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Co. Reg No. 196900406D
GST Reg No. M2-0009922-2

redefining / insurance

Application Form

SmartCare Optimum

A. Know Your Client

Confidential Fact Find for	By your Insurance Advisor	
(Client's Name)	(Name of Advisor)	(Account Code)

Important Notice to Clients

For General Agents/Banks

Your insurance advisor is a representative with **AXA Insurance** and can advise you on the products of:
1) AXA Insurance Singapore Pte Ltd 2)_____ 3)_____

For Insurance Brokers/Financial Advisers/Banks

Your insurance advisory is a broker with _____.
As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he/she sources the products.

Standard Statement Applicable to All Advisors:

Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given.

A policy purchased without the proper completion of a "Know Your Client" form may not be appropriate to your needs.

Application Type

Client's Choice

1. ❑ I/We wish to disclose all information requested for in this Form. (Please complete and sign "Know Your Client" and all sections of "Our Advice and Reasons Why")
2. ❑ I/We wish to receive product advice only. (Please complete and sign "Know Your Client" and sections 2 & 3 of "Our Advice and Reasons Why")
3. ❑ I/We do not wish to receive any advice from my/our advisor. (Please complete and sign "Know Your Client")

I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.

Advisor's Declaration:

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

_____ _____

Signature of Client (on behalf of all applicants) Signature of Advisor
Date: Date:

B. Our Advice and Reasons Why

Section 1 – Analysis and Calculation Worksheet

(a) Personal Priorities (Please tick)

Your Health Insurance Concerns	Level of Concerns		
	Low	Medium	High
Cover for hospitalisation expenses	o	o	o
Cover for outpatient medical expenses	o	o	o
Cover for major illnesses (e.g. cancer, kidney dialysis)	o	o	o
Cover for loss of income due to illness or sickness	o	o	o

(b) Medical Expenses (also known as Hospital / Surgical Expenses)

(i) Which type of hospital do you or your family members prefer in the event of hospitalisation? **Private / Public***

(ii) What type of hospital ward do you or your family members prefer in the event of hospitalisation? **1 / 2 / 4 / 6 bedded***

(iii) Do you have an existing hospitalisation insurance plan? **Yes / No***

(iv) Is your existing policy an Individual policy or Group Employee Benefits policy? **Individual / Group***

Section 2 – Advisor Analysis and Recommendations

Total Health Insurance Budget: _____ per year

Advisor's recommendations	Reasons for recommendations	Remarks
Hospital/Surgical Expense Protection o **Smart***Care Optimum*		**Replacement Y/N***

Note: If this product is intended to replace any existing health insurance policy, advisor should state the reasons for recommending a replacement.

Section 3 – Acknowledgement

Client's Declaration:

I/We understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I/we **agree / do not agree*** with the proposed recommendation(s).

If I/we should decide to switch from one health insurance product to another health insurance product, I/we understand that:

(a) I/We may not be insurable at standard terms

(b) I/We may have to pay a different premium

(c) Terms and conditions may defer **(*Circle as appropriate.)**

Statement by Advisor:

The recommendations in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the "Know Your Client" Form.

Signature of Client (on behalf of all applicants)
Date:

Signature of Advisor
Date:

C. Declaration For Product Summary

I hereby confirm that the following documents were given and the contents have been explained to me satisfactorily;

(a) Your Guide to Health Insurance and;

(b) Product Summary

Signature of Client (on behalf of all applicants)
Date:

Signature of Advisor
Date:

For Office Use Only – INTERNAL

I understand that the recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I **agree / do not agree*** with the proposed recommendation(s).

Comments (necessary if in disagreement with recommendation):			
Remedial Action			
Signature	Name	Position	Date

D. Application Details

Important Notes

1. Under Section 25(5) of the Insurance Act Cap 142 or any subsequent amendment thereof, you are to disclose in this Application form, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued may be void.
2. Please complete this form by answering carefully all questions. It is important that a complete answer be given to every question including dates where applicable in order to avoid unnecessary delay in the processing of this application. Any question not answered on this form will be taken as an answer in the negative. Please complete in BLOCK LETTERS and tick the appropriate boxes.

