income
made different

# Life Insurance Application
## with Medical Underwriting

## The Application Form Process

### Personal Information

Details about the Proposer (policyholder) and the Insured (the person being covered).

### Plan Information

Details about the selected policy and its riders.

### Underwriting

Other critical information needed to process your application.

### Declarations

Everything to take note of before you sign.

## Submission Checklist

Please check that you have included all the necessary documents.
Any omissions may result in a delay of the processing of your application.

- Photocopy of NRIC or FIN or other relevant identity documents, if applicable
- Proof of address documentation, if applicable
- Tax residency certification for FATCA and/or CRS, if applicable
- All relevant underwriting forms
- Copy of medical reports or test results, if applicable

**For official use only**

Receipt number

Payment received date (dd/mm/yyyy)

/ /

Source code

**For adviser use only**

Adviser code

Adviser name

Remarks

- ☐ Tick (✓) if ILP application
- ☐ Tick (✓) if to be delivered by adviser
- ☐ Tick (✓) if premium funding is required and indicate the policy number of the specified application.

**NTUC Income Insurance Co-operative Limited**
Income Centre 75 Bras Basah Road Singapore 189557 · Tel: 6788 1777 · Fax: 6338 1500 · Email: csquery@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

**PLEASE USE BLOCK LETTERS TO COMPLETE THIS FORM.**
If you require additional space for your answer, please state the question number and answer clearly on page 19.

**WARNING:** STATEMENT UNDER SECTION 25(5) OF THE INSURANCE ACT, CAP. 142 (OR ANY FUTURE AMENDMENTS TO IT) YOU MUST REVEAL ALL FACTS YOU KNOW, OR OUGHT TO KNOW, WHICH MAY AFFECT THE INSURANCE COVER YOU ARE APPLYING FOR. OTHERWISE, THE INSURANCE POLICY MAY NOT BE VALID.

## 1 Proposer Details (Policyholder)

### 1.1 Personal Particulars

Full name
(as in NRIC or FIN)

NRIC/Passport number/FIN

Date of birth
(dd/mm/yyyy) / /

Gender ○ Male ○ Female

Nationality ○ Singaporean ○ Singapore PR (Nationality) ○ Others

Country of birth

Marital status ○ Single ○ Married ○ Widowed ○ Divorced

### 1.2 Work Details

Occupation Nature of work

Name of organisation Annual income (S$)

### 1.3 Contact Information

Contact number
*Please provide at least one number*
Mobile Home Work

**Important Notes:** It is important to state your personal email address as this will be used for future correspondence.

Email address

Residential address

Postal code Country

Mailing address
*If different from residential address*

Postal code Country

**Important Notes:** For existing Income policyholders, if your contact information on this form is different from those in our records, we will automatically update all your existing policies with the new information. If you **DO NOT** want us to update the contact information for specific policies, please state the policy number(s) here:

**Residential address verification**

For Singapore Citizen/Permanent Resident – If the residential address stated in the application 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 past 6 months) with letterhead, name, address and date clearly shown.*

## 2 Insured Details (Person To Be Covered) — *Required if Insured is not Proposer*

### 2.1 Personal Particulars

Relationship to Proposer ○ Child (below age 18) ○ Spouse ○ Others

Full name (as in NRIC or FIN)

NRIC/Passport number/FIN

Date of birth (dd/mm/yyyy) / /

Gender ○ Male ○ Female

Nationality ○ Singaporean ○ Singapore PR (Nationality)

○ Others

Country of birth

Marital status ○ Single ○ Married ○ Widowed ○ Divorced

### 2.2 Work Details

Occupation

Nature of work

Name of organisation

Annual income (S$)

### 2.3 Contact Information

Contact number
*Please provide at least one number*

Mobile

Home

Work

Email address

Residential address

Postal code

Country

Mailing address
*If different from residential address*

Postal code

Country

## 3 Tax Residency Declaration

**Important Notes:**

- If you are required to self-certify on behalf of any Entity Account Holder, please complete and submit a FATCA and CRS self-certification form for Entity Account Holder. You do not need to complete this section.
- If you are a Controlling Person of any Entity, please complete and submit a FATCA and CRS self-certification form for Controlling Person. You do not need to complete this section.
- If there are multiple Account Holders, please submit a separate form for each Account Holder.
- If you require further details, please consult your tax/legal adviser or local tax authority. It is important for you to provide us with complete and accurate information in this form, as these are pursuant to requirements under Singapore Income Tax Act (Chapter 134) and its subsidiary legislation.
- If any information should change in the future, please notify us promptly.

1. Are you a tax resident of Singapore?

○ Yes, I am solely a tax resident of Singapore and do not have a foreign tax residency. My Singapore TIN is my NRIC or FIN.

If your TIN is not your NRIC or FIN,
please state it here: | | | | | | | | | |

○ No, I am currently a tax resident in the following list of countries/jurisdictions (include Singapore, if applicable and provide details below):

| No. | Country(ies) or jurisdiction(s) of tax residence^ | Tax Identification Number (TIN) | If TIN is not available, please tick (✓) the reason code (refer to Table 1 below) | If reason B is selected, please indicate why TIN is not available |
|---|---|---|---|---|
| 1 | | | ○ A ○ B ○ C | |
| 2 | | | ○ A ○ B ○ C | |
| 3 | | | ○ A ○ B ○ C | |

^ If you are a United States (U.S.) citizen or U.S. resident for tax purposes, you are required to submit Form W-9.

Table 1

| Reason code | Description |
|---|---|
| A | The country/jurisdiction where the Account Holder is resident does not issue TINs to its residents. |
| B | The Account Holder is otherwise unable to obtain a TIN or equivalent number. (Please explain why you are unable to obtain a TIN if you have selected this reason). |
| C | No TIN is required. (Note: Only select this reason if the domestic law of the relevant jurisdiction does not require the collection of the TIN issued by such jurisdiction). |

Please refer to the OECD website for more information on tax residency:
http://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance/tax-residency/

2. If your residential address, mailing address or contact number is different from your country(ies) of tax residence, please select a reason that applies:

Tick (✓) ONE only and submit relevant supporting documents:

○ Student at an education institution in the country of residence.
○ Working in the country of residence for less than 6 months.
○ On an educational or cultural exchange visitor program in the country of residence for less than 6 months.
○ Regular travel between jurisdictions for work and home.
○ Others, please specify

## 4 Beneficial Ownership Declaration — *This is NOT a nomination of beneficiaries for this policy*

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

If there is a Beneficial Ownership arrangement, please

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

| Name of Beneficial Owner | NRIC/Passport number/FIN | Date of birth (dd/mm/yyyy) |
|---|---|---|
| | | |
| **Nationality** | **Gender** | **Relationship to Proposer** |
| ◯ Singaporean<br>◯ Singapore PR (Nationality) ____<br>◯ Others ____ | ◯ Male<br>◯ Female | |

## 5 Politically Exposed Person (PEP) Declaration

A Politically Exposed Person (PEP) is an individual who is, or has been entrusted with prominent public functions whether in Singapore, a foreign country or an international organisation. Prominent public function includes the roles held by head of state, a head of government, government ministers, senior civil or public servants, senior judicial or military officials, senior executives of state owned corporations, senior political party officials, members of the legislature, and senior management of international organisations.

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

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

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

## 6 Policy Information

### 6.1 Plan Details

Please state the name of the plan and/or rider(s) for this application.

| Details | Basic plan | Rider ◯ Proposer ◯ Insured | Rider ◯ Proposer ◯ Insured | Rider ◯ Proposer ◯ Insured |
|---|---|---|---|---|
| Name | | | | |

Total premium due ____

☐ Tick (✓) here to backdate your policy. You may backdate your policy only if ALL the conditions are met:

1. You are backdating a traditional life insurance policy to qualify for a lower premium or higher minimum protection value. Backdating for investment-linked policy is not allowed.
2. The policy is backdated to a date:
   a. one day before the Insured's last birthday;
   b. within 6 months from date of receipt of application by us; and
   c. not earlier than the official launch date of the main plan or rider, if applicable.
3. For backdating of VivoLegacy Solitaire, you are required to pay interest charges at our prevailing policy loan rate if the backdating is more than 1 month or if the single premium is more than S$1 million. The interest payable will be from one day before the Insured's last birthday to the date of receipt of application by us and based on the single premium.

