

## Abridged Fact Find form for Investment-Linked 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 transact in investment-linked policies (ILPs) or make changes to your insurance policies.**

### Policyholder's or assignee's particulars

Name of policyholder or assignee <sup>1</sup> (as shown in NRIC)	NRIC/passport no.	Are you 62 years old and above? <input type="checkbox"/> Yes <input type="checkbox"/> No
<sup>1</sup> Delete where applicable. For policies with assignment, assignee needs to complete and sign the form.		
Proficient in both spoken and written English <input type="checkbox"/> Yes <input type="checkbox"/> No, please indicate language below <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>Language spoken</b>  <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay  <input type="checkbox"/> Tamil <input type="checkbox"/> Others         </div> <div style="width: 45%;"> <b>Language written</b>  <input type="checkbox"/> English <input type="checkbox"/> Mandarin <input type="checkbox"/> Malay  <input type="checkbox"/> Tamil <input type="checkbox"/> Others         </div> </div>	Highest educational level attained <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> GCE 'O'/'N' level <input type="checkbox"/> Pre-U/JC <input type="checkbox"/> Diploma <input type="checkbox"/> Degree <input type="checkbox"/> 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 two 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 no. \_\_\_\_\_ (last 4 characters)  
 E.g. use "567A" if the NRIC number is S1234567A.

Note: A "Trusted Individual" is a person who is/has: (i) At least aged 18; (ii) At least GCE 'N' or 'O' Level Certificate, or Equivalent Academic Qualification; (iii) Proficient in spoken and written English; (iv) A person who has the trust of the Client.  
 Representative or Supervisor is not allowed to be the Trusted Individual for client.

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

### Policyholder's or assignee's transaction request(s)

<sup>^</sup> For policyholder/assignee who wishes to proceed with one time top-up/recurring single premium/fund switch/change in fund percentage ILP post-purchase transactions and do not want any advice from Income, you must complete SECTION A, SECTION B & SECTION C. This is only available if policyholder/assignee is assessed in SECTION B to have relevant experience and/or knowledge in ILPs.

<input type="checkbox"/> ^One time or ^recurring single premium <input type="checkbox"/> ^Fund switch or ^change in fund percentage <input type="checkbox"/> Increase in regular premium or sum assured <input type="checkbox"/> Increase rider cover term <input type="checkbox"/> RevoSave ILP Account <input type="checkbox"/> Add rider	This Abridged Fact Find form is used for the recommendation of the following policies:  1. _____  2. _____  3. _____  4. _____
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## Section A: Policyholder's or assignee's Risk Profile

It is important to recommend suitable products that reflect your risk preferences. People make investment decisions based on time, performance of an investment and the risk they are prepared to accept. You should consider that short-term capital losses might be a consequence of aiming for higher, longer-term returns. As a general rule, the higher the potential return, the higher the risk that capital may not be returned.

**This risk profile questionnaire helps to assess your risk tolerance level. Please answer each question accordingly.**

Question	Myself
<b>1. Investment Time Horizon</b> <ul style="list-style-type: none"> <li>This is assuming that you have already made plans to meet your short term financial goals and to handle emergencies.</li> <li>How long would you keep your money invested before you would need to assess it?</li> </ul>	_____ years (Please indicate from 0-100)
<b>2. Your current Age</b> <ul style="list-style-type: none"> <li>What is your current age (Last Birthday)?</li> </ul>	_____ years (Please indicate from 0-100)
<b>3. Percentage of Assets to be set aside for Investments</b> <ul style="list-style-type: none"> <li>What percentage of your total assets would you like to set aside for investments (existing plus intended amount)?</li> </ul>	_____ % (Please indicate from 0-100)
<b>4. Market Decline Tolerance Level</b> <ul style="list-style-type: none"> <li>In an extreme market downturn, what is the maximum decline you can tolerate?</li> <li>"0" means you cannot tolerate any decline.</li> </ul>	_____ % (Please indicate from 0-100)
<b>5. Investment Decline Response (a)</b> <ul style="list-style-type: none"> <li>Following your response to <u>question 4</u>, if your investment declines by this much, would you be able to sleep peacefully at night and function properly at work?</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>6. Investment Decline Response (b)</b> <ul style="list-style-type: none"> <li>Following your response to <u>question 4</u>, if your investment declines by this much, what would you do? Sell, buy more or hold and do nothing? (Please indicate 1 answer)</li> </ul>	<input type="checkbox"/> Sell <input type="checkbox"/> Buy <input type="checkbox"/> Hold
<b>7. Percentage to sell or buy based on Initial Investment Value</b> <ul style="list-style-type: none"> <li>Following your response to <u>question 6</u>, please indicate how much (in percentage) would you sell or buy based on your initial investment value?</li> <li>If you decide to hold and do nothing, please indicate "0"</li> </ul>	_____ % (Please indicate from 0-100)

### Suitability criteria

Does your answers above fall under any of the categories below (Please indicate 'yes' or 'no'):

Question 1: Time horizon is stated as 1 year or less

Yes    No

Question 3: Percentage of your total assets you would like to set aside for investments is 0%

Yes    No

Question 4: Maximum decline you can tolerate is less than 6%

Yes    No

#### Important Note:

The suitability criteria is to assess if you are suitable to buy into an ILP.

If you have been assessed to be not suitable for the purchasing of ILP products (at least 1 box is 'checked' as yes), it is recommended for you not to purchase an ILP.

Please scan the QR code (or use the link below) and input your answers to generate your Risk Profile

[https://www.income.com.sg/crp\\_questionnaire](https://www.income.com.sg/crp_questionnaire)



### My Risk Profile (Please indicate your risk profile)

Client risk profile	Description	To be completed <b>ONLY</b> if you <b>disagree</b> with your risk profile
<b>Conservative</b>	Objective is to preserve capital. Prefers high liquidity and reduced risk of capital loss.	Please indicate the risk profile deemed more suitable:  <input type="checkbox"/> Conservative <input type="checkbox"/> Moderately Conservative <input type="checkbox"/> Moderately Aggressive <input type="checkbox"/> Aggressive  Comments: _____ _____
<b>Moderately Conservative</b>	Objective is to obtain dependable regular stream of income from investment. Willing to accept some risks of capital loss.	
<b>Moderately Aggressive</b>	Objective is to strike a balance between fixed income and equity investment for growth opportunities.	
<b>Aggressive</b>	Objective is to achieve above average growth over time and current income concerns will be minimal. Willing to take substantial risks in investment.	