Part I – Particulars of Person to be Insured

Surname ❑ Mr ❑ Ms ❑ Mrs ❑ Mdm ❑ Dr			Given name	
NRIC No. / FIN	Nationality		Marital Status	Age Next Birthday
Date of Birth (ddmmyyyy)	Height (m)	Weight (kg)	Gender: ❑ Male ❑ Female	Smoker: ❑ Yes / ❑ No No. of sticks / day: Yrs of smoking:
Mailing Address				Postal code
Have you been in Singapore for more than 182 days at the time of application? ❑ Yes ❑ No				
Tel (H)		(O)		(Mobile / Pager)
Email			Occupation/Profession/Job nature	

Part II – Particulars of Family Members to be Insured

Full name	NRIC / FIN / BC No.	Date of birth (ddmmyyyy)	Gender	Height (m)	Weight (kg)	Smoker (Y/N)
Spouse						
Child 1						
Child 2						
Child 3						

Occupation/Profession of Spouse: _____ For Smoker only - No. of sticks/day: _____ Yrs of smoking: _____

Note: Proposal for children must include at least one parent (If more space is required, please write on separate sheet of paper and attach herewith).

Part III – Details of Employer

Please complete this section ONLY if policy is to be issued to your employer.

Name of Employer: _____

Address of Employer: _____

Nature of Employer's Business: _____

Is your Employer a GST registered company? ❑ Yes ❑ No If yes, what is the GST Registration no? _____

Part IV – Details of Insurance (Please tick the appropriate box)

PERIOD OF INSURANCE	From (ddmmyyyy) ☐☐☐☐☐☐☐☐	To (ddmmyyyy) ☐☐☐☐☐☐☐☐	
HOSPITAL PLAN:	❑ Elite Plan	❑ Deluxe Plan	❑ Classic Plan
OUTPATIENT RIDER:	❑ Plan A	❑ Plan B	Bank Name/Branch: _____ Bank Account No.: _____
ANNUAL PREMIUM DUE (inclusive of GST): S$			

Part V – Individual Take Over

(Applicable only if the applicants are currently insured under an individual Health insurance plan with other insurance company in Singapore. Please provide a copy of your renewal invitation and previous policy documents including terms and conditions of the policy contract.)

	Yes	No
1. Has any one of the applicants had treatment in hospital or consulted a specialist in the last 12 months?	❑	❑
2. Does any of the applicants have any consultation, treatment, investigation or test planned or pending (this applies whether it is to be provided by a Specialist or General Practitioner)?	❑	❑
3. Has any one of the applicants suffered from any form of heart disease, renal failure, cancer, diabetes, any alcohol or drug problems or mental illness including depression?	❑	❑

If all the above answer is NO, please skip "Part VI – Questionnaire". Please complete "Part VI - Questionnaire" if any of the above answer is YES.

Part VI – Questionnaire

	Yes	No
1. Has any one of the applicants ever had any physical defects or infirmity?	❑	❑
2. Has any one of the applicants ever,		
(a) had a surgical operation?	❑	❑
(b) been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed?	❑	❑
3. Has any one of the applicants ever had or been told to have, or currently undergoing any medical treatment for, ever been treated for, under observation for,		
(a) any nervous or mental disorders (e.g. epilepsy/fits, prolonged headache or depression)?	❑	❑
(b) any lung trouble, eg. asthma, bronchitis?	❑	❑
(c) any heart trouble, stroke or circulatory disease?	❑	❑
(d) any stomach, bowel, kidney, liver or bladder trouble?	❑	❑
(e) any form of rheumatism, arthritis or back trouble?	❑	❑
(f) any enlarge glands or any form of cancer, tumor or disorder of the blood?	❑	❑
(g) any condition requiring treatment, eg. raised blood pressure, diabetes or used drugs for any other reason?	❑	❑
(h) any medical or surgical advice or treatment other than those already stated?	❑	❑
(i) any alcohol or drug problems?	❑	❑
4. Has any one of the applicants during the past 5 years, had any treatment, examination or advice for a complaint by a physician or other medical practitioners, at a clinic, hospital, dispensary, or sanitorium?	❑	❑

5. If the answer to any of the above questions is YES, please provide details below. If surgery is undertaken, please provide name/nature of surgical procedure. (If more space is required, please write on a separate sheet of paper and attach herewith.)