### 6.2 Allocation Of Funds — *For Investment-Linked Plans Only*

1. The premium allocation across funds must add up to 100%.
2. For regular premium plans or funds that are paid for through CPFIS or SRS, all distribution will be reinvested back into the selected funds.
3. For FlexiLink policies, your premium can be allocated to a maximum of two funds.

| Fund name | Allocation (%) | Fund name | Allocation (%) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 7 Cash Benefit And Distribution Options

### 7.1 Cash Benefit Options — *Applicable to ALL plans with cash benefits, except SAIL and Smart Secure*
*For Smart Secure, please refer to Annex A*

#### 7.1.1 Frequency Of Cash Benefit — *Applicable to plans that offer a choice of monthly or yearly cash benefit*

The default frequency is yearly. Please indicate your choice below if you want monthly cash benefit:

○ Monthly

#### 7.1.2 Payout Method

Your cash benefit amount will be placed with Income to earn interest at the prevailing interest which is non-guaranteed.

If you want the cash benefit to be paid out, please select one of the following options:

○ Option 1: To receive payout by cheque (not applicable for plans with monthly cash benefit)

○ Option 2: To receive payout via direct credit (please provide the account details of Proposer below)

| Name of account holder | Name of bank and branch | NRIC of account holder | Bank account number |
|---|---|---|---|
| | | | |

If the option selected and/or information provided is not valid, your cash benefit will be placed with Income to earn interest at the prevailing interest rate which is non-guaranteed.

### 7.2 Distribution Options — *Applicable to investment-linked policy using cash, except for VivaLink*

All distribution from applicable fund(s) will be reinvested into the same fund(s). If you want to encash your distribution (via direct credit only), please indicate below:

Select fund(s) you wish to encash

☐ Aim Now Fund
☐ Asian Bond Fund
☐ Asian Income Fund
☐ Global Income Fund
☐ Multi-Asset Premium Fund
☐ Others

To receive the payout via direct credit, please provide the account details of the Proposer below:

| Name of account holder | Name of bank and branch | NRIC of account holder | Bank account number |
|---|---|---|---|
| | | | |

In the event of an invalid account, the distribution payout will be delayed.

## 8 Premium Payment Information

### 8.1 Payment Method And Frequency

| | | | | |
|---|---|---|---|---|
| **For Regular Premium Plans** | | | | |
| Frequency | ◯ Monthly | ◯ Quarterly | ◯ Half-yearly | ◯ Yearly |
| First Premium | ◯ Cash | ◯ GIRO[1] | ◯ Credit Card | |
| | ◯ Cashier's order[2]/Cheque (Number) _____ *payable to "NTUC Income"* | | | |
| Renewal | ◯ Cash | ◯ GIRO[1] | | |
| **For Recurring Single Premium Plans** | | | | |
| Frequency | ◯ Monthly | ◯ Quarterly | ◯ Half-yearly | ◯ Yearly |
| Recurring Top-Up | Term (Years) _____ | | Top-up amount (S$) _____ | |
| | ◯ GIRO[1] | | ◯ SRS Account | |
| | ◯ CPFIS Ordinary Account | | ◯ CPFIS Special Account | |

**Important Notes:**

- A minimum top-up amount applies to:
  a. FlexiLink – minimum S$100 per month, S$250 per quarter, S$500 per half-year and S$1,000 per year.
  b. GrowthLink and VivoLink – minimum S$2,500 per transaction; at least S$1,000 per fund.
  c. VivaLink – minimum S$100 per month; up to S$1,200 per year.
- For recurring top-ups, the amount will be allocated to your pre-selected fund(s), according to your existing premium allocation.

**For Single Premium Plans**

◯ Cash
◯ Cashier's order[2]/Cheque (Number) _____ *payable to "NTUC Income"*
◯ CPFIS Ordinary Account
◯ CPFIS Special Account
◯ SRS Account

**Important Notes:**

[1] For payment by GIRO, please complete and submit GIRO form. Please note that we will default to cash payment if we do not receive the form.
[2] For payment by cashier's order, please submit a copy of the cashier's order application form or debit advice with Payor's details.

### 8.2 Payor Details

You do not need to complete Section 8.2 if you are using CPF or SRS funds to pay premium.
The Payor refers to the person making the premium payment. Is the Proposer the Payor?

◯ Yes ◯ No, please disclose Payor details.

| | |
|---|---|
| Payor name (as in NRIC/Passport) | |
| NRIC/Passport number/FIN | |
| Occupation | |
| Relationship to Proposer | ◯ Parent ◯ Spouse ◯ Child ◯ Others _____ |
| Please state reason for paying the premiums on behalf of Proposer | |

## 8.3 Source Of Funds

You do not need to complete Section 8.3 if you are using CPF or SRS funds to pay premium.

1. Who is funding the insurance premium for this application?

◯ Proposer/Payor ◯ Others, please provide details below:

| Name of person funding the policy | NRIC/Passport number/FIN | Relationship to Proposer | Occupation and organisation |
|---|---|---|---|
| | | | |

2. What is the source of funds used to pay the premiums?

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

*Details for "Personal savings/Proceeds from a policy/Others"*

## 8.4 Source Of Wealth

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
☐ Inheritance and gifts
☐ Sale of property, company, or other assets
☐ Business or trade income
☐ Investments (shares, bonds, unit trusts, etc.)
☐ Others

## 8.5 Payment Authorisation — *Please complete all the relevant sections*

### 8.5.1 Credit Card

**Important Notes:**

- We will default to cash payment if the credit card number or details are invalid.
- Credit card payment is allowed for payment of first premium only. It is not allowed for payment of renewal premiums.

I authorise NTUC Income Insurance Co-operative Limited ("Income") to deduct the amount of the first premium from my credit card account.

| | | |
|---|---|---|
| Cardholder name | | |
| Credit card number *Visa/Mastercard only* | ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ | |
| Card expiration date (mm/yy) | ☐☐ / ☐☐ | |
| Issuing bank | | Signature of cardholder |
| Relationship to Proposer *If not Proposer* | | Signed in Singapore on (dd/mm/yyyy) |

### 8.5.2 Supplementary Retirement Scheme (SRS) Account

I authorise NTUC Income Insurance Co-operative Limited ("Income") to deduct the premium from my SRS account once the policy is accepted.

| SRS operator | SRS account number |
|---|---|
| | |

### 8.5.3 Central Provident Fund Investment Scheme Ordinary Account (CPFIS-OA)

**Important Notes:** If you have not signed a Standing Instruction with your bank, please complete the relevant form, and submit it to your bank.

I authorise NTUC Income Insurance Co-operative Limited ("Income") to deduct the premium from my CPF Ordinary Account once the policy is accepted.

| Name of agent bank | CPF investment account number | CPF account number |
|---|---|---|
| | | |

### 8.5.4 Central Provident Fund Investment Scheme Special Account (CPFIS-SA)

**Declaration for CPFIS-SA Investment**

To: The Central Provident Fund Board

I hereby irrevocably authorise the Board to:

1. Debit my CPF Special Account the sum of monies specified by Income or the amount determined by the Board for the purchase or placement of the life insurance policies approved under the CPFIS-SA including any related fees, expenses, and charges under the CPF Investment Scheme – Special Account (CPFIS-SA);
2. Credit my CPF Special Account with any income or any proceeds from the liquidation of the life insurance policies approved under the CPFIS-SA that are received from Income; and
3. Disclose any or information whatsoever relating to, or in connection with my investment with Income to facilitate any transaction that cannot be settled due to data discrepancies, insufficient funds or any other reasons that the Board deems fit.