**Important note:** If you disagree with your predicted risk profile, the minimum of your predicted risk profile and stated risk profile will be used as a basis of recommendation.

- Predicted Risk Profile is the Risk profile generated for the Client
- Stated Risk Profile is the Client's preferred Risk Profile if Client disagrees with their Predicted Risk Profile

## Section B: Policyholder's or assignee's investment knowledge

This questionnaire, also known as the Customer Knowledge Assessment, helps to assess if you have any relevant knowledge or investment experience to understand the risks and features of unlisted "Specified Investment Products", which includes investment-linked policies ("ILPs") or similar products. Any inaccurate or incomplete information provided by you may affect the suitability of the recommendation.

### Outcome of Customer Knowledge Assessment

- If you have indicated a "Yes" in at least one of the below questions, you are assessed to have the relevant experience and/or knowledge in ILPs.
- If you have indicated a "NO" in all the below questions, you are assessed NOT to have the relevant experience and/or knowledge in ILPs. We would need you to seek advice from your Income advisor before transacting in your ILP(s).

<b>Educational Qualifications</b>	<p>Q1. Do you hold any Diploma or higher qualification in the finance-related disciplines as below?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> <li>Accountancy</li> <li>Actuarial Science</li> <li>Business/Business Administration</li> <li>Business Management/ Business Studies</li> <li>Capital Markets</li> </ul> </td> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> <li>Computational Finance</li> <li>Economics</li> <li>Finance/Commerce</li> <li>Finance Engineering</li> <li>Financial Planning</li> <li>Insurance</li> </ul> </td> </tr> </table>	<ul style="list-style-type: none"> <li>Accountancy</li> <li>Actuarial Science</li> <li>Business/Business Administration</li> <li>Business Management/ Business Studies</li> <li>Capital Markets</li> </ul>	<ul style="list-style-type: none"> <li>Computational Finance</li> <li>Economics</li> <li>Finance/Commerce</li> <li>Finance Engineering</li> <li>Financial Planning</li> <li>Insurance</li> </ul>	<p>If "Yes" to any questions, provide details below</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>
<ul style="list-style-type: none"> <li>Accountancy</li> <li>Actuarial Science</li> <li>Business/Business Administration</li> <li>Business Management/ Business Studies</li> <li>Capital Markets</li> </ul>	<ul style="list-style-type: none"> <li>Computational Finance</li> <li>Economics</li> <li>Finance/Commerce</li> <li>Finance Engineering</li> <li>Financial Planning</li> <li>Insurance</li> </ul>			
	<p>Q2. Do you have any other professional finance-related qualifications? Eg: Chartered Financial Analyst (CFA)/Association of Chartered Certified Accountants (ACCA)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>		
<b>Investment Experience</b>	<p>Q3. Have you made at least 6 transactions in collective investment schemes ("CIS") (example: unit trusts) or ILPs in the last 3 years?</p> <p><u>Transactions that would NOT qualify:</u></p> <ul style="list-style-type: none"> <li>Subsequent investments into a regular premium ILP, recurring single premium ILP or instalment savings plan of Unit Trust after the first premium/instalment.</li> <li>Shares listed in the Stock Exchange</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>		
<b>Work Experience</b>	<p>Q4. Do you have a minimum of 3 consecutive years of working experience in the past 10 years in the development of, structuring of, management of, sale of, trading of, research on and analysis of investment products or the provision of training in investment products?</p> <p>Note: Work experience in accountancy, actuarial science, treasury or financial risk management activities will also be considered relevant experience.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/>		

## Section C: Policyholder's or assignee's declaration (to be completed if you do not wish to seek advice from Income)

This section is only available to policyholder or assignee who is assessed to have the relevant experience and/or knowledge in ILPs in Section B and wishes to transact in one of the following post-purchase transactions to ILP(s) without seeking advice from Income.

- One time top-up
- Recurring single premium
- Fund switch
- Change in fund percentage

### Important notice to policyholder or assignee:

*If you are unsure whether the intended transaction is suitable for your circumstances, you are encouraged to seek advice from a qualified Income advisor who will be able to advise you on a suitable product or transaction to your existing policy.*

*Please read the following declaration together with the Product Highlight Sheet(s), Fund Report(s) or Monthly Fund Fact Sheet(s) available from [www.income.com.sg](http://www.income.com.sg) carefully before submission of this form.*

As the policyholder or assignee,

1. I acknowledge that I have the option to complete "My Financial Portfolio" (fact find form) with my advisor but I wish to receive factual information only.
2. I am aware the outcome of my completed Customer Knowledge Assessment under Section B where I am assessed to have relevant knowledge and/or experience in ILPs.
3. I am aware of my risk profile, completed under Section A.
4. I am advised to read and understand the corresponding Product Highlight Sheet(s), Fund Report(s) or Monthly Fund Fact Sheet(s) available from [www.income.com.sg](http://www.income.com.sg) with respect to the relevant investment fund(s) before deciding whether to invest or transact in such fund(s). Where appropriate, I understand that I can cease to proceed with this transaction at any time before the submission of this form and seek financial advice from a qualified Income advisor, or seek independent legal, tax and/or other professional advice.
5. All investment decisions are made independently by me, as the policyholder or assignee, after duly considering and understanding the investment fund(s), benefits and risks. I understand that the information contained herein is not intended as financial advice and shall not be relied on as such by me. I am responsible to ensure the suitability of the fund(s) selected.
6. I am aware of my responsibility to ensure the suitability of the ILP transaction(s) and will waive the right to receive any advice as to whether the product or fund(s) is suitable under the Financial Advisers Act.

Name of policyholder or assignee<sup>2</sup> \_\_\_\_\_ NRIC number or FIN \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ (dd/mm/yyyy)

<sup>2</sup> Delete where applicable. For policies with assignment, assignee needs to complete and sign the form.

**Please proceed to complete the transaction request in the appending form.**

**Section D: 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" (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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saving for children's educational needs Dependant _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Income protection (disability)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Saving for retirement needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enhancement to existing wealth accumulation plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical and hospitalisation costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Long-term care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>When fund is needed (Time Horizon)</b>				
Others _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

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

<b>Cash</b>	<b>Other source of funds</b>
Regular amount \$ _____ ( <input type="checkbox"/> A / <input type="checkbox"/> H / <input type="checkbox"/> Q / <input type="checkbox"/> 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

**Advisor's recommendation**

Advisor's recommendation (continued)

Empty space for advisor's recommendation.

