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www.hsbclife.com.sg
GST Reg No. 199903512M
Co. Reg No. 199903512M

Application Form

SmartCare Executive

A. 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 all questions carefully. 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 Applicant (all fields are compulsory)

Surname ❑ Mr ❑ Ms ❑ Mrs ❑ Mdm ❑ Dr			Given name
NRIC No. / FIN		Nationality	Marital Status
Date of Birth (ddmmyyyy)	Height (m)	Weight (kg)	Gender: ❑ Male ❑ Female
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 I – Particulars of Family Members to be Insured

	Full name	NRIC/ FIN/BC No.	Date of Birth (ddmmyyyy)	Gender	Nationality	Height (m)	Weight (kg)
Spouse							
Child 1							
Child 2							
Child 3							

Occupation/Profession of Spouse: _____

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 d d m m y y y y To d d m m y y y y

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% ❑ 20% ❑ 30%	S$0 S$2,000 S$2,000	10% 0% 10%	❑ 10% ❑ 20% ❑ 30%	S$0 S$1,000 S$1,000	10% 0% 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 – Questionnaire

1. Please provide the name and address of your most frequently visited medical practitioner. Please also indicate when each applicant last visited a doctor for any illness.

	Nature of illness/disability	Date of last visit	Type & Result of Treatment / Surgery	Need for any follow up Treatment / Consultation	Name & Address of Doctor / Clinic / Hospital
Applicant					
Spouse					
Child 1					
Child 2					
Child 3					

2. Most people suffer from at least one of these conditions at some point in their lives. Please indicate if any person is, or has ever been diagnosed, hospitalised, placed under observation, undergone surgical operations or medical treatment, or received medication for any of the conditions below:

	Applicant		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
(a) Brain, nervous system or mental disorders? eg. dementia, migraine, repeated headaches, unconsciousness, epilepsy/fi s, stroke, multiple sclerosis, paralysis, weakness of limbs, nerve pain (including sciatica and shingles), meningitis, nervous breakdown, anxiety, depression, schizophrenia, compulsive or eating disorders, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(b) Lung trouble, breathing or respiratory disorders? eg. shortness of breath, persistent cough, coughing with blood, chest or breathing discomfort, asthma, chronic obstructive pulmonary disease, pneumonia, bronchitis, tuberculosis or allergies (including hay fever and anaphylaxis), etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

(c) Heart trouble, stroke or circulatory disease? eg. high or low blood pressure, high cholesterol, chest pains, aneurysms, varicose veins or deep vein thrombosis, angina, heart attack, heart failure, abnormal heartbeat, heart murmur, mitral valve prolapse or other heart valve disorder, breathlessness, chest discomfort or pain, heart enlargement, coronary artery disease, or ischemic heart disease, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(d) Stomach, intestines, bowel or liver or gall bladder problems? eg. gastro-esophageal reflux dis ase, gastritis, stomach inflamm tion/ulcers, duodenal ulcers, diverticulitis, irritable bowel, crohn's disease, colitis, change in bowel habits, abdominal pain, fi tula, haemorrhoids / piles, rectal bleeding or blood in stools, pancreatitis, Hepatitis B Carrier or any forms of hepatitis, liver inflamm tion, cirrhosis, fatty liver, jaundice, gall stones or hernias, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(e) Arthritic or rheumatological condition or disorder, muscle or skeletal problems? eg. arthritis, slipped discs, spine, back, hip, or knee pain, neck/ shoulder problems, cartilage, joint, ligament or tendon problems, fractures or injuries, osteoporosis, gout or infla - matory conditions, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(f) Blood /infective /immune disorders/ lymphatic disease? eg. abnormal blood tests, anaemia, thalassaemia, blood clotting disorder, hepatitis, HIV, malaria, or advised to abstain from donating blood or receive blood transfusion or blood products on account of haemophilia or any other reason, systemic lupus erythematosus, any other autoimmune disease, or lymphoma, lymphadenitis, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(g) Endocrine (glandular, metabolism) disorders? eg. diabetes (Type 1 or Type 2), thyroid problems, or hormonal problems, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(h) Physical disabilities or impairment? eg. amputations, cerebral palsy, muscular dystrophy, polio syndrome or spina bifida, tc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(i) Eye, ear, nose, throat problems? eg. cataracts, glaucoma, macular degeneration, visual impairment, deafness, otitis, recurrent ear infections, tinnitus, deviated nasal septum, sinus problems, tonsillitis, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(j) Congenital or hereditary condition?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

