income made different

**NTUC Income Insurance Co-operative Limited**
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an NTUC Social Enterprise

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

# Alteration form for life policy

**Important notes:**

1 Please use this form for traditional life policies. If you are making changes to an Investment-Linked Policy (ILP), please use forms meant for ILP. (not applicable for freelook)

2 We need the following identification documents to be submitted with this form.

For Singaporean or Singapore permanent resident
- Clear image of NRIC (front and back)

For foreigner staying, studying or working in Singapore
- Clear image of passport showing validity dates, passport number, photograph, nationality, date of birth and name;
- Singapore employment pass, S pass, work permit, student pass or dependent's pass (front and back); and
- Clear image of a document (issued within the last 6 months e.g. utility bill, phone bill) that shows your name and address.

The passport, passes or permits must be valid for at least 6 months.

## Details of policyholder or assignee

| Name (as shown in NRIC) | NRIC number or FIN | Policy number |
|---|---|---|
| Occupation | Nature of work | |
| Name of organisation | | |

## Details of insured

| Name (as shown in NRIC) | NRIC number or FIN |
|---|---|
| Occupation | Nature of work |
| Name of organisation | |

## Type of request

| Request | Details | For official use |
|---|---|---|
| ☐ Increase sum assured or premium Notes 1, 2, 3, 4, 7 *(Not allowed if plan is withdrawn)* | From _____ to _____ | Increase sum assured |
| ☐ Decrease sum assured or premium Notes 4, 5, 7 | From _____ to _____ | Decrease sum assured |
| ☐ Increase cover term Notes 1, 2, 3, 4 | From _____ to _____ | Premium payment term change |
| ☐ Decrease cover term Notes 1, 2, 4 | From _____ to _____ | |
| ☐ Increase payment term Notes 1, 3, 4 *(For policies with limited premium feature only, except for FlexRetire/RevoRetire)* | From _____ to _____ | |
| ☐ Decrease payment term Notes 1, 2, 4 *(For policies with limited premium feature only, except for FlexRetire/RevoRetire)* | From _____ to _____ | |
| ☐ Add riders Notes 2, 3, 4 | Please indicate rider name, sum assured and cover term. | Add rider |
| ☐ Remove riders | Please indicate the riders to remove. | Precontract terminating rider |
| ☐ Change of payout period (For FlexRetire/RevoRetire only) Note 6 | Please choose the revised payout period. ☐ 10 years ☐ 20 years ☐ 30 years | Change payout period |
| ☐ Convert policy to paid-up | | Paidup |
| ☐ Free look Policy type (please select one): ☐ Non-ILP ☐ ILP | | Cooling period withdrawal (For ILP, franking of form is required) |
| ☐ Change premium due option from Automatic Premium Loan (APL) to paid-up | | Premium overdue option alteration |
| ☐ Cancel existing Automatic Premium Loan (APL) arrangement | | Cancel automatic premium loan |

## Type of request (continued)

| | |
|---|---|
| ☐ Reprint of policy document ($10 for each policy document) | Policy reissue |
| ☐ Other request: _____ | Modify extra mortality |

**Note:**

1 For policies that are in force for less than 1 year and have not acquired any cash value.
2 Please complete "Abridged fact find form" on page 4 and 5. For non-Income advisers, please submit a valid fact find form with supervisor's validation.
3 Please complete "Declaration of continued assurability" form on pages 6 to 10.
4 Please submit a revised Policy Illustration. Not required if it is to decrease the sum assured or premium of a policy which has acquired cash value.
5 Please submit completed partial surrender discharge voucher (generated by LHO on a working day) for policy which has acquired cash value.
6 Your request must be submitted at least 30 days before the first regular payment is due.
7 For RevoRetire, premium alteration is not allowed when there is a claim for Disability Care benefit.