Policy number	ILP fund(s) selected	Fund percentage	Risk classification of fund(s) according to policyholder's or assignee's risk profile	Remarks
			<input type="checkbox"/> Below <input type="checkbox"/> Match <input type="checkbox"/> Above	
			<input type="checkbox"/> Below <input type="checkbox"/> Match <input type="checkbox"/> Above	
			<input type="checkbox"/> Below <input type="checkbox"/> Match <input type="checkbox"/> Above	

## Replacement of policy

### Policyholder's or assignee's declaration on policy replacement

Do you intend to purchase a policy to replace in part or full any existing or recently terminated insurance policy or investment product from any insurer or other financial institution?

No  Yes (If 'yes', please complete the sections below.)

Is the replacement of policy advised by the representative?

No  Yes

My representative has explained the following to my satisfaction in the event a replacement of policy should take place.

No  Yes

- I may incur transaction costs without gaining any real benefit from the replacement.
- I may incur penalties for terminating any of my existing policies.
- I may not be insurable at standard terms.
- 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.
- The replacement plan may be less suitable and the terms and conditions may differ.
- There may be other options available besides policy replacement (e.g. free switching facilities for investment policy).
- Upon Income's acceptance of your IncomeShield/Enhanced IncomeShield application, any MediShield-approved Integrated Shield Plan with another Private Medical Insurance scheme (PMIS) will be automatically terminated.

### Advisor's declaration on policy replacement

I have explained to the client the possible disadvantages of policy replacement and where applicable, informed him/her of other options available besides policy replacement.

I have also explained the basis for policy replacement and why the replacement of policy is suitable for the client below:

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### Advisor'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 advisor \_\_\_\_\_ Advisor's code \_\_\_\_\_

Signature \_\_\_\_\_  Date \_\_\_\_\_ (dd/mm/yyyy)

### Policyholder's or assignee's acknowledgement

- 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).
- I understand that I can request for a comprehensive financial review of my existing insurance policy(ies) before I proceed with this transaction(s).
- My advisor has used a copy of the Abridged Fact Find form, Benefit/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](http://www.income.com.sg).

I agree with the proposed recommendation(s).

I do not agree with the proposed recommendation. I am aware that it is my responsibility to ensure the suitability of the product(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 27 of the Financial Advisers Act to file a civil claim in the event of a loss.

Comments

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4. Location where the client was prospected.

I was prospected at:

- |   |  |
|---|--|
| <input type="checkbox"/> Income's premises (for events held in Income's premises, select "Close Door Event" option) | <input type="checkbox"/> Roadshow*             |
| <input type="checkbox"/> Representative/agency's premises (e.g. home, rented office)                                | <input type="checkbox"/> Internet/social media |
| <input type="checkbox"/> Client's premises (e.g. home, place of work, family/friend's premises)                     | <input type="checkbox"/> Unable to recall      |
| <input type="checkbox"/> Retailer (tie-up arrangements with Income)*  | <input type="checkbox"/> Others*               |
| <input type="checkbox"/> Close Door Event (e.g. Worksite/Seminar etc)   |  |
| <input type="checkbox"/> Street canvassing <input type="checkbox"/> Referral  |  |
| <input type="checkbox"/> Over the phone <input type="checkbox"/> Over video conference                              |  |
| <input type="checkbox"/> Not applicable (if no advice was sought from Income)                                       |  |

\*Please specify location: \_\_\_\_\_

**Policyholder's or assignee's acknowledgement (continued)**

5. Location where the sale was closed.

Please note that the sale cannot be closed over the phone for MediSave-Approved Plans and/or Selected Clients.

The sale was closed at:

- Income's premises (for events held in Income's premises, select "Close Door Event" option)
- Representative/agency's premises (e.g. home, rented office)
- Client's premises (e.g. home, place of work, family/friend's premises)
- Retailer (tie-up arrangements with Income)\*
- Retailer (no tie-up arrangements with Income. E.g. at a restaurant/café)\*
- Close Door Event (e.g. Worksite/Seminar etc)       Roadshow\*
- Over the phone       Over video conference
- Not applicable (if no advice was sought from Income)       Others\*

\*Please specify location: \_\_\_\_\_

**To be completed if policyholder or assignee is assessed NOT to have knowledge or experience in ILP, and selects a fund that is higher than his or her risk profile.**

- My advisor has confirmed and informed me of the following:
  - I am aware that it is my responsibility to ensure the suitability of the ILP fund(s) chosen.
  - I understand that Income may be contacting me to confirm this transaction.
  - I understand that this application is subject to approval by Income.

Name of policyholder or assignee<sup>3</sup> \_\_\_\_\_ NRIC number or FIN \_\_\_\_\_

Signature \_\_\_\_\_  Date \_\_\_\_\_ (dd/mm/yyyy)

<sup>3</sup> 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 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: \_\_\_\_\_ (dd/mm/yyyy)      Phone number used for the call back: \_\_\_\_\_

Time of call: \_\_\_\_\_ (am/pm)      Policyholder's or assignee's phone number: \_\_\_\_\_

Comments on the sales process and quality of advice provided by the representative after the call back:  
\_\_\_\_\_  
\_\_\_\_\_

**To be completed for ILP transaction(s)**

Please complete client's investment profile:

Fulfills customer knowledge assessment criteria:  Yes       No  
Client's final risk profile:  Conservative       Moderately conservative       Moderately aggressive       Aggressive

Note: If there is a deviation, a lower of the two risk profiles will be selected for the purpose of recommendation.

Risk of the sub-fund(s) selected is higher than client's risk profile:  Yes       No

Senior management's confirmation ('SMC') is required when client is assessed NOT to have relevant knowledge and/or experience in ILP and/or wishes to purchase an ILP against recommendation or when the risk of the sub-fund(s) selected is higher than client's risk profile.

I have reviewed the ILP application and noted that:

SMC is not required.       SMC is required. (Please submit SMC Form together with the application.)

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

I agree with the recommendation made by my advisor.       I disagree with the recommendations made by my advisor.

Comments:  
\_\_\_\_\_  
\_\_\_\_\_

I had accompanied the representative for the sales advisory session.

Yes       No

Name of supervisor \_\_\_\_\_ Supervisor's code \_\_\_\_\_

Signature \_\_\_\_\_  Date \_\_\_\_\_ (dd/mm/yyyy)

## Alteration form for investment-linked 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:**

For Singaporeans/PRs, submit a Clear copy of your NRIC/Passport/Long-Term Pass

For foreigners, submit a CLEAR copy of an identification (front & back) (e.g. employment pass, passport) and a CLEAR copy of documentary proof of the address, such as copies of utility bills, bank statements or letters issued by statutory or government bodies (dated within past 6 months) with letterhead, name, address and date clearly shown.