I understand that the above transactions shall be made, subject to the provisions of the Central Provident Fund Act and the Central Provident Fund (Investment Schemes) regulations as may be amended from time to time and to all such terms and conditions as may be imposed by the Board from time to time.

I hereby agree to indemnify the Board and shall keep the Board indemnified against all actions, proceedings, liabilities, claims, damages, expenses, or legal costs whatsoever arising out of in connection with the Board accepting and acting upon this authorisation.

**Additional Declaration for CPFIS Self-Awareness Questionnaire**

I declare that I have

1. Opened a CPF Investment Account before;
2. Invested in the CPF Investment Scheme – Special Account before; and/or
3. Completed the Self-Awareness Questionnaire.

If the above declaration is found to be false, I understand and agree that CPF Board will reject the withdrawal of moneys from my ordinary or special account, as the Board thinks fit.

| Full name of Proposer (as in NRIC/Passport) | CPF account number |
|---|---|
| | |

Signature of Proposer

Signed in Singapore on (dd/mm/yyyy)

## 9 Concurrent Insurance Applications And Policies

1. Do you have any existing policies or proposal pending approval? If yes, please provide details below:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Policy/Proposal ◯ Proposer ◯ Insured | Policy/Proposal ◯ Proposer ◯ Insured | Policy/Proposal ◯ Proposer ◯ 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* | | | |

**WARNING:**
We would not advise you to replace an existing policy with a new one.
Some of the disadvantages are:
a. the insurance may not be granted on standard terms;
b. you may have to pay a higher premium as you are now older; and
c. you will lose financial benefits built up over the years.

Please consult your present insurer before making a final decision. Make a careful comparison so that you can be sure that you are making a decision that is in your best interest.

2. Is the insurance you are applying for to replace or intended to replace in full or in part, any policy with Income or other insurers? If yes, what is it replacing? Please provide details below:

◯ Yes ◯ No

| | Policy | Policy | Policy |
|---|---|---|---|
| Insurance company | | | |
| Policy details *Please provide policy number and policy type* | | | |
| Reason(s) for replacing policy | | | |

## 10.1 Insurance History

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 by any insurer? If yes, please provide details below:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Policy ◯ Proposer ◯ Insured | Policy ◯ Proposer ◯ 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 (for example: critical illness, disability, terminal illness, accident, hospitalisation)? If yes, please provide details below:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Policy ◯ Proposer ◯ Insured | Policy ◯ Proposer ◯ Insured |
|---|---|---|
| Insurance company | | |
| Nature of claim | | |
| Year of claim | | |
| Reasons | | |

## 10.2 Build

What is your height (metres) and weight (kilograms)?

| Proposer | | | | Insured | | | |
|---|---|---|---|---|---|---|---|
| Height | | m | Weight | Height | | m | Weight |
| | kg | | | | kg | | |

**Important Notes:** If you are applying for Cancer Protect, Silver Protect or Maternity 360, Section 10.3 (Family History), 10.4 (Lifestyle) and 10.5 (Medical Information) are not applicable. Please complete the relevant underwriting questions found in Annex B.

## 10.3 Family History

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:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Family Member 1<br>◯ Proposer ◯ Insured | Family Member 2<br>◯ Proposer ◯ Insured |
|---|---|---|
| Relationship to Proposer or Insured | | |
| Medical condition or cause of death | | |
| Age at which it began | | |
| Age at death (if applicable) | | |

## 10.4 Lifestyle Information

1. Have you smoked cigarettes or cigars in the last 12 months? If yes, please provide details below:

Proposer ◯ Yes ◯ No Insured ◯ Yes ◯ No

| Proposer | Insured |
|---|---|
| ____ years of smoking | ____ years of smoking |
| ____ sticks of cigarettes *(per day)* ____ sticks of cigars *(per day)* | ____ sticks of cigarettes *(per day)* ____ sticks of cigars *(per day)* |

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

Proposer ◯ Yes ◯ No Insured ◯ Yes ◯ No

| Proposer | Insured |
|---|---|
| ____ cans of beer *(per 330ml)* ____ glasses of spirit *(per 30ml)* | ____ cans of beer *(per 330ml)* ____ glasses of spirit *(per 30ml)* |
| ____ glasses of wine *(per 125ml)* | ____ glasses of wine *(per 125ml)* |

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.

Proposer ◯ Yes ◯ No Insured ◯ Yes ◯ No

| | Proposer | Insured |
|---|---|---|
| Name of doctor/support group | | |
| Address of doctor/support group | | |

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

Proposer ◯ Yes ◯ No Insured ◯ Yes ◯ No

| | Proposer | 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.

Proposer ◯ Yes ◯ No Insured ◯ Yes ◯ No

| | Proposer | Insured |
|---|---|---|
| Addictive drug or substance taken | | |

b. 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.

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Proposer | Insured |
|---|---|---|
| Name of doctor/support group | | |
| Address of doctor/support group | | |

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

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Proposer | 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).

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

6. Do you take part in, or plan to take part in other dangerous occupations or pursuits as listed below?
If yes, please tick (✓) the relevant activities:

| Proposer | Insured |
|---|---|
| ☐ Scuba or skin diving ☐ Mountain or rock climbing<br>☐ Free fall parachuting ☐ Motor racing<br>☐ Others | ☐ Scuba or skin diving ☐ Mountain or rock climbing<br>☐ Free fall parachuting ☐ Motor racing<br>☐ Others |
| For **scuba or skin diving**, please complete the following:<br>a. Are you a certified diver? If yes, please specify certification(s) | For **scuba or skin diving**, please complete the following:<br>a. Are you a certified diver? If yes, please specify certification(s) |
| b. Are you an instructor? ◯ Yes ◯ No | b. Are you an instructor? ◯ Yes ◯ No |
| c. Do you usually dive alone and unaccompanied? ◯ Yes ◯ No | c. Do you usually dive alone and unaccompanied? ◯ Yes ◯ No |
| d. Do you participate in specialised forms of diving (for example: cave, pothole, wreck, search and rescue diving) or use underwater explosives? ◯ Yes ◯ No<br>If yes, please provide details and frequency per year.<br>Frequency per year | d. Do you participate in specialised forms of diving (for example: cave, pothole, wreck, search and rescue diving) or use underwater explosives? ◯ Yes ◯ No<br>If yes, please provide details and frequency per year.<br>Frequency per year |
| e. Dive history in the last 12 months:<br>Total no. of dives<br>Average depth(m)<br>Maximum depth(m)<br>Dive sites | e. Dive history in the last 12 months:<br>Total no. of dives<br>Average depth(m)<br>Maximum depth(m)<br>Dive sites |

**Important Notes:** For mountaineering or rock climbing, please complete the Mountaineering and Rock Climbing Questionnaire. For other hazardous activities or pursuits, please complete the Hazardous Pursuits Questionnaire.

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.

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Proposer | Insured |
|---|---|---|
| Name of countries and cities | | |
| Duration of each stay | | |
| Frequency of travel | | |
| Purpose of each travel | | |

**Important Notes:** If you are applying for Silver Secure or FlexiLink, Section 10.5 (Medical Information) is not applicable. Please complete the relevant underwriting questions found in Annex B.