(k) Drug or alcohol dependency or problems?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(l) Cancer, tumours, growths or pre cancerous conditions or any condition which leads to an increased risk of cancer? eg. polyps, benign growths, breast nodules or cysts, lipomas, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(m) Kidney, Urinary, Bladder disorder? eg. kidney or bladder problems (including kidney failure, protein and blood in the urine), cystitis, recurrent urinary infections (UTI), urinary incontinence, urinary retention, kidney stones, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(n) Skin, fin ernails, toenails, or hair problems, including moles and birthmarks? eg. alopecia, eczema, dermatitis, psoriasis, acne, moles that itch, bleed or have changed in appearance, or allergic conditions; ingrowing toenails; port-wine stains, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(o) Any Prosthetic implants and appliances in the body? eg. shunts, pacemakers, joint replacements, etc.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(p) In the past 5 years, have you or any of dependants mentioned in the application had any test done such as X - ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), endoscopy, blood or urine test? If Yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(q) Have you or any of dependants ever had HIV testing done (please state reason and results) or have you or any of the dependants been told to have, received or waiting for any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(r) For males only: Diseases or disorders of the male reproductive system, genitals or prostate? eg. balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility or infertility, phimosis and prostatitis.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

(s) For Females only: (i) Have you suffered from or are aware of any breast lumps or any other disorder of your breasts, irregular or painful or unusually heavy menstruation, endometriosis, fib oids, cysts, polycystic ovaries, uterine polyps, menopause problems or any other disorder involving the female organs?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(ii) Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(iii) Have you had or been advised to have mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or breasts or any other gynaecological investigations? If Yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(t) Any other illness or abnormalities not mentioned in any of the questions above ? (You do not need to answer "yes" if it is for immunisations or for common seasonal flu acute upper respiratory tract infection where the person has fully recovered)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
3. In the next 12 months, does any any person have any known or foreseeable need to consult a medical practitioner or health professional for a follow up consultation or to undergo further investigation or surgery?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
4. In the last 12 months, has any person experienced unexplained weight loss, or recurring symptoms for 2 or more weeks (eg. giddiness, breathlessness, abnormal growth or enlargement, persistent fever, diarrhoea, bodily discomfort or pain)?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

5. If the answer to any of the above questions is YES, please provide details below. If surgery was undertaken, please provide the name and nature of the procedure. If more space is required, please write on a separate sheet of paper and indicate that you have done so by ticking here. ❑

	Relevant section of previous part	Nature of Illness / Disability	Duration of Illness/Disability		Type & Results of Treatment / Surgery	Need for any follow-up Treatment/ Consultation	Name & Address of Doctor/Clinic/ Hospital
			From (mmyyyy)	To (mmyyyy)			
Applicant							
Spouse							
Child 1							
Child 2							
Child 3							

	Yes	No
6. Has anyone named in this form ever,		
i. had a Life, Accident or Health insurance policy declined, postponed, withdrawn or subject to be accepted at special terms and conditions or its renewal refused?	❑	❑
ii. 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 here: _____

7. Is this insurance you are applying for to replace any existing Health plan with other insurer? ❑ ❑

❑ If yes to Question 7, your Financial Planner is required to explain the following to you. Please tick both and confirm the below declaration. My

❑ Financial Planner has explained to me the implications associated with this switch/ replacement. I am aware that the implications that may arise from a switch/ replacement could outweigh any potential benefit such as:

- The new policy may offer a lower level of benefit at a higher cost or same cost, or offer the same level of benefit at higher cost and, the new policy may be less suitable for me.
- If I am switching to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may losecoverage for those conditions.
- If I am replacing my existing plan by upgrading to this plan and I have existing medical conditions that are currently covered by my existing plan, I am aware that I may not be given the enhanced benefits for those conditions.