Electronic Documents: All application and policy correspondence will be sent to you electronically, unless any of these are not available electronically, in which case you will receive the hardcopy by mail.

### For official use

**For official use only – Scan to archive**

1 Please update ICM under "ILP Processing Request (Form)" and attach a copy of the form.

Full name of Advisor (as in NRIC)	Advisor's code
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Please complete one form per policy and ensure that all fields are completed.

### Details of policyholder or assignee

Full name (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN/Unique Entity Number (UEN)	Policy number
Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR (nationality) _____ <input type="checkbox"/> Others (please give details) _____	Country of residence	City of residence
Name of organisation	Place of incorporation	Business activity/Sector
Occupation	Nature of work	Annual income (S\$)

### Details of insured (if different from policyholder or assignee)

Full name (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN	
Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR (nationality) _____ <input type="checkbox"/> Others (please give details) _____	Country of Residence	City of residence

### Changes to coverage/premium/riders

Request	Details	Notes						
<input type="checkbox"/> Fund allocation	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Name of fund</td> <td style="width: 50%; text-align: center;">Allocation (%) (no decimal)</td> </tr> <tr> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"></td> <td style="border-top: 1px solid black; border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center;">Total</td> <td style="text-align: center;">100%</td> </tr> </table>	Name of fund	Allocation (%) (no decimal)			Total	100%	Please refer to Terms point 29. This form is to be submitted together with "Abridged Fact Find" form.
Name of fund	Allocation (%) (no decimal)							
Total	100%							
<input type="checkbox"/> Add riders	Please indicate rider name, sum assured and cover term.	Please refer to Terms points 14. To 27. This form is to be submitted together with "Abridged Fact Find", "Illustration", "Product Summary" and "Declaration of Continued Insurability" forms (where applicable).						
<input type="checkbox"/> Increase regular premium	From _____ to _____	VA1 only: For Life event, please refer to Terms point 22.						
<input type="checkbox"/> Increase sum assured (for IP1/IP2/VA1/VA2 policies only)	From _____ to _____	Please refer to Terms points 14. To 27. To submit this form only.						
<input type="checkbox"/> Decrease regular premium	From _____ to _____	This will be processed upon next anniversary date						
<input type="checkbox"/> Decrease sum assured (for IP1/IP2/VA1/VA2 policies only)	From _____ to _____	VA1 and VA2 only: This form is to be submitted together with "Illustration" and "Product Summary" forms.						
<input type="checkbox"/> Remove riders (Please indicate the rider name to remove)	Type of Riders _____	Please refer to Terms point 28. To submit this form only.						
<input type="checkbox"/> Riders - Decrease Sum Assured	From _____ to _____							
<input type="checkbox"/> Cessation of Recurring Single Premium request	N.A.							



### Change distribution payout option

Fund Types	Reinvestment	Encashment - Direct Credit	
<input type="checkbox"/> Asian Income Fund			Please refer to Terms points 30. To 32. To submit this form only. Please select and tick only one distribution option for each fund.  Your submission must reach us at least 30 days before the next declaration date and the new option will be effective from the next payout.  If you have selected "Encashment - Direct Credit", please submit a copy of your Singapore bank book/statement for verification (Note: you can only have one direct credit account per policy).
<input type="checkbox"/> Global Income Fund			
<input type="checkbox"/> Asia Dynamic Return Fund			

### Premium holiday

<input type="checkbox"/> Premium holiday up to now	<input type="checkbox"/> I wish to pay for my premiums using a new GIRO account, I need to submit a new interbank GIRO form and you will extend my premium holidays by 2 months.	To submit this form only. To submit a new interbank GIRO form (if applicable). If the premiums for your policy were outstanding, and you wish to resume premium payment starting from now.
<input type="checkbox"/> Premium holiday from now, for (maximum of six months)	<input type="checkbox"/> One month <input type="checkbox"/> Two months <input type="checkbox"/> Three months <input type="checkbox"/> Four months <input type="checkbox"/> Five months <input type="checkbox"/> Six months <input type="checkbox"/> Twelve months (if you are paying your premiums yearly)	To submit this form only. Your premium holiday will start from the next premium due date.
<input type="checkbox"/> Cessation of premium holiday	<input type="checkbox"/> I wish to pay for my premiums using a new GIRO account, I need to submit a new interbank GIRO form and you will extend my premium holidays by 2 months.	To submit this form only. To submit a new interbank GIRO form (if applicable). This will be effective from the next premium due date.

### Terms for premium holiday

**For all regular premium plans except VivaLink (VA1) and AstraLink (VA2)**

- 1 All regular premiums due for the first twelve (12) months and any subsequent increase of premium must be fully paid before any request for premium holiday is allowed.
- 2 For policies that are on GIRO, the process of deduction takes place between 21st of the month to 8th of the next month. During this period, no changes to your premium can be made. If the form is received during this period, your request will be handled after the GIRO deduction process is completed
- 3 For policies that are on GIRO, deduction will automatically resume once the premium holiday period ends, unless you apply for another premium holiday before the period ends.
- 4 We will only consider your application for premium holiday if the value of the fund(s) in your policy is positive.
- 5 All policy charges will continue to be chargeable (e.g. policy fee, mortality charges, advisory fee and rider charges) during the premium holiday period

**For VivaLink (VA1) plan**

- 6 If premium holiday is applied within the first ten (10) years from the policy entry date, the 'No lapse guarantee (NLG)' benefit will end and we will not reinstate it.
- 7 If there is 'Premium paying rider (PPR)' attached, we will terminate the riders and apply premium holiday. Once premium holiday is applied, term 6 will apply.
- 8 All regular premiums due for the first twelve (12) months and any subsequent increase of premium must be fully paid before any request for premium holiday is allowed. Once premium holiday is applied, term 6 will apply. In addition, you cannot make any One-time and Recurring single premium top-ups when your policy is on premium holiday.
- 9 For policies that are on GIRO, the process of deduction takes place between 21st of the month to 8th of the next month. During this period, no changes to your premium can be made. If the form is received during this period, your request will be handled after the GIRO deduction process is completed.
- 10 For policies that are on GIRO, deduction will automatically resume once the premium holiday period ends, unless you apply for another premium holiday before the period ends.
- 11 All policy charges will continue to be chargeable (e.g. policy fee, mortality charges, advisory fee and rider charges) during the premium holiday period.

