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redefining / insurance

Application Form

SmartCare Critical

A. Know Your Client

Confidential Fact Find for	By your Insurance Advisor	
	Pacific Prime Singapore Insurance Agency Pte. Ltd.	11607
(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 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) Critical Illness

	Client	Spouse
(i) What is the lump sum amount required if you or your spouse is diagnosed with a critical illness?	S$ _____	S$ _____
(ii) Do you or your spouse have an existing critical illness insurance plan?	☐ Yes/No*	☐ Yes/No*
(iii) If yes, what is the lump sum benefit payable to you or your spouse on diagnosis of a critical illness?	S$ _____	S$ _____

Section 2 - Advisor Analysis and Recommendations

Total Health Insurance Budget : _____ per year

Advisor's recommendations	*Reasons for recommendations*	*Remarks*
Critical Illness Protection o ***Smart****Care Critical*		*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 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) *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
Tel (H)	(O)		(Mobile/ Pager)	
Email			Occupation/Profession/Job nature	

Part II - Particulars of Spouse to be Insured

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

Occupation/Profession of Spouse: _____

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

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

Insurance to commence: From (ddmmyyyy) | | | | | | | | To (ddmmyyyy) | | | | | | | |

CHOICE OF PLAN (Please tick where applicable)

Main Applicant	❑ Plan A	❑ Plan B	❑ Plan C	❑ Plan D
Spouse	❑ Plan A	❑ Plan B	❑ Plan C	❑ Plan D

ANNUAL PREMIUM DUE (inclusive of GST) : S$

Part V - Payment Method

❑ CHEQUE - Crossed and made payable to **AXA Insurance Singapore Pte Ltd**

Bank: _____ Cheque No.: _____

❑ 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 Plan

❑ 6 months ❑ 12 Months

Cardholder's Name: _____

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

Credit 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.

Part VI - Questionnaire

	MAIN APPLICANT		SPOUSE	
1. Has any one of the Applicants proposed for insurance hereunder suffered from or received medical advice, counselling or treatment or is suffering or receiving medical advice, counselling or treatment, in connection with:	Yes	No	Yes	No
(a) any lung trouble, eg. asthma, bronchitis?	❑	❑	❑	❑
(b) any heart trouble, stroke or circulatory disease?	❑	❑	❑	❑
(c) any stomach, bowel, kidney, liver or bladder trouble?	❑	❑	❑	❑
(d) any form of rheumatism, arthritis or back trouble?	❑	❑	❑	❑
(e) any enlarge glands or any form of cancer, tumor or disorder of the blood?	❑	❑	❑	❑
(f) any condition requiring treatment, eg. raised blood pressure, diabetes or used drugs for any other reason?	❑	❑	❑	❑
(g) any medical or surgical advice or treatment other than those already stated?	❑	❑	❑	❑
2. Has any one of the Applicants proposed for insurance hereunder ever been declined, postponed or accepted on special terms for Life or Critical Illness or Accident or Medical Insurance policy? If "YES", please give details of company(ies) and why?	❑	❑	❑	❑
3. Has either of the Applicant's natural parents or siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If "YES", please provide details of age(s), relationship and cause of death or condition(s).	❑	❑	❑	❑

4. If the answer to any of the above questions 1(a) to (g) in Part VI is "YES", please provide details of Name of Applicant, Nature of disability, Date & Duration of disability, Type & Result of Treatment/Surgery and Name & Address of Doctor/Hospital 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 attached herewith.)

Name of person	Nature of disability	Date & Duration of disability	Type & Result of treatment/surgery	Name & Address of doctor/hospital

5. Please give your family or regular doctor's name, address and telephone number:

_____

Part VII - 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 VIII - 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 declare that all persons proposed for insurance are in good health and are free from any form of physical defect or infirmity.
3. I/We understand that no coverage will be granted due to any illness or condition for which treatment or medication or advice has been sought or received prior to my/our enrolment in the Policy.
4. 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.
5. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
6. 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, 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.
7. I/We understand that AXA Insurance 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.
8. I/We have been given a copy of "Your Guide to Health Insurance" and "Product Summary" and their contents have been explained to my/our satisfaction.

_____ _____

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

E. Product Summary for SmartCare Critical

PRODUCT INFORMATION

This policy will pay the lump sum benefit specified on the Benefits Schedule when the Insured is diagnosed as suffering from any one of the 30 covered Critical Illnesses listed below, as defined in the policy contract. With effect from 01/07/03, the Insurance Industry has adopted common definitions for all critical illnesses. This means that all insurance companies will define each illness covered the same way. Please refer to the policy contract for definitions of the covered Critical Illnesses.

