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For official use
Proposal stage:
820/001: Alteration Form
In force:
Scan under the following CS

Alteration form for life policy

WARNING: Under Section 23(5) of the Insurance Act 1966 (or any other future amendments to it), you must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for. Otherwise, the insurance policy may not be valid.

Important notes:

1 Residential address verification
For Singaporean/Permanent Resident – Please provide a clear copy of your NRIC (front and back). If the residential address in our existing records is different from the address in your identity document, please provide billing proof or update your residential address via our online portal https://me.income.com.sg.

For non Singapore Citizen/Non-Permanent Resident – Please provide a valid identity document or passport with your residential address indicated, or billing proof (if residential address is not shown on the identity document).

Examples of billing proof – utility bills, bank statements and letters issued by a statutory or government bodies (dated within past 6 months) with letterhead, name, address, date clearly shown.

2 If you have used the policy to be exempted from the CPF Board's Home Protection Scheme (HPS), the policy must remain in force so that you and your family are protected from losing your HDB flat in the event of death, terminal illness or total permanent disability. If there are changes to the policy, your exemption would be voided and you would be required to reapply for exemption from HPS by purchasing other private policies or apply to be insured under HPS. Otherwise, if you are using CPF monies to service the monthly instalment, CPF Board may automatically extend HPS coverage to you, based on the declared percentage that you are exempted for, subject to you being in good health.

Details of policyholder or assignee

Full name (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN	Policy number
Nationality ☐ Singaporean ☐ Others (please give details) _____	Country of residence	
Name of organisation	Occupation	Nature of work

Type of request

Request	Details	For official use
☐ Increase sum assured or premium Refer to Notes 1, 2 *(Not allowed if plan is withdrawn)*	From _____ to _____	Increase sum assured
☐ Add riders Refer to Notes 3	Please indicate rider name, sum assured and cover term.	Add rider
☐ Increase cover term Refer to Notes 1	From _____ to _____	Premium payment term change
☐ Decrease cover term Refer to Notes 1	From _____ to _____	
☐ Increase payment term Refer to Notes 1	From _____ to _____	
☐ Decrease payment term Refer to Notes 1	From _____ to _____	

Notes:
1 Applicable for policies incepted within 1 year and has not acquired a cash value. Please approach your advisor to submit a revised Policy Illustration with this form.
2 Premium alteration is not allowed when there is a claim for Disability Care benefit.
3 Only applicable for eligible products. Please approach your advisor to submit a Policy Illustration with this form.

Mandatory declarations

1 **Source of funds and wealth** (we may request for additional information or supporting documents, if necessary)
If this policy is fully paid, it is not compulsory to complete "i. Source of funds" but it is compulsory to complete "ii. Source of wealth" below.

i Source of funds

a Who is paying the insurance premium for this application? ☐ Policyholder ☐ Others
If your answer is others, please provide details below.

Full name of payor (as in NRIC/Passport/Long-Term Pass/ACRA business profile)	NRIC/Passport number/FIN/Unique Entity Number (UEN)
Relationship to policyholder	Occupation and organisation
Reason for paying the premiums on behalf of policyholder	

Mandatory declarations (continued)

b What is the source of funds used to finance the premiums? Please select at least one option.
If this policy is fully paid, it is not compulsory to complete "i. Source of funds" but it is compulsory to complete "ii. Source of wealth" below.

- ☐ Salary or commission
- ☐ Sale of assets
- ☐ Personal savings
  If currently not employed, please provide details below
  (for example: previous employment, allowance from family members)
- ☐ Proceeds from a policy (please give details below)
- ☐ Inheritance
- ☐ Other (please give details below)

Details _____

_____

_____

ii Source of wealth[1] – to be declared on the party who is paying/have paid the insurance premium for this policy. Otherwise, it is to be declared on the policyholder or beneficial owner. It is mandatory to complete this sub-section (including fully paid policies) and you may choose more than one option:

a How did you accumulate your wealth (i.e. your total assets)?

- ☐ Salary or commission from current and/or past employment
  For past employment, please provide details of past occupation and organisation below
- ☐ Inheritance and gift
- ☐ Others, please specify _____
- ☐ Business or trade income
- ☐ Investments (shares, bonds, unit trusts, and so on)
- ☐ Sale of property or company or other assets

_____

[1] Source of wealth refers to the origin of the policyholder's, payor's and beneficial owner's entire body of wealth (i.e. total assets).

2 Beneficial ownership declaration – This is NOT a nomination of beneficiaries for this policy

A Beneficial Owner is defined in the MAS Notice on Prevention of Money Laundering and Countering the Financing of Terrorism as an individual who ultimately owns or controls the customer or the individual on whose behalf business relations are established.

Please complete this section only if you are not the Beneficial Owner of this policy.

If you are not the beneficial owner and there is a Beneficial Owner arrangement, please

i Submit a copy of their NRIC or passport and a completed copy of the FATCA and CRS self-certification form for Individual Account Holder, Entity Account Holder or Controlling Person available here: www.income.com.sg/Policy-downloads-and-forms; and

ii Provide details below:

Full name of Beneficial Owner (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Date of birth (dd/mm/yyyy)	Relationship to Policyholder	Gender	Country of Residence	Nationality (Singaporean/Others)

3 Politically Exposed Person (PEP)

A Politically Exposed Person (PEP) is an individual who is, or has been entrusted with prominent public functions whether in Singapore, a foreign country or an international organisation.

Prominent public function includes the roles held by head of state, a head of government, government ministers, senior civil or public servants, senior judicial or military officials, senior executives of state owned corporations, senior political party officials, members of the legislature, and senior management of international organisations.

Please complete this section and disclose this information if you, or the Beneficial Owner, are a PEP or related^ to a PEP.

^ An individual closely connected to a PEP either socially or professionally, such as a parent, stepparent, child, stepchild, adopted child, spouse, sibling, step-sibling, or adopted sibling.