Name of Person	Nature of Illness/ Disability	Date & Duration of Disability	Type & Result of Treatment/Surgery	Name & Address of Doctor, Clinic/Hospital

	Yes	No
6. Has any one of the applicants ever,		
(a) had an Accident or Health insurance policy cancelled or its renewal refused?	❑	❑
(b) had a Life, Accident or Health insurance policy declined, postponed, withdrawn or subject to special terms and conditions?	❑	❑
(c) made a claim against any Insurer in respect of bodily injury or sickness?	❑	❑
If the answer to any of the questions is YES, please give details: _____		
7. Has any one of the applicants experienced any symptoms but not consulted a medical practitioner in the last 5 years?	❑	❑
If the answer to any of the questions is YES, please give details: _____		
8. Is there any known or foreseeable need to consult any doctor or other health professional?	❑	❑
If YES, please give details: _____		
9. In the last 1 year, has any one of the applicants experienced unexplained weight loss, or recurring symptoms for more than 2 weeks (e.g. giddiness, breathlessness, abnormal growth or enlargement, persistent fever, diarrhea, bodily discomfort or pain?)	❑	❑
If YES, please give details: _____		

10. When did you including your dependents last consult a doctor for any illness?

Name of Person	Nature of Illness/Disability	Date of Last Visit	Type & Result of Treatment received	Date of follow up (if any)	Name & Address of Doctor, Clinic/Hospital

Part VII – Raised Blood Pressure / Hyperlipidaemia (high cholesterol)

Applicable only to applicants who have ever had or been told to have, or currently undergoing any medical treatment for, ever been treated for, under observation for, Raised Blood Pressure/ Hyperlipidaemia (high cholesterol).

1. Please provide the latest blood pressure and cholesterol reading and date.

   (If more space is required, please write on a separate sheet of paper and attach herewith.)

A. Raised Blood Pressure

Name of Person	Systolic & Diastolic Reading	Date of Reading	Are you receiving medical treatment for Raised Blood Pressure?	Has your Raised Blood Pressure been managed and under the control* of a medical practitioner for at least twelve months?
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

* By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Raised Blood Pressure.

B. Hyperlipidaemia (high cholesterol)

Name of Person	Total Cholesterol Level (Tchol)	Date of Reading	Are you receiving medical treatment for Hyperlipidaemia (high cholesterol)?	Has your Hyperlipidaemia (high cholesterol) been managed and under the control* of a medical practitioner for at least twelve months?
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

* By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Hyperlipidaemia (high cholesterol).

2. Please provide name and address of the treating doctor and clinic.

Part VIII – Personal Data

I confirm that the information I have provided is my personal data and, where it is not my personal data, that I have the consent of the owner of such personal data to provide such information.

By providing this information, I understand and give my consent for AXA Insurance Singapore and AXA Life Insurance Singapore (collectively "AXA") and their respective representatives or agents to:

a. Collect, use, store, transfer and/ or disclose the information, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore) for the purpose of enabling AXA to provide me with services required of an insurance provider, including the evaluating, processing, administering and/ or managing of my relationship and policy(ies) with AXA, and for the purposes set out in AXA's Data Use Statement which can be found at http://www.axa.com.sg ("Purposes").

b. Collect, use, store, transfer and/ or disclose personal data about me and those whose personal data I have provided from sources other than myself for the Purposes.

c. Contact me to share with me information about products and services from AXA that may be of interest to me by post and e-mail and