## Mandatory declarations

**1 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.

If there is a Beneficial Ownership 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:

| Name of beneficial owner | NRIC/Passport number/FIN | Date of birth (dd/mm/yyyy) |
|---|---|---|
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality) _____<br>☐ Others _____ | Gender<br>☐ Male<br>☐ Female | Relationship to Policyowner |

**2 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.

If you, or the Beneficial Owner, are a PEP or related^ to a PEP, you must disclose this information.

^ 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 of related person to PEP |

**3 Source of funds and wealth** (we may request for additional information or supporting documents, if necessary)

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.

| Name of person funding the policy | Identification number of payor (NRIC or Passport or FIN number) |
|---|---|
| Relationship to policyholder | Occupation and organisation |

b What is the source of funds used to finance the premiums?

☐ Salary or commission
☐ Sale of assets (please give details below)
☐ 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 (please give details below)
☐ Other (please give details below)

Details _____

_____

_____

_____

## Mandatory declarations (continued)

ii Source of wealth[4] (to be declared on the party who is paying the insurance premium for this policy. Otherwise, it is to be declared on the policyholder or beneficial owner)

a What is your source of wealth?

- ☐ Salary or employment income
- ☐ Business or trade income
- ☐ Cash and savings
- ☐ Investments (shares, bonds, unit trusts, and so on)
- ☐ Inheritance and gift
- ☐ Sale of property or company or other assets
- ☐ Withdrawal of CPF money
- ☐ Others, please specify _____

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

**5 Personal data consent**

**i Personal data**

The information I have provided is my personal data and, where it is not, I have the consent of the owner of the personal data to provide such information. The personal data includes personal data provided in this application or any document to Income, whether by me or any other party or source for this application.

By providing this information, I or we understand, and give my or our consent for Income as well as Income's respective representatives and agents to collect, use, store, transfer and disclose the information, to or with all such persons (including Income's third party service providers, whether located within or outside Singapore) for the purpose of enabling Income to provide me with the services required of by an insurer, including the evaluation, processing, administration, and/or managing of my relationship and policies with Income and for the purpose set out in Income's Privacy Policy which can be found at http://www.income.com.sg/privacy-policy ("How we use your personal data (Purpose & Notification Obligation)").

**ii Access and correction rights**

You can request access to any personal data of yours that we have, and request to know how it is being used and disclosed for the last 12 months to the extent your right is allowed by law. If we allow you access, we may charge you a reasonable fee. You also have the right to request correction of your personal data.

For any request to access or correct your personal data, please write to: The Data Protection Officer, Income Centre, 75 Bras Basah Road, Singapore 189557 or email to DPO@income.com.sg

For any request to withdraw your consent, please contact Income Contact Centre at 6788 1777 or email to consentwithdrawal@income.com.sg

## 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 confirm that I am not an undischarged bankrupt and no bankruptcy application (including any statutory order) or order has been made against me.

| 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 declaration of continued assurability 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 adviser 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 adviser 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 number or FIN | Are you 62 years old and above? |
|---|---|---|
| [1] Delete where applicable. For policies with assignment, assignee needs to complete and sign the form. | | ☐ Yes ☐ No |

| Language spoken | Language written | Highest educational level attained |
|---|---|---|
| ☐ English ☐ Mandarin ☐ Malay<br>☐ Tamil ☐ Others _____ | ☐ English ☐ Mandarin ☐ Malay<br>☐ Tamil ☐ Others _____ | ☐ Primary ☐ Secondary ☐ GCE 'O'/'N' level ☐ Pre-U/JC<br>☐ Diploma ☐ Degree ☐ Post graduate |

## Policyholder's or assignee's accompaniment

Note: It is recommended for you to be accompanied by a Trusted Individual if you belong to any <u>two</u> of the following profiles:
- 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

Would you like to be accompanied by a Trusted Individual?
☐ No ☐ Yes (If 'Yes', please provide details below)

Name of Trusted Individual _____

Relationship to client _____ NRIC number _____

*Please note that you will be receiving a call from the company to confirm your understanding of the products recommended by your adviser (if you have purchased a product from us).*

## Policyholder's or assignee's summary of needs (to be completed by Income adviser)

Your Income adviser 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 adviser for a comprehensive review of your financial needs by completing the "My Financial Portfolio" (fact find form).