Name of PEP	Title of PEP	Name of person related to PEP	Relationship to PEP

Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income Insurance"), its representatives, agents, relevant third parties (referred to in Income Insurance's Privacy Policy at https://www.income.com.sg/privacy-policy), Income Insurance's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Insurance Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income Insurance including providing me/us with financial advice/financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income Insurance, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income Insurance, its affiliates, business partners and/or NTUC Enterprise group of social enterprises ("NE Group") where required for Income Insurance, its affiliates, business partners and/or NE Group, to develop, improve and/or customise their products/services and/or to provide me/us with their respective products/services, and in the manner and for other purposes described in Income Insurance's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of the insured person, my family member, employee, payee/payor or beneficiary) is provided by me/us (whether in this or subsequent submissions) or from other sources to Income Insurance Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorisation and approval on their behalf

for the purposes as set out in this Personal Data Use Statement.

I/We agree that if my/our policy(ies) premiums are paid by third-party payor(s), I/We consent to the use and disclosure of my/insured name(s) and relevant policy(ies) information by Income Insurance to such third-party payor(s) for the purposes of processing and/or administering premiums payments for my/our policy(ies).

Please refer to Income Insurance's Privacy Policy (https://www.income.com.sg/privacy-policy) for more information, including access and correction to personal data and consent withdrawal.

I/we agree and understand that Income Insurance's Privacy Policy available on its website may be amended, supplemented and/or substituted by Income Insurance from time to time.

Declaration and authorisation

I wish to make changes to the policy indicated in this form. I understand and agree that the changes:

a are subjected to your underwriting and acceptance;
b if accepted, may be subject to terms, conditions and exclusions imposed by you;
c I have paid the required premiums in full; and
d will take effect only when you accept and approve my request and notify me in writing of the effective date of the changes.

I understand that there are some possible disadvantages if I proceed with this application. I may be losing valuable benefits and may not be able to achieve my intended financial objective. It may not be possible for me to obtain a similar level of protection on the same terms in the future. Buying another policy in the future could result in higher premiums and loss of specific policy features due to changes in age or health.

For the purposes of policy administration including processing these changes, and deciding whether you insure or continue to insure me for my insurance applications or policies,

1 I authorise:
  a any medical source, insurance office or organisation to release to you; and
  b you to release to any medical source or insurance office;
  any relevant information to do with me or the insured whether you accept my application or not. A photocopy is valid as an original copy.
2 I am authorised to disclose information (including personal health information) about my spouse and/or dependants if they are insured under the insurance applications or policies.
3 I declare that all details provided in this form are true, accurate and complete.
4 I confirm that I am not an undischarged bankrupt and no bankruptcy application (including any statutory order) or order has been made against me.
5 I confirm (a) that I understand and agree to the collection, use and disclosure of my personal data as stated in the "Personal Data Use Statement" (PDUS); and (b) on the representation and warranty made in the PDUS.

Signed in Singapore on the day of 20	
Signature of policyholder or assignee[1]	Signature of insured[2]

[1] For policies that are assigned, the assignee needs to sign this form.
[2] Signature of insured (age 16 and above) is also required if you need to submit the Application for alteration with medical underwriting form on the insured's health.

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Abridged Fact Find form for traditional life policy

Important notice to Policyholder or Assignee

You would have provided your Income advisor information about yourself in relation to your financial goals, financial situation and your particular needs before the purchase of the insurance product(s).

It is recommended that you seek advice from your Income advisor if you wish to make changes to your insurance policies.

Policyholder's or Assignee's particulars

Name of policyholder or assignee[1] (as shown in NRIC)	NRIC/passport number	Are you 62 years old and above? ☐ Yes ☐ No

Proficient in both spoken and written English

☐ Yes
☐ No, please indicate proficient language below

Language spoken	Language written
☐ English ☐ Mandarin ☐ Malay	☐ English ☐ Mandarin ☐ Malay
☐ Tamil ☐ Others _____	☐ Tamil ☐ Others _____

Highest educational level attained

☐ Primary ☐ Secondary ☐ GCE 'O'/'N' level
☐ Pre-U/JC ☐ Diploma ☐ Degree
☐ Post graduate

[1] Delete where applicable. For policies with assignment, assignee needs to complete and sign the form.

Policyholder's or Assignee's accompaniment (Please check accordingly, if applicable)

You are identified as a **Selected Client** as you belong to **at least two** of the following profiles.

It is strongly recommended for you to have someone you can trust with your personal information and help with your financial decision to join you in the meetings.

☐ 62 years of age or older
☐ Below GCE 'O' level or 'N' level certifications, or equivalent academic qualifications
☐ Not proficient in spoken or written English

Note to Selected Client

If you have purchased a product from us, you will be receiving a call from the company to confirm your understanding of the product and/or transaction recommended.

Would you like to be accompanied by a Trusted Individual?

☐ Yes (Please provide details below) ☐ No *(For selected client, please acknowledge section A)*

Name of Trusted Individual	Relationship to customer

NRIC number (last 4 characters e.g., use "567A" if the NRIC number is S1234567A.)

Important note to Advisor

Please ensure the Trusted Individual:

(i) is present throughout the entire sales and advisory process;
(ii) should not be a Selected Client; and
(iii) should not be someone who presents potential conflicts of interests such as the advisor's supervisor or any other relationship or circumstances where a potential conflict of interests could arise.

Section A: Customer's acknowledgement (selected clients only)

☐ **I confirmed that the above information of my Trusted Individual is accurate and he/she is**

1. At least 21 years old.
2. Holding at least GCE 'O' or 'N' level certifications or equivalent academic qualifications.
3. Proficient in both spoken and written English.
4. Not an Income Insurance advisor or sales supervisor.

And I agree to this Trusted Individual knowing my personal information during the course of the sales and advisory process.

☐ **I acknowledged and confirmed that**

1. I do not wish to have a Trusted Individual present.
2. I am fully able to make decisions on my own without a Trusted Individual.

Policyholder's or Assignee's summary of needs (to be completed by Income advisor)

Your Income advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial goals, budget and your particular needs will be the basis on which financial advice and recommendation will be given. Alternatively, you may request your Income advisor for a comprehensive review of your financial needs by completing the "My Financial Portfolio" (MFP).