## 10.5 Medical Information

### 10.5.1 Questions For All Ages

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:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

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

2. In the last 5 years, have you had, or been advised to undergo any medical tests or investigations? Or do you intend to have or awaiting for any tests or investigations in the coming year? (For example: blood test, urine test, X-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, Pap smear, prostate check). If yes, please provide details below and submit a copy of the results, if any:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Test/Investigation 1<br>◯ Proposer ◯ Insured | Test/Investigation 2<br>◯ Proposer ◯ Insured |
|---|---|---|
| Type of test/investigation | | |
| Date of test/investigation | | |
| Reasons for test/investigation | | |
| Test/investigation result | | |
| Name and address of clinic | | |

## 10.5.2 Additional Questions To Be Completed For Age 16 to Age 50

**Important Notes:** If you answered "Yes" to any of the questions in Section 10.5.2 to Section 10.5.6, please provide details on page 18.

| | Proposer | Insured |
|---|---|---|
| 3. Have you ever had diabetes, high blood pressure, high cholesterol, cardiomyopathy, heart attack, heart valve disorders, heart or blood vessels disorders (other than irregular heart rate or heart murmurs), stroke, transient ischemic attack, bipolar disorder, schizophrenia, tumour, cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesion, polyps, cysts, fibroids or other growths of any kind, kidney failure, HIV or AIDS? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 4. In the last 5 years, have you had any of the medical conditions indicated between 4a to 4j, regardless of when it was diagnosed that has required any of the following:<br>• Medical leave for 2 consecutive weeks and beyond;<br>• Medication for 2 consecutive weeks and beyond;<br>• Hospitalization;<br>• Regular follow up with a medical practitioner;<br>• On regular medications;<br>• Use of assisting device or help from another person to carry out your daily activities | | |
| a. Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis | ◯ Yes ◯ No | ◯ Yes ◯ No |
| b. Heart murmur, chest pain, fast or irregular heart rate | ◯ Yes ◯ No | ◯ Yes ◯ No |
| c. Alzheimer's disease, Parkinson's disease, dementia, multiple sclerosis, motor neuron disease, epilepsy, aneurysm, paralysis, numbness, autism, attention deficit hyperactivity disease, anxiety or depression | ◯ Yes ◯ No | ◯ Yes ◯ No |
| d. Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver | ◯ Yes ◯ No | ◯ Yes ◯ No |
| e. Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease | ◯ Yes ◯ No | ◯ Yes ◯ No |
| f. Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full) | ◯ Yes ◯ No | ◯ Yes ◯ No |
| g. Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week) | ◯ Yes ◯ No | ◯ Yes ◯ No |
| h. Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases | ◯ Yes ◯ No | ◯ Yes ◯ No |
| i. Sexually transmitted diseases | ◯ Yes ◯ No | ◯ Yes ◯ No |
| j. Overactive or underactive thyroid hormone secretion | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 5. Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above? | ◯ Yes ◯ No | ◯ Yes ◯ No |

## 10.5.3 Additional Questions To Be Completed For Female (Age 16 to Age 50)

6a. Are you now pregnant? If yes, please state the number of weeks pregnant:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Proposer | Insured |
|---|---|---|
| No. of weeks pregnant | | |

b. 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:

| Proposer | ◯ Yes ◯ No | Insured | ◯ Yes ◯ No |
|---|---|---|---|

| | Proposer | Insured |
|---|---|---|
| Pregnancy | ◯ Past pregnancy ◯ Current pregnancy | ◯ Past pregnancy ◯ Current pregnancy |
| Date of diagnosis | | |
| Details of complications | | |

### 10.5.4 Additional Questions To Be Completed For Above Age 50

| | Proposer | Insured |
|---|---|---|
| 7. Have you ever had diabetes, cardiomyopathy, heart attack, heart valve disorders, heart or blood vessels disorders (other than irregular heart rate or heart murmurs), stroke, transient ischemic attack, bipolar disorder, schizophrenia, tumour, cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesion, polyps, cysts, fibroids or other growths of any kind, kidney failure, HIV or AIDS? | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 8. In the last 5 years, have you had any of the medical conditions indicated between 8a to 8i, regardless of when it was diagnosed that has required any of the following:<br>• Medical leave for 2 consecutive weeks and beyond;<br>• Medication for 2 consecutive weeks and beyond;<br>• Hospitalization;<br>• Regular follow up with a medical practitioner;<br>• On regular medications;<br>• Use of assisting device or help from another person to carry out your daily activities | | |
| a. Asthma, bronchitis, breathlessness, coughing with blood, emphysema, chronic obstructive pulmonary disease (COPD) or tuberculosis | ◯ Yes ◯ No | ◯ Yes ◯ No |
| b. High blood pressure, high cholesterol, heart murmur, chest pain, fast or irregular heart rate | ◯ Yes ◯ No | ◯ Yes ◯ No |
| c. Alzheimer's disease, Parkinson's disease, dementia, multiple sclerosis, epilepsy, aneurysm, paralysis, numbness, anxiety or depression | ◯ Yes ◯ No | ◯ Yes ◯ No |
| d. Stomach ulcer, colitis, Crohn's disease, pancreatitis, gastro-intestinal bleeding, cirrhosis, hepatitis or fatty liver | ◯ Yes ◯ No | ◯ Yes ◯ No |
| e. Prostate enlargement, blood or protein or sugar in urine, kidney infection, kidney stones or polycystic kidney disease | ◯ Yes ◯ No | ◯ Yes ◯ No |
| f. Arthritis, gout, osteoporosis, slipped disc, rheumatism, chronic back pain or amputation of limbs (partial or full) | ◯ Yes ◯ No | ◯ Yes ◯ No |
| g. Impaired vision, impaired hearing, impaired speech or nose bleeds (intermittent or continuous longer than 1 week) | ◯ Yes ◯ No | ◯ Yes ◯ No |
| h. Anaemia, thalassaemia, systemic lupus erythematosus or autoimmune diseases | ◯ Yes ◯ No | ◯ Yes ◯ No |
| i. Overactive or underactive thyroid hormone secretion | ◯ Yes ◯ No | ◯ Yes ◯ No |
| 9. Do you have any medical condition, signs or symptoms, physical disability or injury other than those already indicated in above? | ◯ Yes ◯ No | ◯ Yes ◯ No |

### 10.5.5 Additional Questions To Be Completed For Juvenile Applications (Age Below 16)

| | Insured |
|---|---|
| 10. Please provide details below for Juvenile Applicants: | |
| a. Does either of the child's parents have equivalent cover as proposed in this application? If no, please select the reason:<br>◯ Ineligible due to medical reasons<br>◯ Pending application with other insurers<br>◯ Others, please provide reason and details | ◯ Yes ◯ No |
| b. Does the child have other siblings?<br>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:<br>◯ Ineligible due to medical reasons<br>◯ Others, please provide reason and details | ◯ Yes ◯ No |
| c. Has the child ever had, or been told that he/she has, or been told to seek treatment, or have been treated for any of the following medical conditions or symptoms? | |
| i. Diabetes, thyroid disorders or any other endocrine disorders | ◯ Yes ◯ No |
| ii. Asthma, bronchitis, pneumonia, persistent cough (longer than 4 weeks) or any other lung disease or disorder | ◯ Yes ◯ No |
| iii. Heart murmur, heart valve disorders or diseases, Kawasaki's disease, irregular or fast heart rate, or any other disease or disorder of the heart or blood vessels | ◯ Yes ◯ No |
| iv. Epilepsy, fits, weakness of limbs, unconsciousness, developmental delay or abnormality in respect of physical, neurological, cognitive, language or psychosocial aspect or any other neurological, nervous or mental disorders | ◯ Yes ◯ No |
| v. Jaundice, hepatitis, or any other disorder of the digestive system including oesophagus, stomach, intestines, colon, rectum, anus, liver, gallbladder, pancreas | ◯ Yes ◯ No |
| vi. Kidney infection, urinary tract infection, blood in urine, protein in urine or sugar in urine, or any other disease or disorder of the kidney, bladder | ◯ Yes ◯ No |
| vii. Impaired hearing, impaired sight, impaired speech, ear discharge, double vision, nose bleeds (intermittent or continuous longer than 1 week) or any other disorders of eyes, ears and nose | ◯ Yes ◯ No |
| viii. Anaemia, thalassemia, HIV infection (AIDs or any other disorders of the blood or autoimmune disease) | ◯ Yes ◯ No |
| ix. Cancer, enlarged lymph nodes, unusual skin lesions, tumours, or other growths of any kind | ◯ Yes ◯ No |