**For AstraLink (VA2) plan**

12. The premium holiday charge applies if you did not pay any premiums from the 2nd anniversary to the end of the minimum investment period.  
 Charges will continue to apply during premium holiday. No top-ups and recurring single premium top-ups can be made during premium holiday. Premium holiday ceases once the regular premium payment resumes.  
 If there is non-payment of regular premium (during the first 2 policy years), the policy will end with no cash-in value.
13. Increase or decrease in regular premium can be made after second policy anniversary, provided the policy remains in force and is not on premium holiday.

## Terms for all other alterations

### For all regular premium plans except VivaLink (VA1) and AstraLink (VA2)

- 14 For VivoLink (VL1) policies, the minimum regular premium is \$150/monthly. For decrease/increase of regular premium, it will be subjected to the respective allocation rates as set out in the policy contract. The new premium after any increase is capped at \$500/monthly per life.
- 15 For Ideal (ID2) policies, the minimum regular premium is \$50/monthly. For increase of regular premium, a 45% advisory fee will be deducted upfront for the annualised portion that is in excess of the highest regular premium paid before the increase.
- 16 For Ideal (ID5/ID6/ID7) policies, the minimum regular premium is \$100/monthly.  
For Ideal (ID6) policies, any increase of regular premium, you must bear a monthly advisory fee equivalent to 25% of the increased portion for a period of twelve (12) months, in addition to any prevailing advisory fee being paid by you.  
For Ideal (ID7) policies, any increase of regular premium that is sold through an Insurance Advisor under your policy, you must bear a monthly advisory fee equivalent to 15% of the increased portion for a period of twelve (12) months, in addition to any prevailing advisory fee being paid by you.

### For VivaLink (VA1) and AstraLink (VA2) plans

- 17 Please submit a revised Illustration for each request. All requests submitted are subject to review and our acceptance.
- 18 For increase/decrease regular premium, it may increase/decrease the sum assured for the plan and the rider(s) of the life assured. The 'Insurance Cover Charge' for the plan and the rider(s) will be deducted accordingly. For premium paying riders, we might request for pro-rate premium before the request is approved.
- 19 For increase/decrease in sum assured, it may increase/decrease the premium for the plan and the rider(s) of the life assured. The 'Insurance Cover Charge' for the plan and the rider(s) will be deducted accordingly. For premium paying riders, we might request for pro-rate premium before the request is approved.
- 20 The new sum assured will take effect from the next monthiversary date regardless of the policy payment frequency.
- 21 If your policy is on premium holiday, we may not accept your request submitted.
- 22 \* If there is an occurrence of a life event as defined under your policy (VA1) and you intend to increase your sum assured or regular premium, you will need to indicate the name of the life event and to provide the supporting documents.  
\* Life event is not applicable to AstraLink (VA2)

### Applies to all regular and/or single premium plans

- 23 The increase/decrease in regular premium if accepted by us is usually effected from the next premium due date unless we notify you otherwise.
- 24 All regular premiums due for the first twelve (12) months and any subsequent increase of premium must be fully paid before any decrease in premium amount is allowed.
- 25 After the premium change has been approved and completed, kindly pay the new premium in full. Partial payments are not allowed.
- 26 For cash payment, the offer price will be based on the date that Income receives the new premium by **3:00pm**. Any submission after **3:00pm** will be considered as the next business day's pricing.
- 27 For policies that are on GIRO, the process of deduction takes place between 21st of the month to 8th of the next month. During this period, no changes to your premium can be made. If the form is received during this period, your request will be handled after the GIRO deduction process is completed.
- 28 For policies with GIRO payments, the cessation of recurring single premium request will take effect from the next deduction date.
- 29 Please be informed that you are allowed to invest up to two (2) funds per policy except GrowthLink (GL1), WealthLink (GL2), VivaLink (VA1), AstraLink(VA2) and VivoLink (VL1) policies.
- 30 The new distribution option selected will supersede your previous option (if any).
- 31 Any distributions below \$50 (or such other sums as may be determined by Income) will be reinvested and encashment is not allowed.
- 32 For CPF/SRS policies (if applicable), the distribution option shall be reinvestment only.

## 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 Owner arrangement, please

- i Submit a copy of the Beneficial Owner's 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](http://www.income.com.sg/Policy-downloads-and-forms); and
- ii Please provide details of the Beneficial Owner(s):

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

## Mandatory declarations (continued)

### 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 organization.

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<sup>a</sup> to a PEP, you must disclose this information.

<sup>a</sup> 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

### 3 Source of funds and wealth (To complete for add riders, increase of regular premium and/or sum assured)

#### i Source of funds

##### a Who is funding the insurance premium for this application?

- Policyholder
  Assignee
  Others, please provide details below:

Full name of payor (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN/Unique Entity Number (UEN)
Relationship to policyholder or assignee	Occupation and organisation

##### b What is the source of funds used to pay the premiums?

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

Details

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#### ii Source of wealth

##### a How did you accumulate your wealth (i.e. your total assets)? You may choose more than one option.

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

Details

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#### Important Notes:

*We may request for additional information and/or supporting documents, if necessary.*

*For allowance from family member(s), please provide details on the family member(s).*

*Example – Name of family member(s), occupation of the family member(s) and relationship(s)*

## Residential address verification

For Singapore Citizen/Permanent Resident – If the residential address stated in this form is different from the address in your identity document, please provide billing proof.

For non-Singapore Citizen – Please provide a valid identity document or passport with your residential address indicated, or billing proof.

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

## Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited (“Income”), its representatives, agents, relevant third parties (referred to in Income’s Privacy Policy at <https://www.income.com.sg/privacy-policy>), Income’s appointed insurance intermediaries and their respective third party service providers and representatives (collectively “Income 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 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, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income, its affiliates, business partners and/or NTUC Enterprise group of social enterprises (“NE Group”) where required for Income, its affiliates, business partners and/or NE Group, to develop, improve and/or customise their products/services and/or to provide you with their respective products/services, and in the manner and for other purposes described in Income’s Privacy Policy.

Where the personal data of another person(s) (for example, personal data of the insured person, my family, employee, payee/payer or beneficiary) is provided by me/us (whether in this or subsequent submissions) or from other sources to Income 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.

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

## Declaration and authorisation

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

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 the insured 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 for this application.

I declare that 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. If it is discovered later that I or the insured suffer from a medical condition that is not disclosed in this form, I will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with you. 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 further understand that you may impose special terms according to the information given in respect of this application.