	Policyholder's or Assignee's financial goals			
	Priority			**When fund is needed (Time Horizon)**
Protection	**H**	**M**	**L**	
Death				Upon Occurrence
Disability				Upon Occurrence
Critical Illness				Upon Occurrence
Others: _____				Upon Occurrence
Others: _____				Upon Occurrence
Accumulation				
Retirement[2]				_____ years
Education[3]				_____ years
Accumulation 1: _____				_____ years
Accumulation 2: _____				_____ years
Accumulation 3: _____				_____ years
Legacy & Philanthropy				
Gifting				Upon Occurrence
Equalisation				Upon Occurrence
Estate Preservation				Upon Occurrence

Priority Level – **H**: High - To address immediately **M**: Medium - To address within 1 year **L**: Low - To address after 1 year

Essential financial goals must at least be of low priority as they are always applicable to the Customer. [*Fields underlined and **bold***]

Goal Eligibility – [2] Minimum Age 16 [3] Child, Age 0-18

Policyholder's or Assignee's budget

Reality Check of Emergency Funds

It is generally recommended to set aside 6 months' worth of expenses[4] as an emergency fund.

Start keeping money aside in a combination of Savings Accounts or Singapore Savings Bonds (SSBs) to have ready cash to tide you through when the unexpected happens.

Your Budget[5]	Your Acknowledgement
Cash (Regular Premium): _____ ☐ Monthly ☐ Yearly	**Is your budget within 50% of your Net Cash Flow?** ☐ Yes ☐ No[6] **Note**: Net Cash Flow refers to annual income less annual expenses.
Cash (Single Premium): _____	**Is your budget within your Total Cash/Near Cash Assets and you still have emergency fund to cover at least 6 months of expenses thereafter.** ☐ Yes ☐ No[6] **Note**: Emergency funds refers to total cash or near cash assets divided by monthly total expenses.
SRS Account (Single Premium): _____	**Is your budget within your SRS balance?** ☐ Yes ☐ No[6] **Note**: Please ensure sufficient funds in the SRS account
Ordinary Account (Single Premium): _____	**Is your budget within your CPF-OA balance after setting aside the minimum $20,000?** ☐ Yes ☐ No[6, 7]
Special Account (Single Premium): _____	**Is your budget within your CPF-SA balance after setting aside the minimum $40,000?** ☐ Yes ☐ No[6, 7]

Deviations[6]

[4] Based on Basic Financial Planning Guide which recommends 3 to 6 months of expenses; 6 months is used here for a more conservative approach.
[5] Customers are responsible for self-declaring all relevant personal and financial information. Accurate and complete disclosure is essential to ensure appropriate recommendations and financial advice tailored to their needs.
[6] Deviations to be documented below.
[7] CPFIS will not take effect should there be insufficient funds to proceed in the CPF-OA/ CPF-SA.

Advisor's recommendation

- State how does this transaction meets customer's need(s) and/or goal(s);
- State customer's concern, investment objectives, shortfall amount ($), time horizon, where applicable;
- State and explain features, benefits and limitations, minimally one each, relating to the transaction recommended; and
- State warnings and important disclosures.

Policyholder's or Assignee's declaration on replacement of policy

Is this a replacement of policy? - are you planning to sell off partial or full, stop paying premium for any of your existing insurances or unit trusts; or - have you sold or stop paying premium for any of your existing insurances or unit trusts in the last 12 months?	☐ Yes ☐ No
If the transaction is a replacement of policy:	
Is the replacement of policy advised by the Advisor?	☐ Yes ☐ No
My advisor has explained the following to my satisfaction in the event a replacement of policy takes place. 1. I may incur transaction costs without gaining any real benefit from the replacement. 2. I may incur penalties for terminating any of my existing policies. 3. I may not be insurable at standard terms. 4. The replacement plan may offer a lower level of benefit at a higher cost or same cost, or offer the same level of benefit at a higher cost. 5. The replacement plan may be less suitable and the terms and conditions may differ. 6. There may be other options available besides policy replacement (e.g. free switching facilities for investment policy). 7. Upon Income Insurance's acceptance of my IncomeShield/Enhanced IncomeShield application, any MediShield-approved Integrated Shield Plan with another Private Medical Insurance Scheme (PMIS) will be automatically terminated.	☐ Yes ☐ No

Important note to Customer

Please include any life insurance policy in the following status in addition to surrender/terminate/lapse:
Partial withdrawal, automatic premium loan, policy loan, premium holiday, bonus encashment, premium reduction.

Please tell us more about the transaction(s) and the reason for the transaction(s):

Details such as type of insurance policy or unit trusts, name of financial institution or insurer, type of transaction (surrender/redeem partial or in full, stop paying premium before term ends, etc), month and year of transaction, suffer any loss/penalty cost, etc.

Advisor's declaration and review on replacement of policy

Advisor's assessment of the replacement and whether it is detrimental to the interest of the customer based on the following 4 Main Guiding Principles [FAA-N16, MAS 120] and the basis of recommendation for the replacement.

1. Whether the customer suffers any penalty for terminating the original policy;
2. Whether the customer incurs transaction cost without gaining any real benefit;
3. Whether the replacement policy confers lower benefits at a higher cost or same cost to the customer, or the same benefits at a higher cost; and
4. Whether the replacement policy is less suitable for the customer/insured.

☐ **I have explained to the customer the possible disadvantages of policy replacement and where applicable, informed customer of other options available besides policy replacement. I have explained the basis for policy replacement and why the replacement of policy is suitable for the customer below.**

Product Name and/or Transaction	**Is the replacement of policy detrimental to the interest of the customer?** ☐ Yes ☐ No Explanation of policy replacement:
Product Name and/or Transaction	**Is the replacement of policy detrimental to the interest of the customer?** ☐ Yes ☐ No Explanation of policy replacement:

Please indicate the policy(ies) assessed not to be a replacement of policy.

Replacement of policy assessment is required for same category of products:

- Investment products (life insurance, unit trusts) to the new purchase of life insurance policy;
- Accident & Health (A&H) plans to new purchase of shield plan or any A&H plans.

