



Important note: Pursuant to Section 25(5) of the Insurance Act, you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know otherwise the request effected hereunder may be void.

Policy/certificate no.	
Adviser's/wakil's no.	
Adviser's/wakil's name	

Particulars of policyowner/certificate holder

Name of policyowner/certificate holder _____ NRIC no. _____
 Name of life insured/participant (if differ from above) _____ Contact no. _____

Application for:	Revival	Change of benefit	Others: Please specify _____	Payment made with this application
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Part A - Information concerning the child

1. (a) Full name of the child	(a) _____		
(b) How much life insurance is in force or pending on the child's life?	(b) _____		
2. (a) What is the child's present height and weight?	(a) Height _____ (cm) Weight _____ (kg)		
(b) Has the child lost any weight within the last 6 months?	(b) Yes _____ (kg) No _____		
3. Since application date of the above policy/certificate, has the child been declined, postponed, or rated up for life or accident insurance?	Yes No		
4. Has the child ever resided abroad for more than 3 months in the last 3 years?	Yes No		
5. Has the child ever received any medical advice, counselling or treatment in connection with AIDS, AIDS Related Complex or any AIDS related condition, been told the child had any of these or that the child had a positive HIV blood test, or in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	Yes No		
6. To the best of your knowledge and belief, has any member of the child's immediate family ever had tuberculosis, diabetes, heart or mental disease or any AIDS relating condition?	Yes No		
7. Since application date of the above policy/certificate, has the child had any illness, injury or consulted any physician? If yes, please give details.	Yes No		
Date and duration	Diagnosis, symptoms, nature of sickness or accident	Nature and results of any tests done or advised	Name and address of physician or hospital and if appropriate period of hospitalisation

8. If any of the answers to questions 2 through 7 is 'Yes', please give dates and details, including name of the insurance company if appropriate. (Please quote the question no.)

Part B - Information concerning the policyowner/certificate holder (To be used if payor benefit/comprehensive payor benefit is applied)

1. (a) How much life insurance (including accident and critical illness or similar insurance) is in force or pending on your life?	(a)	Life	Accident	Critical Illness
		HSBC Insurance (Singapore) Pte. Limited _____		
(b) What is your present height and weight?	(b)	Height _____ (cm)	Weight _____ (kg)	
(c) Has it changed by more than 3 kgs (6.6lbs) in the past 6 months?	(c)	Yes	Gain / Loss _____ (kg)	No
(d) Are you pregnant (female only)?	(d)	Yes	_____ months	No
2. Since the date of this policy/certificate, have you:				
(a) Changed your occupation or job? If yes, please specify below the occupation, daily duties & employer's name, address & nature of business.				Yes No
(b) Changed your marital status?				Yes No
(c) Been declined, postponed or rated up for life and other supplementary insurance, or involved in military activities, private flying, hazardous sports, races or flying other than a fare-paying passenger in a licensed passenger carrying aircraft?				Yes No
3. (a) Have you in the last 3 years resided for more than one month in any other country than your present country of residence?				Yes No
(b) Have you ever received any medical advice, counselling or treatment in connection with AIDS, AIDS related complex or any other AIDS related condition, been told you had any of these or that you had a positive HIV blood test or in the last 3 months and had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?				Yes No
4. (a) Have either your father, mother or any brother or sister suffered or died from heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, paralysis or epilepsy before age 60? If yes, specify whom, age and give full details with dates and diagnoses				Yes No
(b) In the last 12 months, have you smoked cigarettes? If yes, please specify below how many per day.				Yes No
5. Have you ever suffered from or been treated or investigated for the following:				
(a) Heart disease, stroke, high blood pressure, diabetes, kidney disease, cancer, paralysis, epilepsy or multiple sclerosis?				Yes No
(b) Sugar in the urine, rheumatic fever, lurch disease, ulcer, disorder of the digestive tract, mental or nervous disorder, or any other disease, disorder, defect or injury?				Yes No
6. Since application date of the above policy/certificate, have you (a) been ill, (b) consulted any doctor for any reason, (c) been treated or been advised to take treatment or (d) been absent from work for more than one week on any occasion due to sickness or accident? If yes, please give details below on the date, duration and nature of sickness or accident, the nature and results of any tests done or advised and the name and the address of physician or hospital.				Yes No
Date and duration	Diagnosis, symptoms, nature of sickness or accident	Nature and results of any tests done or advised	Name and address of physician or hospital and if appropriate period of hospitalisation	

7. If any of the answers to questions 2 through 6 is 'Yes', please give dates and details, including names of the insurance company if appropriate. (Please quote the question no.)

Declaration and authorisation

I confirm that the above answers, given by me are full, complete, true and agree that they form part of any policy/certificate issued, revived or amended, where these answers are, or may be, relied upon by the Company. I further agree that such revival, change or addition shall not be considered as effected by reason of any money paid or settlement made in payment of or on account of any premium/contribution, until this policy/certificate shall be duly approved by an authorized officer of the Company. I further agree that if my application for any revival, change or addition be accepted by the Company, the Incontestability and Suicide Provisions thereof shall have effect from the approval date of my application for revival, change or addition.

I further authorise any physician, hospital, clinic or insurance company or other organisations, institutions or persons, that has any records or knowledge of me/my child or my/my child's health, to disclose to HSBC Insurance (Singapore) Pte. Limited or its representatives any and all such information and expressly waive on behalf of myself or any person, who shall have or claim any interest, in any policy/certificate issued hereunder, all provisions of law forbidding any physician or surgeon from disclosing any information acquired while attending my child and me in a professional capacity.

This authorisation shall irrevocably bind my successor and assigns and remain valid, notwithstanding my death or incapacity and a copy of this authorisation shall be as effective and valid as the original.

Dated thisday at 20.....

Signature of life insured/participant
 Name:
 NRIC no:

Signature of policyowner/certificate holder
 (If differ from life insured/participant)
 Name:
 NRIC no:

Note: We will advise you if a medical examination is required under Company's rule.