### Policyholder's or assignee's financial goals

| **Basic Protection** | **Priority level** | | | | **Savings and Investment** | **Priority level** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **High** | **Med** | **Low** | **N.A.** | | **High** | **Med** | **Low** | **N.A.** |
| Income protection (death) | | | | | Saving for children's educational needs<br>Dependant _____ | | | | |
| Income protection (disability) | | | | | Saving for retirement needs | | | | |
| Critical illness | | | | | Enhancement to existing wealth accumulation plan | | | | |
| Medical and hospitalisation costs | | | | | Others _____ | | | | |
| Personal accident | | | | | _____ | | | | |
| Long-term care | | | | | **When fund is needed (Time Horizon)** | | | | |
| Others _____ | | | | | | | | | |
| _____ | | | | | | | | | |

### Policyholder's or assignee's budget for planning

| **Cash** | **Other source of funds** | |
|---|---|---|
| Regular amount $ _____ (A / H / Q / M) | CPF - Ordinary Account $ _____ | SRS Account $ _____ |
| Single amount $ _____ (SP) | CPF - Special Account $ _____ | Retirement Account $ _____ |

Is the budget you set aside more than 50% of your assets or surplus?
☐ No ☐ Yes

## Adviser's recommendation

## Adviser's declaration

I have provided the policyholder or assignee with a reasonable recommendation(s) based on the information and assumptions he or she has provided in this form.

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 adviser _____ Adviser's code _____

Signature _____ Date _____ (dd/mm/yyyy)

## Policyholder's or assignee's acknowledgement

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 I can request for a comprehensive financial review of my existing insurance policy(ies) before I proceed with this transaction(s).

3. My adviser 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). The Product Highlight Sheet is also available for download at www.income.com.sg.

☐ I agree with the proposed recommendation(s).

☐ I disagree with the proposed recommendation(s). My comments are as indicated below.

Comments

Name of policyholder or assignee[2] _____ NRIC number or FIN _____

Signature _____ Date _____ (dd/mm/yyyy)

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

## Supervisor's validation

### To be completed if call back is required

Call back is required for ☐ 'Selected client' ☐ 'Selected representative'

I have made the call to the customer and confirmed that the customer understands all the material facts that are 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: _____ (dd/mm/yyyy) Phone number used for the call back: _____ (supervisor)

Time of call: _____ (am/pm) _____ (policyholder or assignee)

Feedback (if any) is gathered on the sales process and quality of advice provided by the representative:

Based on the information provided and the policyholder's or assignee's choice,

☐ I agree with the recommendation made by my adviser. ☐ I disagree with the recommendations made by my adviser.

Comments:

Name of supervisor _____ Supervisor's code _____

Signature _____ Date _____ (dd/mm/yyyy)

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# Declaration of continued assurability

**Statement under Section 25(5) of the Insurance Act, Cap. 142 (or any 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.

## Proposer Details (Policyholder)

| Name (as shown in NRIC) | | NRIC number or FIN | |
|---|---|---|---|
| Occupation | | Height (metres) | Weight (kilograms) |
| Name of organisation | Nature of work | | Yearly income (S$) |

## 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)

| Name (as shown in NRIC) | | NRIC number or FIN | Date of birth (dd/mm/yyyy) | |
|---|---|---|---|---|
| Nationality<br>☐ Singaporean ☐ Singapore PR ☐ Others (Please give details) _____ | | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Occupation | Name of organisation | Nature of work | Yearly Income (S$) | |