Product Name and/or Transaction

1. _____

2. _____

Policyholder's or Assignee's decision and acknowledgement

Do you agree with your Advisor's recommendation(s)?

☐ Yes, I agree with all recommendation(s).

☐ Yes, I agree with all recommendation(s), with the exception of the product and/or transaction stated below.

☐ No, I do not wish to proceed with all recommendation(s).

Customer's Disagreement with Recommendation

Please state reason(s) why you disagree and do not wish to proceed with the recommended transaction(s):

Product and/or Transaction	Insured	Reason

Important note to Customer

I am aware that it is my responsibility to ensure the suitability of the transaction(s) selected and wish to make the following amendment(s). I am also aware that for Investment-linked plan(s), I will not be able to rely on Section 36 of the Financial Advisers Act 2001 to file a civil claim in the event of a loss.

I acknowledge on the following:

1. I understand that the recommendation(s) is/are based on information and assumptions that I have provided in this form. Any inaccurate and incomplete information may affect the suitability of the recommendation(s).
2. I understand that this form is intended for limited-scope transactions and does not replace a comprehensive financial review. I also understand that I can request for a comprehensive financial review of my existing portfolio before I proceed with this transaction(s).
3. My advisor has used a copy of the Abridged Fact Find form, Policy Illustration, Product Summary and Product Highlight Sheet where applicable, as a basis to explain the information relating to this transaction(s).

Name of Policyholder or Assignee[8]	NRIC/FIN number
Signature of Policyholder or Assignee[8]	Date (dd/mm/yyyy)

[8] Delete where applicable. For policies with assignment, assignee needs to complete and sign the form.

Advisor's declaration and acknowledgement

The recommendation made by me has taken into account the information disclosed by the Customer in this document and may including information documented in the MFP.

I declare that the information provided to me is strictly confidential and is only to be used in the process of recommending suitable insurance products and shall not be used for any other purposes.

Name of Advisor	Advisor's Code
Advisor's Signature	Date (dd/mm/yyyy)

Supervisor's validation

Call-back details (To be completed if call-back is required)

Call-back is required for ☐ Selected client ☐ Selected representative ☐ High-risk representative ☐ Others: _____

To be completed when customer requests the call to be made to Trusted Individual:

Name of Trusted Individual	Mobile number of Trusted Individual

Note: Ensure there is supporting documentation on specific instruction from the customer or instruction is recorded in the sales advisory documentation.

I have made the call-back to customer and confirmed that customer understands all material facts necessary to make an informed decision including the product features, risks of the product, policy and premium term, and the applicable fees and charges.

Date of Call-back (dd/mm/yyyy)	Time of Call-back (am/pm)
Phone number used for Call-back	Customer's phone number

Call-back checklist (Mandatory)

Self introduction

i. Self-Introduce and state purpose of call
ii. Inform customer the call is on a recorded line
iii. Perform customer verification

Note: Use Income's approved call facility with recording function

	Must cover questions The Supervisor is to verify the following areas. Please tick accordingly.	Yes	No	Not Sure	Not Applicable
1	Customer understands the main features of the transaction being recommended				
2	Customer is aware of the key risks and limitations of the transaction				
2a	[Additional Checks required for Income Global Growth Equity Fund] Customer is aware of Currency and Concentration risk of Income Global Growth Equity Fund				
3	Advisor conducted fact-finding & needs analysis				
4	Advisor explained basis of recommendation				
5	Advisor informed on free-look provision for new application				
6	Advisor asked for presence of Trusted Individual for Selected Client				
7	Advisor is professional and ethical				

Comments on the outcome of call-back (Required if there are any "No" or "Not Sure". Please indicate "Nil" if there are no comments.)

I had accompanied[9] the advisor for the sales advisory session.

☐ Yes ☐ No

[9] If the purpose is to perform Joint Field Work observation (JFW), please complete the necessary JFW form.

Supervisor's validation (continued)

Based on the information gathered,

☐ I agree with the recommendation made by the advisor; the Abridged Fact Find form is completed to my satisfaction in accordance to the following:

- The needs analysis has taken into account the information disclosed by the customer.
- The reasons of recommendation are written clearly and framed in the context of the customer's situation addressing customer's financial objectives and concerns,
- The basis and implications for replacement of policy has been duly explained to customer and documented, when applicable.
- All dates and signature in the Abridged Fact Find form, Policy Illustration(s), Cover Page (if applicable), Bundled Product Disclosure (if applicable) and transaction forms are in order.

☐ I disagree with the recommendation made by the advisor.

Comments:

Name of Supervisor	Supervisor's code
Supervisor's Signature	Date (dd/mm/yyyy)

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Application for alteration with medical underwriting

WARNING: Under Section 23(5) of the Insurance Act 1966 (or any other future amendments to it), you must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for. Otherwise, the insurance policy may not be valid.

Section 1: Proposer Details (Policyholder)

Full name (as in NRIC/Passport/Long-Term Pass/ACRA business profile)		NRIC/Passport number/FIN/Unique Entity Number (UEN)	
Nationality ☐ Singaporean ☐ Singapore PR (nationality) _____ ☐ Others (please give details) _____		Country of residence	City of residence
Occupation		Height (metres)	Weight (kilograms)
Name of organisation	Nature of work		Annual Income (S$)

Section 2: Details of insured (if different from policyholder)

If you need to add another insured, please use another form and submit it together with this form.