I understand that I may receive correspondences for this application and my policy documents electronically (collectively “policy e-document”). I agree that Income can notify me by email or SMS to retrieve and read my policy e-documents via secure online access.

I agree that Income will not be responsible to me (or any other person) if I fail to:

- a provide Income my correct email address or mobile number;
- b inform Income of any update or change to my email address or mobile number; or
- c keep the password to access the policy e-documents confidential.

I understand that the policy e-documents are considered delivered and received, upon my receipt of your SMS or email notification on the availability of the policy e-documents via secure online access.

I 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 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.

For the purpose of processing and/or administrating this application and any claim in connection with my/our policy(ies) with Income, I/we authorise, consent to, and agree to any medical source, insurance office, reinsurance, or organisation to release to you and you to release to any medical source, insurance office, reinsurance, or organisation any relevant information to do with me or the insured whether you accept my application or not.

I understand and agree that the changes:

- a are subjected to your underwriting and acceptance;
- b if accepted, may be subjected 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 have read and understand the corresponding Product Highlight Sheet(s), Fund Report(s) or Monthly Fund Fact Sheet(s) available from [www.income.com.sg](http://www.income.com.sg) with respect to the relevant investment fund(s) before deciding whether to invest or transact in such fund(s). Where appropriate, I understand that I can cease to proceed with this application at any time before the submission of this form and seek financial advice from a qualified Income advisor, or seek independent legal, tax and/or other professional advice.

Applicable to policyholder or assignee who performs a transaction without advice from Income:

As the policyholder or assignee who does not wish to seek advice from Income or refuses to follow advice sought from Income, for any of my proposed transactions under this application form, I understand and agree that:

- 1 This application is based solely on my own judgement and decision. I may be subjected to greater investment risks and that the value of the fund(s) may be volatile and fluctuate from time to time;
- 2 All investment decisions are made independently by me, as the policyholder or assignee, after duly considering and understanding the investment fund(s), benefits and risks.
- 3 The information contained in this application is not intended as financial advice and shall not be relied on as such by me. I am responsible to ensure the suitability of the fund(s) selected.

## Declaration and authorisation (continued)

I agree that if I 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 will inform Income immediately if there is any change in my 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.

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

### Applicable to Takaful Fund Only:

I further understand and agree that no part of my premium contribution shall be used for the establishment of Tabaruu or risk fund for the purpose of paying the difference between the minimum sum assured and the cash surrender value of the policy which I intend to subscribe. Such fund is being financed solely by the insurer's resources and if a payment is made under such circumstances, I shall regard this as donation from the insurer.

**I agree that if I do not reveal any significant fact (which would have affected Income's 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 advisor but was not included in this application.**


Signature of policyholder or assignee <sup>^</sup>	Signature of insured (For age 16 and above)
	
Signed in Singapore on (dd/mm/yyyy):	Signed in Singapore on (dd/mm/yyyy):

<sup>^</sup> Please delete where appropriate. For policies with assignee, the assignee needs to complete and sign the form.

## Parental consent

The parent or legal guardian must fill in this section if the child or ward is the policyholder, and below the age of 21 years.

- 1 I give my permission for my child or ward for the above transaction(s) under this policy.
- 2 I confirm and agree to the consent given by my child/ward on the collection, use and disclosure of his/her personal data under this form.
- 3 I consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties (referred to in Income's Privacy Policy at <https://www.income.com.sg/privacy-policy>), Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") to collect, use, and disclose my personal data in this form for the purposes of administering the application or transaction in this form. I understand that I may refer to Income's Privacy Policy (<https://www.income.com.sg/privacy-policy>) for more information, including access and correction to personal data and consent withdrawal.

Full name of parent or legal guardian (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN
Relationship to policyholder <input type="checkbox"/> Parent (Please submit a copy of NRIC/Passport) <input type="checkbox"/> Legal guardian (Please submit a copy of NRIC/Passport and proof of legal guardianship)	Signature of parent or legal guardian   Signed in Singapore on (dd/mm/yyyy):
	

## 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)		NRIC/Passport number/FIN	
Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR (nationality) _____ <input type="checkbox"/> 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 <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR (nationality) _____ <input type="checkbox"/> Others (please give details) _____		Country of residence	City of residence
Date of birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> 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:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policy/Proposal <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Policy/Proposal <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Policy/Proposal <input type="checkbox"/> Policyholder <input type="checkbox"/> 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

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:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policy <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Policy <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured		
Insurance company				
Type of policy				
Reasons				
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:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policy <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Policy <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured		
Insurance company				
Nature of claim				
Year of claim				
Reasons				

### Section 5: Family history

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:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Family member 1 <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Family member 2 <input type="checkbox"/> Policyholder <input type="checkbox"/> 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

Section 6: Lifestyle information			Policyholder	Insured
1 Have you smoked cigarettes or cigars in the past 12 months? If yes, please provide details below:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (quantity per week)? If yes, please state the quantity of alcohol you drink per year.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policyholder	Insured		
Date of last follow-up				
4a Are you taking or have taken addictive drugs or substances (for example: narcotics or glue sniffing)? If yes, please provide details below and answer Question 4b.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policyholder	Insured		
Name of doctor/support group				
Address of doctor/support group				
4c Have you completed treatment or counselling for addictive drugs or substances? If yes, please provide details below:			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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).			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
<p>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:</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policyholder	Insured		
Date of last consultation (dd/mm/yyyy)				
Reason for last consultation				
Name of doctor				
Name and address of clinic				
<p>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:</p> <ul style="list-style-type: none"> <li>Abnormal results or findings</li> <li>Inconclusive results</li> <li>Additional or repeat test</li> <li>Doctor referral</li> <li>Close monitoring or short interval follow up</li> <li>Regular surveillance test</li> </ul> <p>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.</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Test/Investigation 1 <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured	Test/Investigation 2 <input type="checkbox"/> Policyholder <input type="checkbox"/> Insured		
Type of test/investigation				
Date of test/investigation				
Reasons for test/investigation				
Test/investigation result				
Name and address of clinic				
<p>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.</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Policyholder	Insured		
Party involved	<input type="checkbox"/> Self <input type="checkbox"/> Spouse	<input type="checkbox"/> Self <input type="checkbox"/> Spouse		
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<sup>1</sup>/Pass Permit<sup>2</sup>:

- 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).
- If a genetic test result is negative, we may take it into account to consider better underwriting terms.

<sup>1</sup> It should not be less than a total of 183 days in the 12 months before the insurance application date.