☐ By telephone ☐ By fax ☐ By text message

Part IX – Declaration

1. I/We declare that the above answers are full, complete and true and agree that they shall form part of my/our application which shall be the basis of the contract of insurance.
2. I/We understand that this Policy shall only be effective following full annual premium payment and subject to the acceptance and approval of this application by AXA Insurance Singapore.
3. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
4. I/We also agree that in case of any claims, I/we authorise any hospital, physician or other person who has attended to us, or examined us or is authorised to maintain medical records to disclose when requested to do so by AXA Insurance Singapore, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorisation shall be considered as effective and valid as the original.
5. I/We also understand that membership cards issued for the policy are to be used only for admissions to hospitals for treatments falling under the scope of the policy and in the event the charges incurred are not claimable from the policy for any reason, I/we shall undertake to pay AXA Insurance Singapore within 30 days from the receipt of all expenses that are not claimable under the policy including the interest, if any levied by the hospital. I/We further agree to sign the MediSave Authorisation form at the hospital notwithstanding the production of the membership card. I/We also agree to return the membership card upon request from AXA Insurance Singapore or on termination of the policy.
6. I/We understand that AXA Insurance Singapore reserves the right to request for a copy of the latest medical report from me/us at my/our own expense should further medical information be required.

Signature of Client (for and on behalf of all applicants to be insured)	Name of Client	Date (ddmmyyyy)

Part X – Payment Method

❑ CHEQUE – Crossed and made payable to AXA Insurance Singapore Pte Ltd.

Bank: _____ Cheque Number: _____

❑ CREDIT CARD

Choose only ONE payment mode

Single Deduction

❑ AMEX ❑ DINERS

❑ MASTERCARD ❑ VISA

Issuing Bank: _____

0% Interest Free Installment Plan[1]
(Applicable for Visa and MasterCard Only)

❑ OCBC ❑ DBS ❑ POSB ❑ UOB

Installment Period

❑ 6 Months ❑ 12 Months

Cardholder's Name: _____

State Relationship (where cardholder is not the Insured)[2]: _____

Card No.: | | | | | | | | | | | | | | | | Expiry date: M M Y Y Y Y Card Verification Value Code (CVV)[3]: | | | |

Cardholder's Signature: _____ Contact No: _____ Date: _____

1 Only for participating Banks and subject to their Card Agreement Terms & Conditions. Minimum premium of S$200 is required for OCBC and S$500 for DBS/POSB/UOB.

2 Your security is our concern. If cardholder is not the Insured nor the insured's spouse, parent, parent-in-law, child or sibling, AXA Insurance reserves the right to reject payment via credit card.

3 CVV2 - For Visa & MasterCard, CVV is the last 3-digit no. printed just above the signature panel in reverse italics on the back of your card. For AMEX, it is the 4-digit no. printed on the front of the card above the card number.

E. Product Summary for **Smart***Care Optimum*

PRODUCT INFORMATION

This is an annual hospital & surgical plan that helps to relieve the financial burden of the family while you or your covered family member is hospitalised. We will pay expenses according to the benefits set out in the Benefits Schedule, depending on the plan you have chosen.

Smart*Care Optimum* **Plan**	**Elite**	**Deluxe**	**Classic**
Annual Policy Limit Applicable to All Benefits	1,000,000	500,000	250,000
Hospital & Surgical Benefits			
Bed Type (Standard)	Single	Single	Single
Room & Board Includes meals & general nursing care	As-charged	As-charged	As-charged
Intensive Care Unit			
Hospital Miscellaneous Expenses Includes Prescription drugs, Inpatient Diagnostic Procedures, Operating Theatre Fees & Ancillary Charges			
Inpatient Physiotherapy			
Ambulance Services			
Surgeon's Fee Includes Inpatient Surgery & Day Surgery			
Anesthetist's Fee			
In-Hospital Physician's Visit			
Pre-Hospitalisation/ Surgery Specialist's Consultation Up to 90 days			
Pre-Hospitalisation/ Surgery Diagnostic Services Up to 90 days			
Post-Hospitalisation/ Surgery Treatment Up to 90 days			
Outpatient Treatment Due to accident only			
Outpatient Benefits Per Year			
Outpatient Cancer Treatment	150,000	100,000	75,000
Outpatient Kidney Dialysis	150,000	100,000	75,000
Outpatient Dental Treatment Due to accident only	10,000	8,000	5,000
Extended Benefits Per Disability			
Major Organ Transplant	As-charged	As-charged	As-charged
Miscarriage Due to accident only	5,000	4,000	3,000
Ectopic Pregnancy	5,000	4,000	3,000
Surgical Implants	10,000	8,000	5,000
Medical Report Fees	As-charged	As-charged	As-charged
Daily Recovery Benefits After 7 days of hospitalisation, up to 30 days	250	200	150
Dread Disease Recuperation Benefit Multiple Sclerosis, Heart Attack, Cancer & Stroke	20,000	15,000	10,000
Special Grant	10,000	8,000	5,000
Bonus Benefits			
Parent Accommodation Up to 60 days per year for child below age 12	As-charged	As-charged	As-charged
Home Nursing Up to 26 weeks			
Emergency Medical Evacuation / Repatriation*	Unlimited	Unlimited	Unlimited
Repatriation of Mortal Remain or Local Burial*			