Relationship to policyholder or assignee
☐ Child (Below age 18) ☐ Husband or wife ☐ Others _____ (please give details)

Full name (as in NRIC/Passport/Long-Term Pass)		NRIC/Passport number/FIN	
Nationality ☐ Singaporean ☐ Singapore PR (nationality) _____ ☐ Others (please give details) _____		Country of residence	City of residence
Date of birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Height (metres)	Weight (kilograms)
Occupation	Name of organisation	Nature of work	Annual Income (S$)

Section 3: Concurrent insurance applications and policies

	Policyholder	Insured
1 Do you have any existing in-force insurance policies and/or are you currently applying for insurance with another insurance company? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policy/Proposal ☐ Policyholder ☐ Insured	Policy/Proposal ☐ Policyholder ☐ Insured	Policy/Proposal ☐ Policyholder ☐ Insured
Insurance company			
Year of issue or application			
Death coverage amount (S$)			
Total and permanent disability coverage amount (S$)			
Critical illness coverage amount (S$)			
Personal accident coverage amount (S$)			
Disability income coverage amount (S$)			
Others (please specify type and coverage)			

Section 4: Insurance history

	Policyholder	Insured
1 Has any application or reinstatement for a life, or critical illness, or disability, or accident, or hospital insurance policy ever been refused, postponed or accepted at special terms with any insurer? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policy ☐ Policyholder ☐ Insured	Policy ☐ Policyholder ☐ Insured
Insurance company		
Type of policy		
Reasons		

	Policyholder	Insured
2 Have you ever made any claims or are you intending to make any claims, on any policy with any insurer? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policy ☐ Policyholder ☐ Insured	Policy ☐ Policyholder ☐ Insured
Insurance company		
Nature of claim		
Year of claim		
Reasons		

Section 5: Family history

	Policyholder	Insured
1 Have any of your biological parents or siblings been diagnosed with or passed away as a result of: Alzheimer's disease, cancer, carcinoma-in-situ, mental disorder, diabetes, polycystic kidney disease, stroke, high blood pressure, heart disease, or any other hereditary disease or disorder? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Family member 1 ☐ Policyholder ☐ Insured	Family member 2 ☐ Policyholder ☐ Insured
Relationship to Policyholder or Insured		
Medical condition or cause of death		
Age at which it began		
Age at death (if applicable)		

Section 6: Lifestyle information

	Policyholder	Insured
1 Have you smoked cigarettes or cigars in the past 12 months? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Years of smoking		
Sticks of cigarettes (per day)		
Sticks of cigars (per day)		

Section 6: Lifestyle information (continued)

	Policyholder	Insured

2 Do you consume alcohol? If yes, please state the quantity of alcohol you drink per week.

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Cans of beer (per 330ml)		
Glasses of wine (per 125ml)		
Glasses of spirit (per 30ml)		

3a Have you ever been advised by a health care professional or a counsellor to reduce your alcohol intake, see a specialist, or to attend a support group because of your alcohol intake? If yes, please provide details below and answer Question 3b.

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Name of doctor/support group		
Address of doctor/support group		

3b Have you completed treatment or been discharged from medical follow up? If yes, please provide details below:

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Date of last follow-up		

4a Are you taking or have taken addictive drugs or substances (for example: narcotics of glue sniffing)? If yes, please provide details below and answer Question 4b.

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Addictive drug or substance taken		

4b Have you ever been treated or counselled for the use of addictive drugs or substances? If yes, please provide details below and answer Question 4c.

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Name of doctor/support group		
Address of doctor/support group		

4c Have you completed treatment or counselling for addicituve drugs or substances? If yes, please provide details below:

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Date of last follow-up		

5 Do you take part in or do you plan to take part in military or private flying other than as a passenger on a regular airline? If yes, please complete Military Questionnaire (military flying) or Aviation Questionnaire (private flying).

☐ Yes ☐ No | ☐ Yes ☐ No

6 Do you take part in, or plan to take part in other dangerous occupations or pursuits as listed below?
Scuba or skin diving (please complete the Diving Questionnaire)
Mountain or rock climbing (please complete the Mountaineering and Rock Climbing Questionnaire)
Others _____ (For other hazardous activities or pursuits, please complete the Hazardous Pursuits Questionnaire)

☐ Yes ☐ No | ☐ Yes ☐ No

7 Do you plan to live abroad for more than 3 months other than for holidays or studies? If yes, please provide details below. If there is more than one country, please provide details for each country.

☐ Yes ☐ No | ☐ Yes ☐ No

	Policyholder	Insured
Name of countries and cities		
Duration of each stay		
Frequency of travel		
Purpose of each travel		

Section 7: Medical information
Section 7.1: (Questions for all ages)

	Policyholder	Insured
1 Do you have a doctor whom you consult for medical reasons other than minor illness such as common cold or flu? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Date of last consultation (dd/mm/yyyy)		
Reason for last consultation		
Name of doctor		
Name and address of clinic		

	Policyholder	Insured
2 In the last 5 years, have you had, or been advised to undergo any medical tests or investigations that resulted in any of the following: • Abnormal results or findings • Inconclusive results • Additional or repeat test • Doctor referral • Close monitoring or short interval follow up • Regular surveillance test Typical examples of medical tests or investigations include blood test, urine test, x-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check. You should answer yes if your regular health screenings resulted in further follow up, repeat tests, inconclusive results or doctor referral.	☐ Yes ☐ No	☐ Yes ☐ No

	Test/Investigation 1 ☐ Policyholder ☐ Insured	Test/Investigation 2 ☐ Policyholder ☐ Insured
Type of test/investigation		
Date of test/investigation		
Reasons for test/ investigation		
Test/investigation result		
Name and address of clinic		

	Policyholder	Insured
3 Have you or your spouse taken a HIV test (please give the reason and results), received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS-related complex or any other AIDS-related conditions? If yes, please provide details below and submit a copy of all results, if available.	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Party involved	☐ Self ☐ Spose	☐ Self ☐ Spose
Reason for test/medical advice/counselling		
Exact diagnosis/condition/ concern		
Date of test/medical advice/ counselling (dd/mm/yyyy)		
Type of test done and results (if any)		
Medical advice/counselling given by doctor (if any)		
Name and address of the clinic/hospital		

Section 7: Medical information
Section 7.1: (Questions for all ages) (continued)

Important Notes:
Questions 4 and 5 are only applicable for Singapore Citizens, Permanent Residents of Singapore and Residents with an Employment Pass/Work Permit[1]/Pass Permit[2]:

- You need to disclose the result of a diagnostic genetic test done (i.e. test to confirm or rule out a diagnosis when you have symptoms).
- You do not need to disclose the result of a:
  - ✓ predictive genetic test (test done when you have no symptoms of a genetic disorder) such as Huntington's disease (HTT), BRCA1 and BRCA2 unless your total coverage for a specific benefit exceeds the limits as set out in questions 4a and 5a.
  - ✓ genetic test obtained from Biomedical Research or Direct-to-Consumer (genetic test provided to consumer directly by manufacturer or supplier of the test).
  - ✓ genetic test obtained from National Familial Hypercholesterolaemia (FH) Genetic Testing Programme.
- If a genetic test result is negative, we may take it into account to consider better underwriting terms.