### 10.5.6 Additional Questions To Be Completed For Juvenile Life Insured (Age Below 2)

| | Insured |
|---|---|
| 11. Is the child a premature baby (i.e. less than 37 weeks of gestation)?<br>If yes, please provide details below:<br>Gestation period (weeks) ____ Length at birth ____ cm<br>APGAR score at 1 minute ____ Weight at birth ____ kg<br>APGAR score at 5 minute ____ Date of discharge from hospital ____ | ◯ Yes ◯ No |
| 12. Were there any significant events during pregnancy/delivery such as but not limited to birth difficulty, infection, congenital deformities, lack of mental development, respiratory distress syndrome, prolonged jaundice that lasted more than 2 weeks, G6PD deficiency, respiratory disorder, intrauterine growth retardation? | ◯ Yes ◯ No |
| 13. Any special care needed after birth? | ◯ Yes ◯ No |
| 14. Has the child been advised, or been told to go for further follow-up, or further evaluation, or monitoring after each routine assessment check? | ◯ Yes ◯ No |
| 15. Has the child had any physical, congenital or developmental defects, or shown any sign of slow physical or mental development? | ◯ Yes ◯ No |

If you answered "Yes" to any of the above questions in Section 10.5.2 to Section 10.5.6, 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. | Proposer | Insured |
|---|---|---|
| | | |

## 11 Additional Details

If you require additional space for your answer to any of the questions, please write the question number and answer below:

## 12 Personal Data Use Statement

**Important Notes:**

- You can request access to any personal data of yours that we have, and request to know how it is being used and disclosed for the last 12 months to the extent your right is allowed by law. If we allow you access, we may charge you a reasonable fee. You also have the right to request correction of your personal data.
- You may make your request to access or correct your personal data by writing to: The Data Protection Officer, Income Centre, 75 Bras Basah Road, Singapore 189557. Alternatively, you can email to: DPO@income.com.sg

### 12.1 Personal Data

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

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

### 12.2 Marketing Material

By signing up for this product or service, I give my consent to Income to collect, use and disclose my personal data, and contact me via email and post, for both rewards and privileges, marketing and promotional purposes.

In addition, by checking the boxes below, I consent to being contacted by you via telephone calls, SMS and other phone number-based messaging about products and services offered by Income, regardless of my registration(s) with the Do Not Call registry.

☐ Call ☐ Text messages/SMS

I agree that Income will use the contact particulars, including any update that I have given to Income, to contact me.
I may withdraw my above consent by contacting Income Contact Center at 6788 1777 or consentwithdrawal@income.com.sg.
Please refer to www.income.com.sg/privacy-policy for more information.

## 13 Declarations

1. I cannot alter any of the wordings in this application form. Any attempt to do so will have no effect.
2. 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 you. 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.
3. I am aware that I can refer to the specimen of the standard terms, conditions and exclusions of this plan to be issued at www.income.com.sg.
4. I will notify Income immediately if there is any change in the state of my health, or if I plan to seek medical consultation, investigation, or treatment between the date of this application and the date this policy is in force. You may add special terms to the policy according to the information provided. This applies if I am applying for a non-guaranteed issue basic plan or for any non-guaranteed issue riders.
5. I authorise, consent to, and agree to any medical source, insurance office, reinsurer, or organisation to release to you and you to release to any medical source, insurance office, reinsurer or organisation any relevant information to do with me or the Insured whether you accept my application or not. A photocopy of this authorisation is valid as an original copy.
6. I agree that Income's legal responsibility will only begin when Income accepts this application and I have paid the first premium.
7. 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.
8. I confirm that the entire marketing and selling process for my proposed insurance application has been carried out in Singapore.
9. I agree that the policy is issued as a Singapore Policy and agree that the policy will be entered in the Register of the Singapore policies.
10. I confirm that I understand and agree to the "Personal Data Use Statement" above.
11. I agree and expressly consent that Income shall have the right to provide my personal data and information to any governmental authorities, regulatory bodies and/or any other person(s) to fulfil its obligations under applicable tax regulations, including Singapore Income Tax Act (Chapter 134), the Foreign Account Tax Compliance Act ("FATCA") and the OECD Common Reporting Standard for Common Exchange of Financial Account Information ("CRS"). I understand that such disclosures may:
    a. Involve cross border transfer of personal data and information outside the jurisdiction;
    b. Be in respect to personal data and information provided in this form, or in any document provided, or to be provided to Income by me or from other sources; and
    c. Relate to personal data of the Account Holder and any information about relevant policy or policies.
12. I understand that Income will not be able to sell or administer any insurance product or provide any services to me if I refuse to give this expressed consent.
13. I certify that I am the Account Holder (or am authorised to sign for the Account Holder) of all accounts to which this form relates.
14. I declare that all statements made in this form are correct and complete. I undertake to inform Income within 30 days if there is a change in circumstances that affects the tax residency status of the Account Holder or causes the information in this form to be incorrect or incomplete. I shall provide Income with an updated FATCA and CRS self-certification form within 90 days of such change in circumstances. I understand any false, misleading, or fraudulent information regarding my resident status for tax purposes may result in certain penalties.
15. I understand that it is usually not a good idea for me to replace an existing investment product (for example: life policy/ investment-linked policy/unit trust) with a new investment product, whether from the same or a different financial institution. I further understand that some of the disadvantages of replacement are:
    a. the insurance may not be granted on standard terms;
    b. I may have to pay a higher premium as the Insured or I am now older; and
    c. I will lose financial benefits built up over the years.
16. I agree that the Cover Page, Benefit/Policy Illustration, Product Summary and Bundled Product Disclosure Document (if applicable), have been explained to me to my satisfaction by my adviser.
17. I am aware that I can ask for a copy of Your Guide to Life Insurance and/or Your Guide to Health Insurance from my adviser. Or I can download them from: www.income.com.sg.
18. If I have applied to become a member of Income Rewards, I agree to keep to your by-laws.

19. I acknowledge that I am responsible for making sure that I am allowed to buy this plan under the laws and regulations that apply to my nationality and the country that I reside in. I understand that Income cannot accept liability for any legal consequences under the laws of any other country or any tax effects that may arise in connection with the purchase of this plan. I declare that any funds and assets I place with Income, and any profits generated from them, comply with the tax laws of the countries where I am a resident of, and a citizen of.
20. I agree that if I or any *Relevant Person is found to be a +Prohibited Person, you are entitled not to accept this application. If any policy is issued, you can terminate or void the policy, or not make any transaction under the policy such as not pay any benefit. Your decision will be final. I will inform you 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 you from providing insurance cover or paying any benefit.
21. If a Cancer Premium Waiver (GIO) rider is added, I am aware that the rider covers diagnosis of major cancer as defined in its contract. I understand and agree that if the Insured had consulted a doctor for, suffered symptoms of, was investigated for, was diagnosed with, or received medical treatment for any cancer, including carcinoma-in-situ, before the cover start date, no benefit will be paid under the rider, and the rider will be terminated. Cover start date means the date Income issues the rider, issues an endorsement to include or increase a benefit, or reinstates the rider, whichever is latest.
22. If Annex A and/or Annex B is/are applicable, I confirm and understand that all other sections of this application, including all Declarations will also apply to Annex A and/or Annex B.

**I agree that if I do not reveal any significant facts in this application (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 adviser but was not included in the application.**

| Signature of Proposer | Signature of Insured<br>*If different from Proposer and age 16 and above* |
|---|---|
| Signed in Singapore on (dd/mm/yyyy) | Signed in Singapore on (dd/mm/yyyy) |

| Full name of Witness (as in NRIC/Passport) | NRIC/Passport number/FIN | Signature of Witness<br>*Age 21 and above* |
|---|---|---|
| | | Signed in Singapore on (dd/mm/yyyy) |

## 14 Parental Consent

The Parent or Legal Guardian must fill in this section if the child or ward is the Proposer, and above the age of 10 years and below 16 years.

1. I give my permission for my child or ward to be the Proposer and Insured of this policy.
2. I consent to the selection indicated under the "Marketing Material" option for my child or ward.

| | |
|---|---|
| Name of Parent or Legal Guardian | |
| NRIC/Passport number/FIN | |
| Relationship to Proposer | ○ Parent<br>*Please submit a copy of NRIC/Passport*<br>○ Legal Guardian<br>*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)

## 15 Adviser Declaration

All answers given to me by the Proposer and/or Insured are in the application. I have not withheld any information which may influence Income's decision to accept this application.