<sup>2</sup> It should not be less than a total of 90 days in the 12 months before the insurance 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
4b Have you undergone a genetic test for Huntington’s disease? If yes, please provide details below:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 50%;">Policyholder</th> <th style="width: 25%;">Insured</th> </tr> </thead> <tbody> <tr> <td>Reasons for test</td> <td></td> <td></td> </tr> <tr> <td>Date of test</td> <td></td> <td></td> </tr> <tr> <td>Test results</td> <td></td> <td></td> </tr> </tbody> </table>		Policyholder	Insured	Reasons for test			Date of test			Test results				
	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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 50%;">Policyholder</th> <th style="width: 25%;">Insured</th> </tr> </thead> <tbody> <tr> <td>Reasons for test</td> <td></td> <td></td> </tr> <tr> <td>Date of test</td> <td></td> <td></td> </tr> <tr> <td>Test results</td> <td></td> <td></td> </tr> </tbody> </table>		Policyholder	Insured	Reasons for test			Date of test			Test results				
	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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 50%;">Policyholder</th> <th style="width: 25%;">Insured</th> </tr> </thead> <tbody> <tr> <td>Reasons for test</td> <td></td> <td></td> </tr> <tr> <td>Date of test</td> <td></td> <td></td> </tr> <tr> <td>Test results</td> <td></td> <td></td> </tr> </tbody> </table>		Policyholder	Insured	Reasons for test			Date of test			Test results				
	Policyholder	Insured												
Reasons for test														
Date of test														
Test results														

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

	Policyholder	Insured
<b>Important Notes:</b> If you answered “Yes” to any of the questions in Section 7.2 to Section 7.6, please provide details on page 14.		
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:			
<ul style="list-style-type: none"> <li>• Medical leave for 2 consecutive weeks and beyond;</li> <li>• Medication for 2 consecutive weeks and beyond;</li> <li>• Hospitalisation;</li> <li>• Regular follow up with a medical practitioner;</li> <li>• On regular medications;</li> <li>• Use of assisting device or help from another person to carry out your daily activities</li> </ul>			
		Policyholder	Insured
a	Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	Heart murmur, chest pain, fast or irregular heart rate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d	Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e	Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f	Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g	Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h	Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i	Sexually transmitted diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j	Overactive or underactive thyroid hormone secretion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"></td> <td align="center">Policyholder</td> <td align="center">Insured</td> </tr> <tr> <td>No. of weeks pregnant</td> <td></td> <td></td> </tr> </table>		Policyholder	Insured	No. of weeks pregnant										
	Policyholder	Insured													
No. of weeks pregnant															
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:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No												
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td align="center">Policyholder</td> <td align="center">Insured</td> </tr> <tr> <td>Pregnancy</td> <td><input type="checkbox"/> Past pregnancy <input type="checkbox"/> Current pregnancy</td> <td><input type="checkbox"/> Past pregnancy <input type="checkbox"/> Current pregnancy</td> </tr> <tr> <td>Date of diagnosis</td> <td></td> <td></td> </tr> <tr> <td>Details of complications</td> <td></td> <td></td> </tr> </table>		Policyholder	Insured	Pregnancy	<input type="checkbox"/> Past pregnancy <input type="checkbox"/> Current pregnancy	<input type="checkbox"/> Past pregnancy <input type="checkbox"/> Current pregnancy	Date of diagnosis			Details of complications				
	Policyholder	Insured													
Pregnancy	<input type="checkbox"/> Past pregnancy <input type="checkbox"/> Current pregnancy	<input type="checkbox"/> Past pregnancy <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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:		
<ul style="list-style-type: none"> <li>• Medical leave for 2 consecutive weeks and beyond;</li> <li>• Medication for 2 consecutive weeks and beyond;</li> <li>• Hospitalisation;</li> <li>• Regular follow up with a medical practitioner;</li> <li>• On regular medications;</li> <li>• Use of assisting device or help from another person to carry out your daily activities</li> </ul>			
a	Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b	High blood pressure, high cholesterol, heart murmur, chest pain, fast or irregular heart rate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i Overactive or underactive thyroid hormone secretion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
13 Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

	Insured
14 Please provide details below for Juvenile Applicants:	<input type="checkbox"/> Yes <input type="checkbox"/> No
a Does either of the child's parents have equivalent cover as proposed in this application? If no, please select the reason: <input type="checkbox"/> Ineligible due to medical reasons <input type="checkbox"/> Pending application with other insurers <input type="checkbox"/> Others, please provide reason and details _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Ineligible due to medical reasons <input type="checkbox"/> Others, please provide reason and details _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i Diabetes, thyroid disorders or any other endocrine disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii Asthma, bronchitis, pneumonia, persistent cough (longer than 4 weeks) or any other lung disease or disorder	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
v Jaundice, hepatitis, or any other disorder of the digestive system including oesophagus, stomach, intestines, colon, rectum, anus, liver, gallbladder, pancreas	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
viii Anaemia, thalassemia, HIV infection (AIDs or any other disorders of the blood or autoimmune disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ix Cancer, enlarged lymph nodes, unusual skin lesions, tumours, or other growths of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17 Any special care needed after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19 Has the child had any physical, congenital or developmental defects, or shown any sign of slow physical or mental development?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

### Section 8: Personal data use statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties (referred to in Income's Privacy Policy at <https://www.income.com.sg/privacy-policy>), Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income 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 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, conducting consumer profiling/data analytic/research, which includes data matching based on personal data collected by Income, its affiliates, business partners and/or NTUC Enterprise group of social enterprises ("NE Group") where required for Income, its affiliates, business partners and/or NE Group, to develop, improve and/or customise their products/services and/or to provide you with their respective products/services, and in the manner and for other purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of the insured person, my family, employee, payee/payer or beneficiary) is provided by me/us (whether in this or subsequent submissions) or from other sources to Income 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.