[1] You should hold a valid Work Permit and have resided in Singapore for not less than a total of 183 days in the 12 months before application date.
[2] You should hold a valid Pass Permit and have resided in Singapore for not less than a total of 90 consecutive days in the 12 months before application date.

	Policyholder	Insured
4a Is your total Death coverage or Total and Permanent Disability coverage with Income and other insurers more than S$2,000,000? If yes, please answer Question 4b.	☐ Yes ☐ No	☐ Yes ☐ No
4b Have you undergone a genetic test for Huntington's disease? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Reasons for test		
Date of test		
Test results		

5a If you are applying for Critical Illness coverage, is your total Critical Illness coverage with Income and other insurers more than S$500,000? If yes, please answer Question 5b. (You may select 'No' if you are not applying for Critical Illness coverage)	☐ Yes ☐ No	☐ Yes ☐ No
5b Have you undergone a genetic test for breast cancer (BRCA 1 or BRCA 2) or Huntington's disease? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Reasons for test		
Date of test		
Test results		

Important Notes: Question 6 is only applicable if you are a non-resident of Singapore.

6 Have you undergone any genetic test, e.g. Huntington's disease, breast cancer (BRCA 1 or BRCA 2) or others? If yes, please provide details of test below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
Reasons for test		
Date of test		
Test results		

Section 7.2: Additional questions to be completed for age 16 to age 50

Important Notes: If you answered "Yes" to any of the questions in Section 7.2 to Section 7.6, please provide details on page 14.	Policyholder	Insured
7 Have you ever had diabetes, high blood pressure, high cholesterol, cardiomyopathy, heart attack, heart valve disorders, heart or blood vessels disorders (other than irregular heart rate or heart murmurs), stroke, transient ischemic attack, bipolar disorder, schizophrenia, tumour, cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesion, polyps, cysts, fibroids or other growths of any kind, kidney failure, HIV or AIDS?	☐ Yes ☐ No	☐ Yes ☐ No

Section 7.2: Additional questions to be completed for age 16 to age 50 (continued)

8 In the last 5 years, have you had any of the medical conditions indicated between 8a to 8j, regardless of when it was diagnosed that has required any of the following:
- Medical leave for 2 consecutive weeks and beyond;
- Medication for 2 consecutive weeks and beyond;
- Hospitalisation;
- Regular follow up with a medical practitioner;
- On regular medications;
- Use of assisting device or help from another person to carry out your daily activities

	Policyholder	Insured
a Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
b Heart murmur, chest pain, fast or irregular heart rate	☐ Yes ☐ No	☐ Yes ☐ No
c Alzheimer's disease, Parkinson's disease, dementia, multiple sclerosis, motor neuron disease, epilepsy, aneurysm, paralysis, numbness, autism, attention deficit hyperactivity disease, anxiety or depression	☐ Yes ☐ No	☐ Yes ☐ No
d Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver	☐ Yes ☐ No	☐ Yes ☐ No
e Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease	☐ Yes ☐ No	☐ Yes ☐ No
f Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full)	☐ Yes ☐ No	☐ Yes ☐ No
g Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week)	☐ Yes ☐ No	☐ Yes ☐ No
h Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases	☐ Yes ☐ No	☐ Yes ☐ No
i Sexually transmitted diseases	☐ Yes ☐ No	☐ Yes ☐ No
j Overactive or underactive thyroid hormone secretion	☐ Yes ☐ No	☐ Yes ☐ No
9 Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above?	☐ Yes ☐ No	☐ Yes ☐ No

Section 7.3: Additional questions to be completed for female (age 16 to age 50)

	Policyholder	Insured
10a Are you now pregnant? If yes, please state the number of weeks pregnant:	☐ Yes ☐ No	☐ Yes ☐ No
10b Have there been any complication(s) relating to this and/or previous pregnancies such as gestational diabetes, caesarean section, eclampsia, hypertension, diabetes, thrombosis, miscarriage or others? If yes, please provide details below:	☐ Yes ☐ No	☐ Yes ☐ No

	Policyholder	Insured
No. of weeks pregnant		

	Policyholder	Insured
Pregnancy	☐ Past pregnancy ☐ Current pregnancy	☐ Past pregnancy ☐ Current pregnancy
Date of diagnosis		
Details of complications		

Section 7.4: Additional questions to be completed for above age 50

	Policyholder	Insured
11 Have you ever had diabetes, cardiomyopathy, heart attack, heart valve disorders, heart or blood vessels disorders (other than irregular heart rate or heart murmurs), stroke, transient ischemic attack, bipolar disorder, schizophrenia, tumour, cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesion, polyps, cysts, fibroids or other growths of any kind, kidney failure, HIV or AIDS?	☐ Yes ☐ No	☐ Yes ☐ No

12 In the last 5 years, have you had any of the medical conditions indicated between 12a to 12i, regardless of when it was diagnosed that has required any of the following:
- Medical leave for 2 consecutive weeks and beyond;
- Medication for 2 consecutive weeks and beyond;
- Hospitalisation;
- Regular follow up with a medical practitioner;
- On regular medications;
- Use of assisting device or help from another person to carry out your daily activities

a Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis	☐ Yes ☐ No	☐ Yes ☐ No
b High blood pressure, high cholesterol, heart murmur, chest pain, fast or irregular heart rate	☐ Yes ☐ No	☐ Yes ☐ No

Section 7.4: Additional questions to be completed for above age 50 (continued)