*The above benefits are not subject to annual policy limits.

Please note:

(a) Special Grant benefit is payable upon death due to

(i) injury;

(ii) illness during or after treatment for such illness, at a Hospital or in Day Surgery;

(iii) critical illness

ANNUAL PREMIUM RATE TABLE (INCLUSIVE OF GST)

The basic annual premium rates for this plan are set out below and all rates are subjected to change without prior notice. The basic annual premium is based on the insured's age next birthday and the applicable rates at the time of renewal. All benefits and premiums shown are in Singapore Dollars and are inclusive of GST. The plan will terminate immediately following the 80th birthday of the Insured.

Age	Elite	Deluxe	Classic
1	$750	$675	$555
2	$768	$678	$559
3	$773	$680	$562
4	$779	$683	$566
5	$784	$687	$570
6	$790	$688	$572
7	$795	$691	$575
8	$800	$694	$579
9	$805	$697	$582
10	$812	$700	$585
11	$817	$705	$587
12	$822	$708	$589
13	$827	$711	$592
14	$838	$715	$597
15	$849	$719	$602
16	$860	$725	$606
17	$870	$730	$611
18	$887	$735	$622
19	$898	$741	$633
20	$908	$747	$644
21	$920	$752	$654
22	$930	$757	$664
23	$946	$762	$672
24	$958	$768	$679
25	$960	$777	$687
26	$968	$785	$694
27	$970	$794	$700
28	$982	$805	$708
29	$997	$822	$714
30	$1,019	$849	$735
31	$1,024	$865	$752
32	$1,046	$887	$768
33	$1,072	$908	$784
34	$1,098	$930	$800
35	$1,118	$951	$817
36	$1,144	$968	$833
37	$1,171	$984	$849
38	$1,210	$1,006	$870
39	$1,250	$1,044	$908
40	$1,270	$1,087	$944

Age	Elite	Deluxe	Classic
41	$1,300	$1,119	$972
42	$1,350	$1,158	$999
43	$1,380	$1,212	$1,036
44	$1,400	$1,256	$1,064
45	$1,458	$1,300	$1,097
46	$1,528	$1,345	$1,141
47	$1,600	$1,402	$1,196
48	$1,676	$1,457	$1,240
49	$1,753	$1,513	$1,285
50	$1,848	$1,600	$1,370
51	$1,942	$1,673	$1,420
52	$2,038	$1,729	$1,488
53	$2,132	$1,773	$1,561
54	$2,238	$1,847	$1,671
55	$2,364	$1,926	$1,728
56	$2,482	$2,016	$1,813
57	$2,613	$2,127	$1,944
58	$2,718	$2,247	$2,047
59	$2,875	$2,401	$2,172
60	$3,016	$2,630	$2,356
61	$3,224	$2,789	$2,507
62	$3,381	$3,017	$2,655
63	$3,519	$3,301	$2,806
64	$3,675	$3,512	$2,916
65	$3,830	$3,739	$3,039
66	$3,985	$3,958	$3,157
67	$4,120	$4,128	$3,271
68	$4,300	$4,289	$3,399
69	$4,481	$4,469	$3,540
70	$4,687	$4,660	$3,704
71	$4,996	$4,940	$3,948
72	$5,305	$5,277	$4,192
73	$5,820	$5,726	$4,599
74	$6,438	$6,343	$5,087
75	$7,210	$6,875	$5,452
76	$7,622	$7,234	$5,793
77	$7,880	$7,465	$6,001
78	$8,034	$7,619	$6,111
79	$8,137	$7,722	$6,185
80	$8,137	$7,722	$6,185