I have personally seen the Proposer and/or Insured, and have explained the terms of the plan to the Proposer.

I have seen all the original identification documents, and have submitted photocopies of them with this application.
I confirm that all submitted documents are copies of their originals.

**Additional Declaration for CPFIS Self-Awareness Questionnaire**

I have checked that the Proposer has

1. Opened a CPF Investment Account before;
2. Invested in the CPF Investment Scheme – Special Account before; and/or
3. Completed the Self-Awareness Questionnaire

| Name of Adviser (as in NRIC) |
|---|
| |

Signature of Adviser

Signed in Singapore on (dd/mm/yyyy)

## A Cash Benefit for Smart Secure

**Important Notes:** You can choose to use the cash benefit from Smart Secure to fund premiums of a specified savings plan. Both policies must be issued on the same date. We will hold back the issuance of one policy when the other policy is not ready for issuance.

Your cash benefit amount will be used to fund premium of a specified savings plan if all of the following conditions are met:

1. The policy number of the specified savings plan is stated in this application form;
2. The annual cash benefit is the same as the annual premium of the specified savings plan;
3. The policy entry date for Smart Secure and the specified savings plan is the same; and
4. You are the policyholder of Smart Secure and specified savings plan when the policies are issued.

If any of the above conditions is not met, you will receive your cash benefit amount as payout.

To receive the payout via direct credit, please provide the account details of the Proposer below:

| Name of account holder | Name of bank and branch | NRIC of account holder | Bank account number |
|---|---|---|---|
| | | | |

If the account details provided is not valid, you will receive the payout via cheque.

# B1 Cancer Protect and Silver Protect

| Name of Insured (as in NRIC/Passport) | NRIC/Passport number/FIN |
|---|---|
| | |

**Important Notes:** When Annex B is completed, please be informed that all other sections of this application, including all Declarations, will also apply to Annex B.

## B1.1 Underwriting Information

| | Insured |
|---|---|
| 1. Do you have 2 or more of your immediate family members (for example: parents or siblings) who have been diagnosed with cancer before age 60, or 1 family member with a history of breast cancer before age 50? If yes, please provide details below: | ◯ Yes ◯ No |

| | Family Member 1 | Family Member 2 |
|---|---|---|
| Relationship to Insured | | |
| Medical condition or cause of death | | |
| Age at which it began | | |
| Age at death (if applicable) | | |

| | |
|---|---|
| 2. Have you smoked cigarettes or cigars in the last 12 months? If yes, please state: ____ years of smoking ____ sticks of cigarettes *(per day)* ____ sticks of cigars *(per day)* | ◯ Yes ◯ No |
| 3. Have you ever had, or been told that you have, or been told to seek treatment, or been treated for, or are currently under investigation for the following medical conditions and/or symptoms? | |
| a. Cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesions, tumours, polyps, cysts or other growths of any kind | ◯ Yes ◯ No |
| b. Excessive weight loss (more than 5 kg) in the past 3 months or fatigue (for more than 1 week) in the past 3 months | ◯ Yes ◯ No |
| 4. Have you ever had or been advised to have any operation, test or treatment^ or have been hospitalised for 7 days or more within the past 12 months?<br>^ Treatment for the following conditions can be ignored: common cold or flu, uncomplicated pregnancy and caesarean section, contraception, hypertension, hyperlipidaemia, diabetes, inoculation or injuries from which you have fully recovered. | ◯ Yes ◯ No |

If you answered "Yes" to any of the above questions (3 to 4), 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. | Insured |
|---|---|
| | |

B2 Silver Secure

| Name of Insured (as in NRIC/Passport) | NRIC/Passport number/FIN |
|---|---|
| | |

**Important Notes:** When Annex B is completed, please be informed that all other sections of this application, including all Declarations, will also apply to Annex B.

## B2.1 Underwriting Information

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

| Date of last consultation | Reason for last consultation |
|---|---|
| | |
| **Name of doctor** | **Name and address of clinic** |
| | |

| | |
|---|---|
| 2. Have you ever had, been told that you have, or been told to seek treatment, or have been treated for any of the following medical conditions or symptoms? | |
| a. Diabetes, thyroid disorders or any other endocrine disorders | ◯ Yes ◯ No |
| b. Asthma, bronchitis, pneumonia, tuberculosis, breathlessness, coughing with blood, persistent cough (longer than 4 weeks), breathing complaints or discomfort or any other lung diseases or disorders | ◯ Yes ◯ No |
| c. Varicose veins or enlarged tortuous veins, cardiomyopathy, heart attack, heart murmur, prolapsed mitral valve or other heart valve disorders or diseases, high cholesterol, high blood pressure, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels | ◯ Yes ◯ No |
| d. Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, motor neuron disease, depression, epilepsy, fits, nervous breakdown, paralysis, stroke, numbness, prolonged headache (longer than 4 weeks), weakness of limbs or any other neurological, nervous or mental disorder | ◯ Yes ◯ No |
| e. Oesophagitis, stomach ulcer, duodenal ulcer, gastritis, gastric reflux, piles, fistula, blood in the stools, diarrhoea (longer than 1 week), jaundice, hepatitis, fatty liver, gallstone, pancreatitis or any other disorders of the digestive system including oesophagus, stomach, liver, gallbladder, pancreas, intestines, colon and rectum | ◯ Yes ◯ No |
| f. Prostate enlargement, kidney infection, kidney stones, urinary tract infection, involuntary release of or frequent and sudden uncontrollable need to urinate, blood in urine, protein in urine or sugar in urine, or any other disorders of the kidney, bladder, genital or urinary systems | ◯ Yes ◯ No |
| g. Arthritis, gout, osteoporosis, slipped disc, any pain or deformity or physical disability or severe injury or any disease or disorder of the muscles, bones, spine, limbs or joints | ◯ Yes ◯ No |
| h. Double vision, impaired sight, ear discharge, impaired hearing, nose bleeds (intermittent or continuous longer than 1 week) or impaired speech, or any other disorders of the eyes, ears, nose or throat | ◯ Yes ◯ No |
| i. Anaemia, haemophilia, systemic lupus erythematosus or any other disorders of the blood or autoimmune disease | ◯ Yes ◯ No |
| j. Cancer, carcinoma-in-situ, enlarged lymph nodes, unusual skin lesions, tumours, polyps, cysts or other growths of any kind | ◯ Yes ◯ No |

| | Insured |
|---|---|
| k. Excessive weight loss (more than 5 kg) in the past 3 months or fatigue (for more than 1 week) in the past 3 months | ◯ Yes ◯ No |
| l. Any other illness, disorder, symptoms, operation, treatment, physical disability, accident or injury not mentioned above | ◯ Yes ◯ No |
| 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? | ◯ Yes ◯ No |
| 4. Do you have tremors, balance problem, difficulty in walking? | ◯ Yes ◯ No |
| 5. Do you have problems related to your memory? | ◯ Yes ◯ No |
| 6. Do you need any help from another person or mechanical aids such as a cane, crutches, wheelchair or walker to carry out your daily activities such as washing (bathing), dressing, feeding (eating), walking, transferring from bed to chair, using the toilet, doing housework, preparing meals, shopping and travelling? | ◯ Yes ◯ No |
| 7. In the past 5 years, have you had any test done such as an X-ray, ultrasound, CT scan, biopsy, Pap smear, electrocardiogram (ECG), blood or urine test? If you answered yes, please provide details of date, type of test, reason for undergoing such test and the test result. | ◯ Yes ◯ No |
| 8. Are you preparing to arrange for any form of medical treatment, consultations or investigation which will be conducted in the next 3 months or awaiting results from medical consultations, test or investigation? | ◯ Yes ◯ No |