	Policyholder	Insured
c Alzheimer's disease, Parkinson's disease, dementia, multiple sclerosis, epilepsy, aneurysm, paralysis, numbness, anxiety or depression	☐ Yes ☐ No	☐ Yes ☐ No
d Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver	☐ Yes ☐ No	☐ Yes ☐ No
e Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease	☐ Yes ☐ No	☐ Yes ☐ No
f Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full)	☐ Yes ☐ No	☐ Yes ☐ No
g Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week)	☐ Yes ☐ No	☐ Yes ☐ No
h Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases	☐ Yes ☐ No	☐ Yes ☐ No
i Overactive or underactive thyroid hormone secretion	☐ Yes ☐ No	☐ Yes ☐ No
13 Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above?	☐ Yes ☐ No	☐ Yes ☐ No

Section 7.5: Additional questions to be completed for juvenile applications (age below 16)

	Insured
14 Please provide details below for Juvenile Applicants:	☐ Yes ☐ No
a Does either of the child's parents have equivalent cover as proposed in this application? If no, please select the reason: ☐ Ineligible due to medical reasons ☐ Pending application with other insurers ☐ Others, please provide reason and details _____	☐ Yes ☐ No
b Does the child have other siblings? If yes, do all of them have equivalent cover (including pending application with other insurers) as proposed in this application? If no, please select the reason: ☐ Ineligible due to medical reasons ☐ Others, please provide reason and details _____	☐ Yes ☐ No
c Has the child ever had, or been told that he/she has, or been told to seek treatment, or have been treated for any of the following medical conditions or symptoms?	☐ Yes ☐ No
i Diabetes, thyroid disorders or any other endocrine disorders	☐ Yes ☐ No
ii Asthma, bronchitis, pneumonia, persistent cough (longer than 4 weeks) or any other lung disease or disorder	☐ Yes ☐ No
iii Heart murmur, heart valve disorders or diseases, Kawasaki's disease, irregular or fast heart rate, or any other disease or disorder of the heart or blood vessels	☐ Yes ☐ No
iv Epilepsy, fits, weakness of limbs, unconsciousness, developmental delay or abnormality in respect of physical, neurological, cognitive, language or psychosocial aspect or any other neurological, nervous or mental disorders	☐ Yes ☐ No
v Jaundice, hepatitis, or any other disorder of the digestive system including oesophagus, stomach, intestines, colon, rectum, anus, liver, gallbladder, pancreas	☐ Yes ☐ No
vi Kidney infection, urinary tract infection, blood in urine, protein in urine or sugar in urine, or any other disease or disorder of the kidney, bladder	☐ Yes ☐ No
vii Impaired hearing, impaired sight, impaired speech, ear discharge, double vision, nose bleeds (intermittent or continuous longer than 1 week) or any other disorders of eyes, ears and nose	☐ Yes ☐ No
viii Anaemia, thalassemia, HIV infection (AIDs or any other disorders of the blood or autoimmune disease)	☐ Yes ☐ No
ix Cancer, enlarged lymph nodes, unusual skin lesions, tumours, or other growths of any kind	☐ Yes ☐ No

Section 7.6: Additional questions to be completed for juvenile life insured (age below 2)

	Insured
15 Is the child a premature baby (i.e. less than 37 weeks of gestation)? If yes, please provide details below: Gestation period (weeks) _____ Length at birth _____ cm APGAR score at 1 minute _____ Weight at birth _____ kg APGAR score at 5 minute _____ Date of discharge from hospital _____	☐ Yes ☐ No
16 Were there any significant events during pregnancy/delivery such as but not limited to birth difficulty, infection, congenital deformities, lack of mental development, respiratory distress syndrome, prolonged jaundice that lasted more than 2 weeks, G6PD deficiency, respiratory disorder, intrauterine growth retardation?	☐ Yes ☐ No
17 Any special care needed after birth?	☐ Yes ☐ No
18 Has the child been advised, or been told to go for further follow-up, or further evaluation, or monitoring after each routine assessment check?	☐ Yes ☐ No
19 Has the child had any physical, congenital or developmental defects, or shown any sign of slow physical or mental development?	☐ Yes ☐ No

Section 7.6: Additional questions to be completed for juvenile life insured (age below 2) (continued)

If you answered "Yes" to any of the above questions in Section 7.2 to Section 7.6, please provide the details in the space below:

- The name of the condition and the date of diagnosis.
- The name and address of each doctor and hospital.
- How long the illness or injury lasted and the date of recovery.
- The nature of the tests done, dates, results and reasons for the tests.
- Please submit a copy of the test result, if any.

Question no.	Policyholder	Insured

Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income Insurance"), its representatives, agents, relevant third parties (referred to in Income Insurance's Privacy Policy at https://www.income.com.sg/privacy-policy), Income Insurance's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Insurance Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income Insurance including providing me/us with financial advice/financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income Insurance, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income Insurance, its affiliates, business partners and/or NTUC Enterprise group of social enterprises ("NE Group") where required for Income Insurance, its affiliates, business partners and/or NE Group, to develop, improve and/or customise their products/services and/or to provide me/us with their respective products/services, and in the manner and for other purposes described in Income Insurance's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of the insured person, my family member, employee, payee/payor or beneficiary) is provided by me/us (whether in this or subsequent submissions) or from other sources to Income Insurance Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorisation and approval on their behalf

for the purposes as set out in this Personal Data Use Statement.

I/We agree that if my/our policy(ies) premiums are paid by third-party payor(s), I/We consent to the use and disclosure of my/insured name(s) and relevant policy(ies) information by Income Insurance to such third-party payor(s) for the purposes of processing and/or administering premiums payments for my/our policy(ies).

Please refer to Income Insurance's Privacy Policy (https://www.income.com.sg/privacy-policy) for more information, including access and correction to personal data and consent withdrawal.

I/we agree and understand that Income Insurance's Privacy Policy available on its website may be amended, supplemented and/or substituted by Income Insurance from time to time.

Section 9: Declarations and authorisations

1 I/We cannot alter any of the wordings in this application form. Any attempt to do so will have no effect.

2 I/We understand that I/we may receive correspondences for this application and my/our policy documents electronically (collectively "policy e[1] document"). I/We agree that Income can notify me/us by email or SMS to retrieve and read my/our policy e-documents via secure online access.