1. *Major Cancers*
2. *Heart Attack*
3. *Stroke*
4. *Coronary Artery By-Pass Surgery*
5. *Kidney Failure*
6. *Aplastic Anaemia*
7. *Blindness (Loss of Sight)*
8. *End Stage Lung Disease*
9. *End Stage Liver Failure*
10. *Coma*
11. *Deafness (Loss of Hearing)*
12. *Heart Valve Surgery*
13. *Loss of Speech*
14. *Major Burns*
15. *Major Organ/Bone Marrow Transplantation*
16. *Multiple Sclerosis*
17. *Muscular Dystrophy*
18. *Paralysis (Loss of Use of Limbs)*
19. *Parkinson's Disease*
20. *Surgery to Aorta*
21. *Alzheimer's Disease/Severe Dementia*
22. *Fulminant Hepatitis*
23. *Motor Neurone Disease*
24. *Primary Pulmonary Hypertension*
25. *Terminal Illness*
26. *HIV Due to Blood Transfusion and Occupationally Acquired HIV*
27. *Benign Brain Tumor*
28. *Encephalitis*
29. *Bacterial Meningitis*
30. *Angioplasty & Other Invasive Treatment for Coronary Artery*

BENEFITS AT A GLANCE (S$)

BENEFITS	PLAN A	PLAN B	PLAN C	PLAN D
A. Diagnosis of any of the 30 covered Critical Illnesses	30,000	50,000	75,000	100,000
B1. Extra Benefit for Female Cancer (Cancer that is of the breast, cervix uteri, uterus, fallopian tube, ovary or vagina/vulva) B2. Extra Benefit for Male Cancer (Cancer that is of the prostate gland, penis or testes)	3,000	5,000	7,500	10,000
C. Daily Hospital Cash Benefit (maximum 60 days per insured person per policy year)	50	100	150	200

Note: Benefits under Section A and Section B1/B2 is payable once during the lifetime of the policy.

PREMIUM RATE TABLE (INCLUSIVE OF GST)

*The annual premium rates for this plan are set out below. Please note that the premium may be revised at each renewal date, based on the profile of all persons insured under the **Smart**Care Critical plan. The annual premium is based on the Insured's age next birthday and the applicable rates at the time of renewal. The plan will terminate at the end of the period of insurance following the 65th birthday of the insured.*

AGE / PLAN	MALE NON-SMOKER				FEMALE NON-SMOKER			
	A	B	C	D	A	B	C	D
18 to 24	169	281	422	562	176	293	439	585
25 to 29	192	321	481	641	206	343	514	685
30 to 34	227	378	566	755	248	414	621	828
35 to 39	293	489	734	978	315	525	788	1,051
40 to 44	398	664	996	1,328	416	694	1,041	1,388
45 to 49	574	957	1,435	1,914	561	935	1,403	1,871
50 to 55	833	1,388	2,081	2,775	752	1,253	1,880	2,506

AGE / PLAN	MALE SMOKER				FEMALE SMOKER			
	A	B	C	D	A	B	C	D
18 to 24	218	363	544	725	208	347	520	694
25 to 29	256	427	641	855	250	416	624	832
30 to 34	314	523	784	1,045	307	511	767	1,023
35 to 39	416	693	1,039	1,385	401	669	1,003	1,337
40 to 44	580	966	1,449	1,933	543	906	1,358	1,811
45 to 49	844	1,406	2,110	2,813	740	1,234	1,851	2,468
50 to 55	1,232	2,053	3,079	4,105	990	1,650	2,475	3,301

Please Note: Upon entering a new age band, the higher rates will apply
Age shall refer to Age Next Birthday
Rates subject to change without prior notice

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 critical 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.

(b) No benefits will be payable for Cancer, Heart Attack and Coronary Artery By-Pass Surgery within (90) days from the commencement date of the Policy or from the time an Insured is first Covered under the Policy.

(c) No benefits will be payable if the Insured dies within 30 days from the day on which the insured is diagnosed as suffering from a Critical Illness.

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.

- Congenital conditions and any physical birth defects arising out of or resulting therefrom.
- All pre-existing conditions unless declared by the Insured Person in the application form and specifically accepted by the Company during underwriting stage and endorsed thereon.
- Suicide or attempted suicide, self-inflicted injuries or any attempt thereat while sane or insane.

3. Terms of renewal

Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

4. Cancellation Clause

The Company reserves the right to terminate coverage, in the event that it decides to cease offering the **Smart**Care Critical plans altogether. At least 30 days' notice in writing of such termination shall be given to the Policyholder. Whenever such cancellation occurs, the Company shall return the unearned portion of the premiums paid. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination.

5. Country of Residence

In the event the Insured intends to remain outside Singapore for more than 180 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.

Information is correct as at June 2014

dna/SC Critical/App/03062014