## B2.2 Additional Health Questions For Females Only

| | Insured |
|---|---|
| 9a. Are you now pregnant? If yes, please state the number of weeks pregnant. ____ weeks | ◯ Yes ◯ No |
| b. Has there been any complication(s) relating to this and/or previous pregnancies such as gestational diabetes, caesarian section, eclampsia, hypertension, diabetes, thrombosis, miscarriage or others? If yes, please provide details below: | ◯ Yes ◯ No |
| c. Have you had or received any treatment for or plan to be treated for breast lump, breast cyst, fibroadenoma of the breast, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma-in-situ of the breast, cancer or growth of the breast or any disease or disorder of the breast? | ◯ Yes ◯ No |
| d. Have you had or received any treatment for or plan to be treated for any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, uterine fibroids, abnormal enlargement of the abdomen, carcinoma-in-situ or cancer? | ◯ Yes ◯ No |
| e. Have you had an abnormal mammogram, Pap smear, pelvis ultrasound, breast ultrasound, cone biopsy, colposcopy, or other gynaecological test; or have you ever been advised for further follow-up on (or to repeat) any one of these tests within the next 6 months? If yes, please provide details below and submit copy of results, if available. | ◯ Yes ◯ No |

| Pregnancy | ◯ Past pregnancy | ◯ Current pregnancy |
|---|---|---|
| Date of diagnosis | | |
| Details of complications | | |

| Type of test | | |
|---|---|---|
| Date of test | | |
| Test results | | |

If you answered “Yes” to any of the above questions (1 to 9), 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. | Insured |
|---|---|
| | |

B3 FlexiLink

| Name of Insured (as in NRIC/Passport) | NRIC/Passport number/FIN |
|---|---|
| | |

**Important Notes:** When Annex B is completed, please be informed that all other sections of this application, including all Declarations, will also apply to Annex B.

## B3.1 Underwriting Information

| | Insured |
|---|---|
| 1. Do you have a doctor whom you consult for medical reasons other than minor illness such as common cold or flu? If yes, please provide details below: | ◯ Yes ◯ No |
| 2. Have you ever had been treated for or been told to get treatment for disease of the heart or circulatory system, stroke, high blood pressure, diabetes, cancer, growth or other malignancy, kidney or bladder disorders, asthma, other respiratory disorders, liver disease such as hepatitis, epilepsy, hereditary diseases and eye disorders? | ◯ Yes ◯ No |
| 3. Have you suffered from physical or mental impairment or deformity? | ◯ Yes ◯ No |
| 4. Have you undergone or are you undergoing any medical treatment or surgical operation? | ◯ Yes ◯ No |

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

# B4 Maternity 360

| Name of Insured (as in NRIC/Passport) | NRIC/Passport number/FIN |
|---|---|
| | |

**Important Notes:** When Annex B is completed, please be informed that all other sections of this application, including all Declarations, will also apply to Annex B.

## B4.1 Underwriting Information

1. Please state:
   a. The number of weeks pregnant ____ weeks
   b. Estimated date of delivery (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

2. How many foetuses are you carrying?
   ◯ Single ◯ Twin ◯ Others, please specify ____

3. What was your weight at the beginning of your pregnancy?
   ____ kg

| | Insured |
|---|---|
| 4. Have you been smoking or consuming alcohol during pregnancy, ever been advised by a health care professional to reduce your alcohol intake, see a specialist because of your alcohol intake, or ever taken any addictive drugs or substances (for example: narcotics) or been treated for drug or substance addiction? | ◯ Yes ◯ No |
| 5. Is your current pregnancy conceived through assisted reproductive technology such as in-vitro fertilisation (IVF), intrauterine insemination (IUI), intracervical insemination (ICI)? | ◯ Yes ◯ No |
| 6. Have you had or been advised to do a first trimester prenatal screening such as OSCAR, detailed ultrasound, amniocentesis/chorionic villous sampling/prenatal test (for example: Harmony, iGene, Panorama, Verifi and/or any other test or investigation)? | ◯ Yes ◯ No |
| 7. Have you ever had, been told to have or received treatment for any of the following pregnancy complication(s)? | |
| a. Pre-eclampsia or eclampsia (pregnancy induced hypertension with protein in urine) | ◯ Yes ◯ No |
| b. Glycosuria (sugar in urine) or gestational diabetes | ◯ Yes ◯ No |
| c. Placental abnormalities | ◯ Yes ◯ No |
| d. Bleeding during pregnancy after first trimester | ◯ Yes ◯ No |
| e. Severe anaemia in pregnancy (haemoglobin level of less than 8mg/dl) | ◯ Yes ◯ No |
| f. Fatty liver due to pregnancy | ◯ Yes ◯ No |
| g. Cervical incompetence or weakness of the cervix | ◯ Yes ◯ No |
| h. Repeated urinary tract infection or infection of the womb | ◯ Yes ◯ No |
| i. Premature uterine contractions | ◯ Yes ◯ No |
| j. Pre-term labour (i.e. before 32 weeks), still birth or premature birth (before 37 weeks) | ◯ Yes ◯ No |
| k. Hospitalisation during pregnancy | ◯ Yes ◯ No |
| l. Late miscarriage after first trimester | ◯ Yes ◯ No |
| m. Excess, under or declining weight | ◯ Yes ◯ No |
| n. Other infections during pregnancy such as hepatitis, influenza, zika, rubella | ◯ Yes ◯ No |
| o. Any pregnancy complications, infections or abnormalities not mentioned above | ◯ Yes ◯ No |

| | Insured |
|---|---|
| 8. Have you ever had or been told that you have or been told to seek treatment or treated for any of the following medical condition or symptoms? | |
| a. Epilepsy, depression or any other mental disorder, stroke | ◯ Yes ◯ No |
| b. Hypertension or high blood pressure, heart disease, cardiomyopathy, heart valve disease, congenital heart disease or any other heart disorder | ◯ Yes ◯ No |
| c. Diabetes, impaired fasting glucose, thyroid disorders | ◯ Yes ◯ No |
| d. Hepatitis or liver disorder | ◯ Yes ◯ No |
| e. Kidney disease | ◯ Yes ◯ No |
| f. Anaemia or other blood disorder | ◯ Yes ◯ No |
| g. Cancer or tumour | ◯ Yes ◯ No |
| h. Asthma | ◯ Yes ◯ No |
| i. Any other illness, disorder, symptoms, operation, treatment, physical disability, accident, injury or hospitalization not mentioned above | ◯ Yes ◯ No |
| 9. Have you had or received any treatment for or plan to be treated for any disease or disorder of the cervix uteri, uterus or ovaries, including ovarian cysts and fibroids? | ◯ Yes ◯ No |
| 10. Have you had a test or investigation such as blood, urine, ultrasound, CT scan, biopsy, Pap smear that you were told was abnormal or required further investigation or follow-up? | ◯ Yes ◯ No |
| 11. Have you been told or have you ever had any test showing any abnormality of the foetus such as foetal size in relation to gestational age, foetal position/presentation, foetal heart rate, foetal movement, intrauterine growth retardation, Down's Syndrome, or any other congenital abnormality? | ◯ Yes ◯ No |
| 12. Have you ever given birth to a child with birth defect, congenital abnormality or hereditary medical condition such as but not limited to Down's Syndrome, structural heart defects, brain and spinal cord disorder, cleft palate or lip? | ◯ Yes ◯ No |
| 13. Have you been advised by a medical doctor not to conceive? | ◯ Yes ◯ No |
| 14. Have you, or has the biological father of the foetus, or have any immediate family members of you or the biological father of the foetus been diagnosed with Thalassaemia, polycystic kidney disease, Duchenne muscular dystrophy, Haemophilia A, Huntington's disease or any other congenital or chromosomal abnormality? | ◯ Yes ◯ No |

15. Please provide the name and address of your gynaecologist.

| Name | Address | Date of your last follow-up |
|---|---|---|
| | | |

If you answered "Yes" to any of the above questions (4 to 14), 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. | Insured |
|---|---|
| | |