KEY PRODUCT PROVISIONS

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are required to refer to the actual terms and conditions in the contract. Please consult your Insurance advisor should you require further explanation.

1. Waiting Period

(a) No benefits will be payable for any illness which commences within thirty (30) days of the commencement date of the Policy or from the time an Insured is first Covered under the Policy. (This does not apply to accidental injuries).

(b) No benefits will be payable under Dread Disease Recuperation Section for Cancer, Stroke, Heart Attack and Multiple Sclerosis within ninety (90) days from the commencement date of the Policy or from the time and Insured Person is first Covered under the Policy.

2. Exclusions

There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. The exclusions for this plan, include, but are not limited to, the following conditions.
You are advised to read the policy contract for the full list of exclusions.

(a) Pre-existing conditions, which refers to an injury or an illness which, prior to the date on which an Insured Person is first Covered under the Policy:

(i) existed (or symptoms or manifestations of which existed) with respect to an Insured Person based on normal medically accepted pathologist development of the injury or illness; or

(ii) the Insured Person was aware or should reasonably have been aware irrespective of whether treatment was actually received.

(b) Congenital conditions, which refers to congenital anomalies as well as neo-natal physical abnormalities developing within six (6) months of birth.

3. Policy Renewal / Renewal Premium

(a) This is a yearly renewable Policy. On or before the expiry of your Policy, and subject to our acceptance, you may renew this Policy by paying the premium applicable at the time of renewal. This shall not apply in the event that the Policy expires, or is terminated or cancelled in accordance with terms of this Policy and you should subsequently wish to reapply for insurance cover under this Policy.

(b) Premium rates are not guaranteed and the premium payable at renewal shall be determined at each renewal based on the Insured Persons' Age Next Birthday, the premium rates then in effect, and any other factors which may materially affect the risk insured.

4. Cancellation Clause

We have the right to terminate this Policy at any time by giving you at least thirty (30) days' written notice of such termination and upon such termination you will be granted a pro-rated refund of the total premium paid corresponding to the unexpired Period of Insurance provided that no claims have been made during the Period of Insurance.

5. Changes in Circumstances

If there is any change in circumstances affecting the risk, the Insured must give the Company immediate written notice. In particular, the Insured must notify the Company of any changes in occupation/business or health.

6. Country of Residence

In the event the Insured intends to remain outside Singapore for more than ninety (90) days, the Insured shall notify the Company in writing prior to the departure. The Company will advise the Insured as to whether the Insured will be covered while outside Singapore, and the Company's terms and conditions for extending such cover.

7. Reasonable & Customary Charges

The benefits payable under this plan shall be the lower of the actual charge incurred or the Reasonable and Customary Charges. This is defined as the charges for medical treatment which do not exceed the general level of fees and charges made by others similar professional standing in the same locality where the charges are incurred, when furnishing like or comparable treatment, services or supplies for a similar illness or injury and which in accordance with accepted medical standards, could not have been omitted without adversely affecting the Insured Person's medical condition.

8. Free look period

You have a free-look period of 14 business days from the date that you receive this Policy to review it. You are deemed to have received the Policy within 3 days after we have dispatched it. If you decide that this Policy does not suit your needs, you may request to cancel it by giving us clear, written instructions and returning the Policy documents to us within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you in full without interest. This free-look period shall not apply to policies with terms of less than 1 year. It will also not apply to policy renewals.

9. Distribution cost

Details of any distribution costs, charges and expenses will be made available upon your request.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).