

**If a material fact is not disclosed in this application, 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 adviser but was not included in the application. Please check to ensure you are fully satisfied with the information declared in this application.**

Signed in Singapore on the \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

Signature of Proposer/Parent/Legal Guardian

Signature of Witness

Signature of Insured  
(For age 16 and above)

Name & NRIC No. of Witness

## Parental Consent

**To be completed by parent/legal guardian if the proposer is between 10-16 years old**

I hereby give my consent for a life insurance policy to be issued on the life of my child/ward and that he/she is the proposer of the policy.

Name of Parent/Legal Guardian

NRIC/Passport No.

Relationship to Child

Parent

Legal Guardian (Please submit legal documents showing proof as legal guardian)

Signature of Parent/Legal Guardian and Date

## Adviser's Declaration

1. I declare that all the answers given to me by the Proposer/Insured are declared in the application. I have not withheld any information which may influence the acceptance of this application by NTUC Income.
2. I am aware that NTUC Income takes a serious view of non-disclosure and action will be taken against me if I am deemed a party to the non-disclosure.
3. I have personally SEEN the Proposer/Insured and have explained the terms of the policy to the Proposer.
4. I have seen the original identification documents and attached a photocopy herewith. I confirm that the attached is a copy of the original.

\_\_\_\_\_  
Signature of Adviser

\_\_\_\_\_  
Date

5. Is the application intended to replace an existing policy? If "Yes", please provide details.

Yes  No