Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6332 1133 · Fax: 6338 1500
Email: healthcare@income.com.sg · Website: www.income.com.sg

Managed Healthcare System (MHS) Health Declaration Form

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 A: Policyholder's details (You must fill this in.)

Full name (as in NRIC/Passport/Long-Term Pass)	NRIC/Passport number/FIN

Section B: Insured's details (You must fill this in.)

Full name (as in NRIC/Passport/Long-Term Pass)		NRIC/Passport number/FIN
Height (metres)	Weight (kilograms)	Policy number

Section C: Health details of 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?

   ☐ No
   ☐ Yes (Please give the reason and medical conditions below.)

2. Have you ever been diagnosed, experienced symptoms, received medical advice or referral or had treatment for any illnesses, disorders, injuries, medical conditions (for example, high cholesterol, arthritis, thalassaemia, hepatitis B carrier or fatty liver), physical impairments or problems or congenital or hereditary disorders (for example, familial adenomatous polyposis)?

   ☐ No
   ☐ Yes (Please give the name of the conditions, diagnosis and symptoms below.)

3. Have you had or do you intend to or been advised to:

   a) consult a doctor/medical specialist for any condition or medical reasons other than minor illness such as common cold or flu;

   b) admit to a hospital or medical facility (including for day surgery);

   c) undergo any medical tests or investigations with the following outcome:

      - abnormal results or findings
      - inconclusive results
      - additional or repeat test
      - doctor referral
      - close monitoring or short interval follow up
      - regular surveillance test

   ☐ No
   ☐ Yes (Please give details below. For example, dates, type of the tests done, results, reasons for the tests, diagnosis, current health status. Please submit a copy of medical report(s), if applicable.)

Section D: 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.

Section E: Declaration

1. I cannot alter any of the wordings in this form. Any attempt to do so will have no effect.
2. 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.
3. I confirm that there has been no change in my heath 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.
4. 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.
5. I confirm:
   a. that I understand and agree to the collection, use and disclosure of my personal data as stated in the "Personal Data Use Statement" (PDUS);
   b. on the representation and warranty made in the PDUS.
6. 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.
7. If I am reinstating my policy, I agree that notwithstanding the terms and conditions under the policy;
   i. I must give Income all material information about the Insured from the expiry date of my policy, up till the reinstatement date that may influence your decision whether to reinstate or to impose any further terms under the policy;
   ii. If I fail to give Income this material information or misrepresent any such information, Income may:
      a. declare the policy as void from the start date of the reinstated policy;
      b. end the cover for the Insured and not pay any benefits; or
      c. add extra terms and conditions to the policy;
   iii. the terms and conditions of my reinstated policy may be different from the terms and conditions of my policy prior to the reinstatement.
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. This application is governed by and interpreted according to the laws of the Republic of Singapore.
10. 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.

Warning:
You must give all the facts truthfully when you make this application. You must also tell us immediately if there is any change in the state of health of the Insured or if the Insured is planning to arrange for any medical consultation, investigation or treatment before the start date of your policy or, if you are reinstating your policy, before the reinstatement date of your policy. If you fail to reveal any material information in this application, you may not receive any benefits under your policy or we may declare your policy as void or add extra terms on your policy. If you are in doubt as to whether a fact is material, you should reveal it anyway. This includes any fact which you may have given to the advisor but is not written in this application. Please check to make sure you are fully satisfied with the information in this application. You may not alter any of the wording in this proposal form. Any attempt to do so will be of no effect.

Signed in Singapore on (dd/mm/yyyy): _____

Signature of policyholder	Signature of Insured (16 years old and above must sign)

Income Insurance Limited | UEN: 202135698W
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg

Product Type
☐ Affinity ☐ IncomeShield
☐ Employee Benefit ☐ Life Insurance
☐ LTC

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 number(s)

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 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):