## Information of existing policies

| | Policyholder | Insured |
|---|---|---|
| 1 Do you have any existing policies or proposals pending approval? If you answered yes, please give details below. | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Policyholder**

| Name of insurer | Year issued or pending | Sum assured | | | Accident and hospitalisation | Others |
|---|---|---|---|---|---|---|
| | | Death | Critical illness | Total and permanent disability | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Insured (to fill below if insured is different from policyholder)**

| Name of insurer | Year issued or pending | Sum assured | | | Accident and hospitalisation | Others |
|---|---|---|---|---|---|---|
| | | Death | Critical illness | Total and permanent disability | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## Details on previous and concurrent applications and claims

| | Policyholder | Insured |
|---|---|---|
| 1 Has any application for a life or critical illness or disability, or accident or hospital insurance policy ever been refused, postponed or accepted at special rates with Income or any other insurer? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2 Are you making or have you made any claims, including hospitalisation claims on any policy with Income or any other insurer? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you answered yes to questions 1 to 2 above, please give details below.**
**Policyholder**

| Question number | Details |
|---|---|
| | |
| | |

**Insured (to fill below if insured is different from policyholder)**

| Question number | Details |
|---|---|
| | |
| | |

## Lifestyle

| | Policyholder | Insured |
|---|---|---|
| 1 Do you drink alcohol or take any other stimulants? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2 Have you smoked cigarettes in the past 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3 Do you plan to live abroad for more than three months other than for holidays or studies? If you answered yes, please give details below including the country, for how long and the reason. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4 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 or any other dangerous occupation or pursuits such as scuba diving, mountain or rock climbing, free-fall parachuting, sky diving or motor racing? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5 Have you been taking any drugs which can become addictive or have you ever been treated for drug or alcohol addiction? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you answered yes to any of the questions above, please give details below.**
**Policyholder**

| Question number | Details |
|---|---|
| 1 | Quantity per week: Beer _____ cans Wine _____ glasses Spirits _____ tots<br>1 standard alcoholic drink equates to a 330ml can of beer, a 125ml glass of wine or a 30ml tot of spirits<br>Other stimulants (please state type and quantity) _____ |
| 2 | Number of years smoked _____ Number of cigarettes per day _____ |
| | |
| | |

**Insured (to fill below if insured is different from policyholder)**

| Question number | Details |
|---|---|
| 1 | Quantity per week: Beer _____ cans Wine _____ glasses Spirits _____ tots<br>1 standard alcoholic drink equates to a 330ml can of beer, a 125ml glass of wine or a 30ml tot of spirits<br>Other stimulants (please state type and quantity) _____ |
| 2 | Number of years smoked _____ Number of cigarettes per day _____ |
| | |
| | |

## Family history

| | Policyholder | Insured |
|---|---|---|
| Have either of your natural parents or any of your brothers or sisters died or suffered from cancer including carcinoma in situ, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If you answered yes, please give details below. | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Policyholder**

| Relationship to insured | Age | Medical condition | Age when it began | Age at death | Cause of death and details |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Insured (to fill below if insured is different from policyholder)**

| Relationship to insured | Age | Medical condition | Age when it began | Age at death | Cause of death and details |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## Details of doctor (part 1)

| | Policyholder | Insured |
|---|---|---|
| Do you have a regular doctor? If you answered yes, please give details below. | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | Policyholder | Insured |
|---|---|---|
| Name of doctor | | |
| Address | | |

## Details of doctor (part 2)

| | Policyholder | Insured |
|---|---|---|
| Have you consulted any doctor in the last 5 years for conditions other than common cough and flu? If you answered yes, please give details below. To clarify, you can indicate the same doctor as the regular doctor you have given above. | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | Policyholder | Insured |
|---|---|---|
| Name of doctor | | |
| Address | | |
| Date last consult | | |
| Reason for consultation | | |
| Result of last consultation | | |