**Appendix – Defined Terms**

Note: These are selected summaries of defined terms provided to assist you with the completion of a FATCA and CRS self-certification form. Further details can be found within the OECD "Common Reporting Standard for Automatic Exchange of Financial Account Information" (the "CRS"), the associated "Commentary" to the CRS, and domestic guidance. This can be found at the OECD automatic exchange of information portal.

| Term | Description |
|---|---|
| Account Holder | The term "Account Holder" means the person listed or identified as the holder of a Financial Account. A person, other than a financial institution, holding a Financial Account for the benefit of another person as an agent, a custodian, a nominee, a signatory, an investment advisor, an intermediary, or as a legal guardian, is not treated as the Account Holder. In these circumstances, that other person is the Account Holder. For example, in the case of a parent/child relationship where the parent is acting as a legal guardian, the child is regarded as the Account Holder. With respect to a jointly held account, each joint holder is treated as an Account Holder. An Account Holder for purposes of this self certification may refer to a Proposer (eventually the Policyowner), Controlling Person, Beneficial Owner, Assignee, Trustee, Beneficiary under a Trust or a Trust Nominee named under section 49L of the Singapore Insurance Act (Chapter 142). |
| FATCA | FATCA stands for the U.S. provisions commonly known as the Foreign Account Tax Compliance Act, which were enacted into U.S. law as part of the Hiring Incentives to Restore Employment (HIRE) Act on March 18, 2010. FATCA creates a new information reporting and withholding regime for payments made to certain non-U.S. financial institutions and other non-U.S. entities. |
| Financial Account | A Financial Account is an account maintained by a Financial Institution and includes: Depository Accounts; Custodial Accounts; Equity and debt interest in certain Investment Entities; Cash Value Insurance Contracts; and Annuity Contracts. |
| Participating Jurisdiction | A Participating Jurisdiction means a jurisdiction with which an agreement is in place pursuant to which it will provide the information required on the automatic exchange of financial account information set out in the Common Reporting Standard and that is identified in a published list. |
| Entity | The term "Entity" means a legal person or a legal arrangement, such as a corporation, organisation, partnership, trust or foundation. |
| Control | Control over an Entity is generally exercised by the natural person(s) who ultimately has a controlling ownership interest (typically on the basis of a certain percentage (e.g. 25%) in the Entity. Where no natural person(s) exercises control through ownership interests, the Controlling Person(s) of the Entity will be the natural person(s) who exercises control of the Entity through other means. Where no natural person or persons are identified as exercising control of the Entity through ownership interests, the Controlling Person of the Entity is deemed to be the natural person who holds the position of senior managing official. |
| Controlling Person(s) | Controlling Persons are the natural person(s) who exercise control over an entity. Where that entity is treated as a Passive Non-Financial Entity ("Passive NFE") then a Financial Institution is required to determine whether or not these Controlling Persons are Reportable Persons. This definition corresponds to the term "beneficial owner" described in Recommendation 10 and the Interpretative Note on Recommendation 10 of the Financial Action Task Force Recommendations (as adopted in February 2012). In the case of a trust, the Controlling Person(s) are the settlor(s), the trustee(s), the protector(s) (if any), the beneficiary(ies) or class(es) of beneficiaries, or any other natural person(s) exercising ultimate effective control over the trust (including through a chain of control or ownership). Under the CRS the settlor(s), the trustee(s), the protector(s) (if any), and the beneficiary(ies) or class(es) of beneficiaries, are always treated as Controlling Persons of a trust, regardless of whether or not any of them exercises control over the activities of the trust. Where the settlor(s) of a trust is an Entity then the CRS requires Financial Institutions to also identify the Controlling Persons of the settlor(s) and when required report them as Controlling Persons of the trust. In the case of a legal arrangement other than a trust, "Controlling Person(s) means persons in equivalent or similar positions. |
| Reportable Account | The term "Reportable Account" means an account held by one or more Reportable Persons or by a Passive NFE with one or more Controlling Persons that is a Reportable Person. |
| Reportable Jurisdiction | A Reportable Jurisdiction is a jurisdiction with which an obligation to provide financial account information is in place and that is identified in a published list. |
| Reportable Person | A Reportable Person is an individual (or entity) that is tax resident in a Reportable Jurisdiction under the laws of that jurisdiction. The Account Holder will normally be the "Reportable Person"; however, in the case of an Account Holder that is a Passive NFE, a Reportable Person also includes any Controlling Persons who are tax resident in a Reportable Jurisdiction. Dual resident individuals may rely on the tiebreaker rules contained in tax conventions (if applicable) to solve cases of double residence for purposes of determining their residence for tax purposes. |
| TIN (including "functional equivalent") | The term "TIN" means Tax Identification Number or a functional equivalent in the absence of a TIN. A TIN is a unique combination of letters or numbers assigned by a jurisdiction to an individual or an Entity and used to identify the individual or Entity for the purposes of administering the tax laws of such jurisdiction. Further details of acceptable TINs can be found at the OECD automatic exchange of information portal. Some jurisdictions do not issue a TIN. However, these jurisdictions often utilize some other high integrity number with an equivalent level of identification (a "functional equivalent"). Examples of that type of number include, for individuals, a social security/insurance number, citizen/personal identification/service code/number, and resident registration number. |

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**NTUC Income Insurance Co-operative Limited**
Income Centre 75 Bras Basah Road Singapore 189557
Tel: 6788 1777 · Fax: 6338 1500
Email: csquery@income.com.sg · Website: www.income.com.sg
an NTUC Social Enterprise

# GIRO APPLICATION FORM

## FOR COMPLETION BY APPLICANT AND THIS INFORMATION IS ONLY FOR INSURANCE COMPANY'S USE

| | |
|---|---|
| Date: | Name of Insurance Company:<br>**NTUC INCOME INSURANCE COOPERATIVE LIMITED** |
| To: Name of Bank | Policyholder's Name: |
| Policy Number/Reference: | NRIC/Passport No: |

a) I/We instruct you to process the above Insurance Company's instruction to debit my /our account.
b) You are entitled to reject the Insurance Company's debit instruction if my/our account does not have sufficient funds and charge me/us a fee for this. You may also at your discretion allow the debit even if this results in an overdraft on the account and impose charges accordingly.
c) This authorisation will remain in force until terminated by your written notice send to my /our last address known to you or upon receipt of my /our written revocation through the Insurance Company.

| | |
|---|---|
| Bank Accountholder's Name : _____<br>Bank Accountholder's NRIC : _____ | Telephone No : _____ Office : _____<br>Handphone : _____ Home : _____ |
| Bank Account Number<br>☐☐☐☐☐☐☐☐☐☐☐☐ | Signature/Thumbprint*/Company Stamp:<br>_____<br>(As in Bank's record)<br>* For thumbprint, please go to any branch of your bank with identification document for verification |

Note: a) Please provide all information/bank account details as per the bank's record correctly to avoid delay in approval.
b) If your premium should alter due to changes in policy contractual terms, the amount deducted will be changed accordingly.

## FOR NTUC INCOME INSURANCE COOPERATIVE LIMITED'S COMPLETION

| Bank | Branch | NTUC Income Insurance Co-operative Limited Bank Account No. |
|---|---|---|
| 7171 | 001 | 0010011219 |

| Bank | Branch | Account No. To be Debited |
|---|---|---|
| | | |

| NTUC Income Insurance Co-operative Limited Customer's Billing Reference |
|---|
| |

## FOR FINANCIAL INSTITUTION'S COMPLETION

To: NTUC INCOME INSURANCE COOPERATIVE LIMITED
75 Bras Basah Road, Income Centre, Singapore 189557

This application is hereby REJECTED (please tick) for the following reason(s):

- ☐ Signature/Thumbprint# differs from financial institution's record
- ☐ Signature/Thumbprint# incomplete/unclear#
- ☐ Account operated by signature/thumbprint#
- ☐ Wrong account number
- ☐ Amendments not countersigned by customer
- ☐ Others: _____

| Name of Bank Officer | Signature of Bank Officer | Date |
|---|---|---|

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