3 I/We agree that Income will not be responsible to me/us (or any other person) if I/we fail to::
   a provide Income my/our correct email address or mobile number;
   b inform Income of any update or change to my/our email address or mobile number; or
   c keep the password to access the policy e-documents confidential.

4 I/We understand that the policy e-documents are considered delivered and received, upon my/our receipt of Income's SMS or email notification on the availability of the policy e-documents via secure online access.

Section 9: Declarations and authorisations (continued)

5 I/We understand and agree that the changes requested in this application:
   a may require medical evidence and I/we will pay any costs involved in providing the medical evidence Income needs;
   b are subject to Income's underwriting and acceptance;
   c if accepted, may be subject to terms, conditions and exclusions imposed by Income; and
   d will take effect only when Income accept and approves my/our application and notifies me/us in writing of the cover start date and provided that I/we have paid the required premiums (and interest, if applicable) in full.

6 I/We declare that the answers given in this application are true, correct and complete. 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. If it is discovered later that I/we or the insured suffer from a medical condition that is not disclosed in this form, I/we will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income. I/We agree that this application and other written answers, statements, information or declarations I/we have made or which have been made on my/our behalf will form the basis of the contract of insurance between the policyholder and Income. If anything is untrue, incorrect or incomplete, the insurance policy will not be valid.

7 I/We confirm that there has been no change in the information provided about me/us since the completion of the application and all additional declarations made in connection with the application. I/We will notify Income immediately if there is any change in the information provided about me/us such as any change in the state of health, financial information, any concurrent insurance policy applications with other insurers or if I/We plan to seek medical consultation, investigation, or treatment between the date of this application and before the cover start date" for this alteration form. I am/We are aware that Income may add special terms to the policy or declare the policy as void according to the information provided or if I/We fail to notify Income of any change in my/our information.

8 I/We have confirmed that I am/we are not an undischarged bankrupt and no bankruptcy application (including any statutory order) or order has been made against me/us.

9 I/We confirm (a) that I/we understand and agree to the collection, use and disclosure of my/our personal data as stated in the "Personal Data Use Statement" (PDUS) and (b) on the representation and warranty made in the PDUS.

10 For the purpose of this application, I/we authorise, consent and agree to:
   a the medical source, insurance office, reinsurer, organisation to release to Income any medical or relevant information to do with me/us or the insured whether Income accepts this application or not;
   b Income and its relevant third parties stated in Income's Privacy Policy to collect from, use and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me/us or the insured; and
   c Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me/us or the insured's health status or condition in relation to this application.

11 I/We agree that a copy of the authorisation in this form is valid and binding as an original copy.

12 Where applicable, I/we further authorise, consent and agree to Income disclosing my/our personal data to the Government of Singapore and statutory boards and organisations approved by the Government of Singapore, for the purpose of determining my/our suitability and eligibility for public schemes (including, without limitation, schemes relating to healthcare, aged care, disability, social assistance, financial assistance, retirement, savings, insurance and/or disability insurance) when required.

13 I/We confirm that I am/we are authorised to disclose information (including personal health information) about the insured to Income.

14 I/We understand that Income will not be able to sell or administer any insurance product or provide any services to me/us if I/we refuse to give this expressed consent.

15 I/We certify that I am/we are the Account Holder (or am/are authorised to sign for the Account Holder) of all accounts to which this form relates.

16 I/We declare that all statements made in this form are correct and complete. I/We undertake to inform Income within 30 days if there is a change in circumstances that affects the tax residency status of the Account Holder or causes the information in this form to be incorrect or incomplete. I/We shall provide Income with an updated FATCA and CRS self-certification form within 90 days of such change in circumstances. I/We understand any false, misleading, or fraudulent information regarding my/our resident status for tax purposes may result in certain penalties.

17 I/We agree that if I/we or any #Relevant Person is found to be a +Prohibited Person:
   - Income is entitled not to accept this application; and
   - if any policy is issued, Income is entitled to end this policy, not pay any benefit or not allow any transaction, such as surrender and assignment, to be carried out under this policy. Income will not refund any unutilised premium when this policy is ended.

   Income's decision in every respect of the above will be final. I/We will inform Income immediately if there is any change in my/our or any Relevant Person's identity, status or identity documents.

   # *Relevant Person includes insured, trustee, settlor, beneficiary, assignee, nominee, payee, mortgagee, financier of this application/policy, and in relation to an entity, its director, partner, manager, person having executive authority, authorised signatory, shareholder or beneficial owner.*

   + *Prohibited Person means a person or entity who is, or who is ^Related to a person or entity:*
   - *subject to laws, regulations or sanctions administered by any inter-government, government, regulatory or law enforcement authorities of any country, which will prohibit or restrict Income from providing insurance or carrying out any transaction under this policy, or*
   - *who is involved in any terrorist or illegal activities or placed on sanctions listing or issued with freezing order.*

   ^ *Related includes relationships such as parent, step-parent, child, step-child, adopted child, spouse, sibling, step-sibling, adopted sibling, parent-in-law, child-in-law, sibling-in-law, cousin, uncle, aunt, grandparents, niece, nephew, grandchild, employee, employer, associate, parent company, subsidiary and shareholder.*

18 This application is governed by and interpreted according to the laws of the Republic of Singapore.

19 I/We agree that this form may be signed by electronic or digital signature, whether encrypted or not, which will be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Electronic signature may include electronically scanned and transmitted versions (e.g., via pdf) of an original signature.

I/We agree that if I/we do not reveal any significant fact (which would have affected Income's decision to accept my/our application on standard terms) in this application, any legal document that is issued for this review may not be valid. This includes any fact I/we may not be sure is significant, and also any information I/we have given to the advisor but was not included in this application.

Signature of policyholder or assignee[1]	Signature of insured (for age 16 and above)
Signed in Singapore on (dd/mm/yyyy):	Signed in Singapore on (dd/mm/yyyy):

[1] For policies that are assigned, the assignee needs to sign this form.