## Questions on health

| | Policyholder | Insured |
|---|---|---|
| 1 Have you ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of any of the following:<br>a epilepsy, fits, stroke, paralysis, weakness of limbs, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous or mental disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b diabetes, thyroid disorders or any other endocrine disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c double vision, impaired sight, hearing or speech, ear discharge, nosebleeds or any other disorders of the eye, ear, nose or throat? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d asthma or a persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints or discomfort or any other lung diseases? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e raised cholesterol, high blood pressure, heart attack, heart murmur, prolapsed mitral valve 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? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g jaundice, being a hepatitis-B carrier or any other form of hepatitis, liver disorder or gall bladder disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| i slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| j cancer, tumour, cyst or growth of any kind? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| k anaemia, any other disorders of the blood, or had been told not to donate blood or received a blood transfusion or blood products for haemophilia or any other reason? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| l any other illness, disorder, operation, physical disability or accident not mentioned above? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2 Have you or your husband or wife received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS-related complex or any other AIDS-related conditions? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3 Have you had a HIV test done (please give the reason and results), or in the last three months had any of the following symptoms for more than one week continuously? Feeling tired, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4 In the past five years, have you had any test done such as an X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine test? If you answered yes, please give details of date, type of test, reason for undergoing such test and the test result. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5 Have you had any gain or loss in weight of more than 5kg in the last 12 months? If you answered yes, please give reasons in the space below. | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Health questions for females only (age 10 and above)** | | |
| 6 a Have you had or received any treatment for or plan to be treated for any disease or disorder of the breast including breast lump, breast cyst, fibroadenoma of the breast, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ of the breast, cancer or growth of the breast? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b Have you had or received any treatment for or plan to be treated for any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, uterine fibroids, abnormal enlargement of the abdomen, carcinoma in situ or cancer? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c Have you had an abnormal mammogram, PAP smear, pelvis ultrasound, breast ultrasound, cone biopsy, colposcopy, or other gynaecological test; or have you ever been advised for further follow-up on (or to repeat) any one of these tests within 6 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d Have you had any complications during your pregnancy or as a result of your pregnancy (for example, an ectopic pregnancy, diabetes, high blood pressure or protein in the urine)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e Has any of your children suffered from hereditary disorders (for example, Spina bifida or Down's syndrome)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f Has any of your children suffered from congenital disorders (for example, club foot, a hole in the heart or cleft lip or palate)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g Are you now pregnant? If you answered yes, how many weeks? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Health questions for juvenile only (age 15 and below)** | | |
| 7 a Was the child born before 37 completed weeks of pregnancy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b Any special care needed after birth? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c Has the child had any physical, congenital or developmental defects or shown any sign of slow physical or mental development? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d Has the child ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of jaundice (other than neonatal jaundice that lasted for less than 2 weeks with no treatment required and fully resolved)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e Has the child ever had, been told to have, been treated for, been told to get treatment for or suffered symptoms of any condition affecting the sight, hearing or speech? | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Questions on health (continued)

**If you answered yes to any of the questions above, please give details 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.
- A copy of the above tests, if any.

Please state whether it is for the policyholder or insured.

## Declaration and authorisation

I will tell you as soon as possible if there is any change in the state of my health or the insured's health or if I or they plan to get any medical consultation, investigation or treatment between the date of this application and before the date you issue the legal documents to effect the changes.

The answers in this application are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information. I agree that this application and other written answers, statements, information or declarations made by me or on my behalf will form the basis of the contract of insurance between me and you.

I understand and agree that the changes:

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

I agree and 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.

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

**I agree that if I do not reveal any significant fact (which would have affected your decision to accept my application on standard terms) in this application, any legal document that is issued to effect the changes may not be valid. This includes any fact whose significance I am unsure of, and also any information I have given to the adviser but was not included in this application.**

| | |
|---|---|
| Signature of policyholder or assignee[1]<br><br>Signed in Singapore on (dd/mm/yyyy): | Signature of witness (Witness needs to be age 21 and above)<br><br>Signed in Singapore on (dd/mm/yyyy): |
| Signature of insured (For age 16 and above)<br><br>Signed in Singapore on (dd/mm/yyyy): | Name, NRIC number and contact number of witness |

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