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

## Section 9: Declarations and authorisations

- 1 I cannot alter any of the wordings in this application form. Any attempt to do so will have no effect.
- 2 I understand that I may receive correspondences for this application and my policy documents electronically (collectively “policy e-document”). I agree that Income can notify me by email or SMS to retrieve and read my policy e-documents via secure online access.
- 3 I agree that Income will not be responsible to me (or any other person) if I fail to:
  - a provide Income my correct email address or mobile number;
  - b inform Income of any update or change to my email address or mobile number; or
  - c keep the password to access the policy e-documents confidential.
- 4 I understand that the policy e-documents are considered delivered and received, upon my receipt of Income’s SMS or email notification on the availability of the policy e-documents via secure online access.
- 5 I understand and agree that the changes requested in this application:
  - a are subject to Income’s underwriting and acceptance;
  - b if accepted, may be subject to terms, conditions and exclusions imposed by Income; and
  - c will take effect only when Income accept and approves my application and notifies me in writing of the cover start date and provided that I have paid the required premiums (and interest, if applicable) in full.
- 6 I declare that the answers given 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. If it is discovered later that I or the Insured suffer from a medical condition that is not disclosed in this form, I 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 agree that this application and other written answers, statements, information or declarations I have made or which have been made on my 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 confirm that there has been no change in my health or the Insured’s health since the completion of the application and all additional declarations made in connection with the application. I will notify Income immediately if there is any change in the state of my health or the Insured’s health, or if I or the Insured plan to seek medical consultation, investigation, or treatment between the date of this application and before the cover start date. I am aware that Income may add special terms to the policy or declare the policy as void according to the information provided or if I fail to notify Income of any change in the state of my health or the Insured’s health. This applies if I am applying for a non-guaranteed issue basic plan or for any non-guaranteed issue riders.
- 8 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.
- 9 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.
- 10 For the purpose of this application, I 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 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 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 or the Insured’s health status or condition in relation to this application.
- 11 I agree that a copy of the authorisation in this form is valid and binding as an original copy.
- 12 Where applicable, I further authorise, consent and agree to Income disclosing my personal data to the Government of Singapore and statutory boards and organizations approved by the Government of Singapore, for the purpose of determining my 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 confirm that I am authorised to disclose information (including personal health information) about the Insured to Income.
- 14 I agree that if I or any \*Relevant Person is found to be a \*Prohibited Person, Income is entitled not to accept this application. If any policy is issued, Income can terminate or void the policy, or not make any transaction under the policy such as not pay any benefit. Income’s decision will be final. I will inform Income immediately if there is any change in my or any Relevant Person’s identity, status or identification documents.
 

# *Relevant Person* includes insured, trustee, assignee, beneficiary, beneficial owner or nominee and mortgagee or financier.

\* *Prohibited Person* means a person or entity who is subject to laws, regulations or sanctions administered by any governmental or regulatory authorities or law enforcement in any country, which will prohibit Income from providing insurance cover or paying any benefit.
- 15 This application is governed by and interpreted according to the laws of the Republic of Singapore.
- 16 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 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 for this review may not be valid. This includes any fact I may not be sure is significant, and also any information I have given to the advisor but was not included in this application.**

Signature of policyholder or assignee <sup>1</sup>  <div style="text-align: right; margin-right: 20px;"></div>	Signature of insured (for age 16 and above)  <div style="text-align: right; margin-right: 20px;"></div>
Signed in Singapore on (dd/mm/yyyy):	Signed in Singapore on (dd/mm/yyyy):

<sup>1</sup> For policies that are assigned, the assignee needs to sign this form.

## Additional Medical Questionnaire

**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.

### Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal/Policy number(s)
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### Questions for insured

1. Have you ever been tested positive or hospitalised for COVID-19?
- No
- Yes, tested positive for COVID-19 more than 1 month ago and not hospitalised (please proceed to Question 2 & 3)
- Yes, tested positive for COVID-19 less than 1 month ago and not hospitalised
- Please state the date you tested positive \_\_\_\_\_ (dd/mm/yyyy) (please proceed to Question 2 & 3)
- Yes, tested positive for COVID-19 and hospitalised (please proceed to Question 2, 3 & 4)

**For applicants with history of COVID-19 infection ONLY**

2. a. Do you have any of the following symptoms during or after the infection, other than fever, cough, sore throat, running nose, or loss of taste/smell?

Please select all that apply.

- Chest pain or tightness
- Shortness of breath
- Dizziness
- Heart palpitations
- Chronic fatigue
- Others, please specify the symptoms: \_\_\_\_\_

- None of the above (please proceed to Question 3)

Please state the date of last symptoms (if applicable) \_\_\_\_\_ (dd/mm/yyyy)

- b. Have you had or are you undergoing or awaiting referral, investigation for above condition(s)?

- Investigation done
- Awaiting referral or investigation
- Advised for investigation but do not plan to do so
- I have not been advised for further investigation

Please provide details below.

Date of tests	Type of tests	Results	Name of doctor	Name of hospital

3. Have you fully recovered, discharged from follow up and/or returned to normal physical function and activities?

- Yes
- No. Please provide details: \_\_\_\_\_

4. Hospitalisation information

Please select the applicable option:

\***HDU:** High-dependency unit, **ICU:** Intensive care unit

- Admitted to General ward only without any need of mechanical ventilation
- Admitted to HDU, ICU, or equivalent ward without any need of mechanical ventilation
- Admitted to HDU, ICU, or equivalent ward with need of mechanical ventilation

Date of admission	Duration of stay	Name of hospital

### Details of insured

Full name (as in NRIC/BC/Passport/Long-Term Pass)	NRIC/BC/Passport number/FIN	Proposal/Policy number(s)
---	-----------------------------	---------------------------

### Declaration by the proposer and insured

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



I declare that the answers given in this form 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. If it is discovered later that I or the Insured suffer from a medical condition that is not disclosed in this form, I 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 agree that this form and other written answers, statements, information or declarations I have made or which have been made on my 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.

I confirm that there has been no change in my health or the Insured's health since the completion of the application and all additional declarations made in connection with the application. I will notify Income immediately if there is any change in the state of my health or the Insured's health, or if I or the Insured plan to seek medical consultation, investigation, or treatment between the date of this application and the date this policy is in force. I am aware that Income may add special terms to the policy or declare the policy as void according to the information provided or if I fail to notify Income of any change in the state of my health or the Insured's health.

I acknowledge and agree that this form will constitute part of my application for life or health insurance, and will form the basis of the contract of insurance.

I confirm that I understand and agree to the 'Personal Data Use Statement' and declaration set out in my policy application form which I have submitted to Income. I understand that I can refer to Income's [Privacy Policy](#) for more information, including access and correction of my personal data and consent withdrawal.

I agree that if I do not reveal any significant fact (which would have affected Income's decision to accept my application on standard terms), any policy issued may be invalid. This includes any facts I may not be sure is significant, and any information I have given to my advisor but was not included in this form.

Signature of proposer  	Signature of insured (for age 16 and above)  
Date (dd/mm/yyyy):	Date (dd/mm/yyyy):