redefining / insurance

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Application Form

*Smart*Care Executive

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 adviser 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 Reason 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 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 Executive*		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)	Signature of Advisor
Date:	Date:

C. Declaration For Products 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)	Signature of Advisor
Date:	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: _____

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

PERIOD OF INSURANCE From (ddmmyyyy) |_|_|_|_|_|_|_|_| To (ddmmyyyy) |_|_|_|_|_|_|_|_|

CHOICE OF PLAN & OPTIONAL DEDUCTIBLE &/OR CO-PAYMENT

Private Hospital Plan			Public Hospital Plan		
❑ Plan A	❑ Plan B	❑ Plan C	❑ Plan D	❑ Plan E	❑ Plan F
Premium Discount	**Deductible**	**Co-payment**	**Premium Discount**	**Deductible**	**Co-payment**
❑ 10%	S$0	10%	❑ 10%	S$0	10%
❑ 30%	S$2,000	0%	❑ 30%	S$1,000	0%
❑ 45%	S$2,000	10%	❑ 40%	S$1,000	10%

Note: The deductible & co-payment apply to Hospital & Surgical Benefits except Emergency Outpatient Treatment (due to accident only) and Major Organ Transplant.

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 treatment 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 persons to be insured) Date (ddmmyyyy)

Part X – Payment Mode

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

Bank: _____ Cheque Number: _____

☐ CREDIT CARD

Choose only ONE payment mode

Single Deduction		**0% Interest Free Installment Plan**[1] (Applicable for Visa and MasterCard Only)			
☐ AMEX	☐ DINERS	☐ OCBC	☐ DBS	☐ POSB	☐ UOB
☐ MASTERCARD	☐ VISA	Installment Period			
Issuing Bank: _____		☐ 6 Months		☐ 12 Months	

Cardholder's name: _____

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

Card No.: | | | | | | | | | | | | | | | | Expiry date: | | | | | Card Verification Value (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] CVV – 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.

Information is correct as at July 2014

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

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 hospitalized. Subject to the full terms and condition, we will pay expenses according to the benefits set out in the benefits schedule, depending on the plan you have chosen.

Benefits Table	**Private Hospital Plan**			**Public Hospital Plan**		
	Plan A	**Plan B**	**Plan C**	**Plan D**	**Plan E**	**Plan F**
ANNUAL LIMIT Applicable to All Benefits (S$)	**70,000**	**55,000**	**40,000**	**70,000**	**40,000**	**25,000**
Hospital and Surgical Benefits (S$)						
Bed Type (Standard Types)	1-Bedded	2-Bedded	4-Bedded	1-Bedded	4-Bedded	6-Bedded
Room & Board Includes meal & general nursing care	**As charged** up to 20,000 Per disability	**As charged** up to 15,000 Per disability	**As charged** up to 10,000 Per disability	**As charged** up to 20,000 Per disability	**As charged** up to 10,000 Per disability	**As charged** up to 5,000 Per disability
Intensive Care Unit						
Hospital Miscellaneous Expenses 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)						
Emergency Outpatient Treatment (due to accident only)						
Outpatient Benefits (S$)						
Outpatient Cancer Treatment Per Year	20,000	15,000	10,000	20,000	10,000	5,000
Outpatient Kidney Dialysis Per Year	20,000	15,000	10,000	20,000	10,000	5,000
Emergency Outpatient Dental Treatment (due to accident only)	2,000	1,500	1,000	2,000	1,500	1,000
Extended Benefits (S$)						
Major Organ Transplant	As charged	As charged	As charged	As charged	As charged	As charged
Miscarriage due to accident Per Occurrence	3,000	2,000	1,000	3,000	2,000	1,000
Ectopic Pregnancy Per Occurrence	3,000	2,000	1,000	3,000	2,000	1,000
Surgical Implants Per Disability	3,000	2,000	1,000	3,000	2,000	1,000
Medical Report Fees	As charged	As charged	As charged	As charged	As charged	As charged
Daily Recovery Benefits Per Day After 7 days of hospitalisation, up to 20 days	200	150	100	200	100	50
Special Grant	5,000	3,000	3,000	5,000	3,000	3,000

