

## APPLICATION FOR VIVOLIFE 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	Exact Nature of Work	

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

Relationship with Proposer <input type="checkbox"/> CHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER _____ (Please specify)				
Name (as shown in NRIC)			Birth Cert/NRIC No.	
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (m)	Weight (kg)	Occupation

### Details of Plan(s)/Rider(s)

<input type="checkbox"/> Own Life <input type="checkbox"/> Third Party	Policy No.	Receipt No.
Basic Policy	Sum Assured \$	Premium Payable \$
<b>Riders</b>		
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Details of Plan(s)/Rider(s)

<input type="checkbox"/> Own Life <input type="checkbox"/> Third Party	Policy No.	Receipt No.
Basic Policy	Sum Assured \$	Premium Payable \$
<b>Riders</b>		
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Payment Method And Mode

Premium Payment Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly <input type="checkbox"/> Yearly <input type="checkbox"/> Single	Payment Method <input type="checkbox"/> GIRO <input type="checkbox"/> Cash/Cheque	Commencement Date (dd/mm/yyyy)
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## GIRO Arrangement

New GIRO application (Please complete and attach new Application for Interbank GIRO Form)
  Third Party  
 Existing GIRO arrangement (Please furnish details below):-

Name of Account Holder	NRIC No. of Account Holder	Name of Bank/Branch	Bank Account No.
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## Declaration/Replacement of Existing Policy(ies)

### Declaration of Existing Policies

Do you have any existing policy(ies)? If "Yes", please provide details.  Yes  No

Name of Company	Sum Assured	Type of Policy	Year Issued

Warning: It is usually disadvantageous to replace an existing life assurance policy(ies) with a new one for the following reasons: -

- (i) insurance may not be granted on standard terms;
- (ii) a higher premium may have to be paid in view of increased age;
- (iii) the financial benefits accumulated over the years may be lost.

In your own interest, we would advise that you consult your present insurer(s) before making a final decision. Hear out both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

Is the assurance now applied for intended to replace any policy(ies) listed above? If "Yes", which policy(ies)? We need the information as we are required to inform the existing insurer(s) that the policy(ies) may be replaced.  Yes  No

Has any proposal or application for a Life or Accident or Hospital Assurance Policy ever been declined, postponed and accepted at other than normal terms? If "Yes", please provide details of company(ies) and why.  Yes  No

## Lifestyle

		Proposer	Insured
Do you consume beer, alcohol, opium or any other stimulants? If "Yes", please indicate quantity per day.	_____ bottles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke cigarettes, cigars, etc.? If "Yes", please indicate quantity per day.	_____ sticks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you engage or have you any prospect or intention of engaging in aviation other than as a passenger on a regular airline or any other hazardous occupation, sports or pursuits? If "Yes", please provide particulars.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Family History On Insured

	Proposer	Insured
Has either of your natural parents or any of siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If "Yes", please provide details of age(s), relationship and cause of death or condition(s).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Particulars of Regular Doctor

Name and Address of Regular Doctor	Proposer	Insured
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
Last Date of Consultation and Reason	Proposer	Insured
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

## Questions on Health

Please complete this section: **For total sum assured of \$50,000 and below**

	Proposer	Insured
1. Have you suffered from or received treatment for or are you now suffering from disease of the heart or circulatory system, stroke, high blood pressure, diabetes, cancer, growth or other malignancy, kidney or bladder disorders, asthma, other respiratory disorders, liver disease such as Hepatitis, epilepsy, hereditary diseases, eye disorders?	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had or been advised or planning to go for any appointment for surgery or any investigation or tests such as X-ray, ultrasound, CT scan, biopsy, pap smear, 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	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this section: **For total sum assured above \$50,000**

	Proposer	Insured
1. Have you had or been told to have or been treated for:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) epilepsy, fits, stroke, paralysis, weakness of limb, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diabetes, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) double vision, impaired sight, hearing or speech, ear discharge, nose bleeds or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) jaundice, hepatitis B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(k) anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or your spouse received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS Related Complex or any other AIDS related conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had HIV testing done (please state reason and results), or in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had or been advised or planning to go for any appointment for surgery or any investigation or tests such as X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine tests, etc or have you had or been advised for any hospital admissions? If "Yes", please provide details of condition(s) and any abnormalities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### For Females only

5. (a) Have you had or are you aware of any breast lumps or any other disorders of your breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Have you had irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Have you had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If "Yes", please state type, reason, date of test done and results of test (copy to be submitted if available).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to the above health questions, please indicate the disorder and provide the full details accordingly.		
Name of disorder/operation/disability	Proposer	Life Assured
i. When did the symptoms start? (mm/yyyy)		
ii. Date of recovery, if any. (mm/yyyy)		
iii. Have you been discharged from follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Have you ever been hospitalised for this disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Has the disorder occurred several times?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 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 hereby declare that the foregoing answers are true and whether written by me or by anyone else on my behalf I accept full responsibility for them; and that I have not withheld any material information; and that this assurance is to be taken out by me and the premiums to be paid thereon are to be paid by me. I agree that there shall be no liability upon NTUC Income until a policy has been issued and delivered to me and the first premium paid in full. And I, the Life to be Assured, 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, insurance office,

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

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

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

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

**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 adviser but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.**

Signed in Singapore on the _____ day of _____ 20____	Signature of Witness   Name & NRIC No. of Witness
Signature of Proposer/Insured	

### Parental Consent

To be completed if child taking policy on his/her life is aged between 10 - 16 years.

I hereby give my consent for a life insurance policy to be issued on the life of my child/ward. Relationship to Insured  Parent  Guardian

Signature	Name (as shown in NRIC)
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### Adviser's Declaration

1. I declare that all the answers given to me by the Proposer/Insured are declared in the proposal. I have not withheld any other information which may influence the acceptance of this proposal 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/Life 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 photocopy of the original.

	Proposer	Insured	Signature of Adviser & Date
NRIC/Passport No.			
Date of Birth (dd/mm/yyyy)			

5. Is the life assurance intended to replace an existing policy? If "Yes", please give details.  Yes  No

6. Is the proposed life assured related to any other Income representative? If "Yes", why is this insurance being proposed?  Yes  No