Please note:

a) Per Disability shall mean all medical conditions resulting from an Illness or Injury arising from the same cause, including any and all complications arising therefrom or closely related thereto as well as concurrent medical conditions from different causes during the same hospital confinement, except that after fourteen (14) days following the latest discharge from Hospital or Day Surgery, any subsequent Illness or Injury from the same cause shall be considered as a new Illness or Injury.

b) 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

c) Deductible is the amount out of an eligible claim which has to be borne by the Insured Person before the relevant benefits are payable under this Policy.

d) Co-payment is the percentage of the Covered Expenses in excess of any Deductible, which is borne by you.

e) We will pay up to a percentage of the Covered Expenses as per the following Pro-ratio Table if you are treated and/or stay in a different type of:
   - ward; and/or
   - Hospital (i.e. Private Hospital or Public Hospital)

   from that stated on the Schedule or Endorsement.

My Plan is	I am warded in the Standard Room of the Hospital	I will receive ___% of the Covered Expenses
A	Private or Public Hospital 1, 2, 4 or 6-Bedded	100%
B	Private Hospital : 1-bedded Private Hospital : 4-bedded Public Hospital : 1, 4 or 6-bedded	60% 100% 100%
C	Private Hospital : 1-bedded Private Hospital : 2-bedded Public Hospital : 1-bedded Public Hospital : 4 or 6-bedded	50% 60% 60% 100%

My Plan is	I am warded in the Standard Room of the Hospital	I will receive ___% of the Covered Expenses
D	Private Hospital : 1-bedded Private Hospital : 2 or 4-bedded Public Hospital : 4 or 6-bedded	50% 60% 100%
E	Private Hospital : 1, 2 or 4-bedded Public Hospital : 1-bedded Public Hospital : 6-bedded	50% 60% 100%
F	Private Hospital : 1, 2 or 4-bedded Public Hospital : 1 or 4-bedded	50% 60%

ANNUAL PREMIUM RATE TABLE (INCLUSIVE OF GST)

The annual premium rates for this plan are set out below and all rates are subjected to change without prior notice. The 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.

Private Hospital Plan

Age Next Birthday	1-17	18-29	30-39	40-44	45-49	50-54	55-59	60-65	66-69*	70-74*	75-80*
Plan A	334	440	545	619	692	966	1,088	1,528	2,188	3,288	5,046
Plan B	282	366	450	513	577	798	910	1,278	1,823	2,736	3,836
Plan C	240	303	387	440	482	682	757	1,087	1,527	2,187	3,177

Public Hospital Plan**

Age Next Birthday	1-17	18-29	30-39	40-44	45-49	50-54	55-59	60-65	66-69*	70-74*	75-80*
Plan D	261	313	387	471	524	734	878	1,208	1,747	2,715	3,782
Plan E	176	219	271	324	366	513	587	822	1,208	1,884	2,625
Plan F	92	113	134	166	187	261	292	408	586	955	1,318

Please note:

* For renewal only

** Public Hospitals refer to Government and Restructured Hospitals

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 full actual terms and conditions in the contract. Please consult your insurance advisor should you require further explanation.

1. **Waiting Period**
   No benefit will be payable for any illness suffered by an Insured Person that commence within thirty (30) days from the date an Insured Person is first Covered under the Policy except for Injuries sustained during an Accident which occurs after the date an Insured Person is 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 pathological 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) 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 the terms of this Policy and you should subsequently wish to reapply for insurance cover under this Policy.

   (b) The premium rates payable shall be determined at each renewal based on the Insured Persons' Age Next Birthday, the table of premium rates then in effect, and any other factors which may materially affect the risks insured. We reserve the right to change the table of premium rates on a class basis for our Individual **Smart***Care Executive* and all similar policies.
4. **Cancellation Clause**
   We have the right to cancel this Policy in the event that we decide to cease offering our **Smart***Care Executive* Individual plan (i) totally; or (ii) to any particular groups of persons insured with us or proposing to be insured with us. We will give you at least thirty (30) days' written notice of such cancellation and upon such cancellation you will be granted a pro-rated refund of the total premium paid corresponding to the unexpired 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 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 or charges made by others of 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).