Part VI – 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 HSBC Life (Singapore) Pte. Ltd. ("HSBC Life") 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 HSBC Group or any third party service provider, and whether within or outside of Singapore) for the purpose of enabling HSBC Life 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 HSBC Life, and for the purposes set out in the Data Use Statement which can be found at www.hsbclife.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 HSBC Life that may be of interest to me by post and e-mail and

☐ By telephone ☐ By fax ☐ By text message

Part VII – 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 are aware that I/we can seek advice from a qualified Financial Planner before I/we sign this proposal form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.
3. I/We understand that this Policy shall only be effectivefollowing full annual premium payment and subject to the acceptance and approval of this application by HSBC Life.
4. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
5. 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 HSBC Life, 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.
6. I/We also understand that membership cards issued for the policy are to be used only for visits to outpatient panel clinics. I/We also agree to return the membership card upon request from HSBC Life or on termination of the policy.
7. I/We understand that HSBC Life 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 agree that I/We are obliged to disclose in this application form the same medical history that I/We previously stated in past declarations, if any, in addition to the new conditions that have arisen after signing the previous proposal form, if any.
9. I/We agree that if the health status of any of the above mentioned persons to be insured changes after this Health Declaration Form is signed and before HSBC Life issues the policy, I/we shall immediately notify HSBC Life of the changes, otherwise HSBC Life reserves the right to void the policy

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

Part VIII – Payment Method

You may choose from a range of payment modes for your products, please visit www.hsbclife.com.sg/payment/how-to-pay to view the payment modes available.

B. Product Summary for SmartCare 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 hospitalised. 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.

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

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 /treated in the Standard Room of the Hospital / Clinic	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 / treated in the Standard Room of the Hospital / Clinic	I will receive _____% of the Covered Expenses
D	Private Hospital : 1-bedded Private Hospital : 2 or 4-bedded Private Hospital/ Clinic: Day Surgery Public Hospital : 4 or 6-bedded	50% 60% 60% 100%
E	Private Hospital : 1, 2 or 4-bedded Private Hospital/ Clinic: Day surgery Public Hospital : 1-bedded Public Hospital : 6-bedded	50% 50% 60% 100%
F	Private Hospital : 1, 2 or 4-bedded Private Hospital/ Clinic: Day Surgery Public Hospital : 1 or 4-bedded	50% 50% 60%

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 requiredto referto full actual terms and conditions in the contract. Please consult your Financial Planner 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

This is a short-term accident and health policy and we are not required to renew this policy. We may terminate this policy by giving you 30 days' notice in writing.

If you have any existing medical condition at the policy renewal date, you may not be covered under the renewed policy for such a medical condition. If such a medical condition is covered under the renewed policy, you may need to pay additional premiums.

(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 SmartCare 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 SmartCare 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. Claims Conditions

There are stipulated time limits, procedures and submission of documents required to comply for claim submission.

i) We require written notice us as soon as possible and in any event, within thirty (30) days after the occurrence of any event which may give rise to a claim under this Policy.

ii) A claim form is obtainable from us upon request and we will require all necessary supporting documents covering the nature and extent of loss, within sixty (60) days after the occurrence of the event giving rise to the claim.

iii) Costs related to obtaining the necessary certificates, receipts, information and evidence required for assessing the claim, are to be borne by the policyholder, and given to us in the form we require.

For further information, you can visit or contact us at the following designations:
Website: www.hsbclife.com.sg/customer-care/file-a-claim
Telephone: +65 6880 4888

6. 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.

7. 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.

8. Reasonable & Customary Charges

This refers to charges for medical care which shall be considered by us or by our medical advisers to be reasonable and customary to the extent that they do not exceed the general level of charges being made by others of similar standing in the locality where the charges are incurred when giving like or comparable treatment. We will base that calculation on a combination of our global experience, statistical information provided by local health authoritative body and information collected from medical specialists and surgeons practicing in the country or area where the treatment is received.

For the avoidance of doubt when comparing treatment, we will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received. If the charges are higher than is customary, we will only pay the amount which is, in our experience, customarily charged and you will have to pay the rest. If your treatment requires more than one specialist or surgeon present at the same operative (surgical) session, we shall review the medical necessity in the management of such surgical problem or medical condition in terms of the different trained skills and complexity of the services provided as an identification to cover the total services. No additional benefits or cost is payable for surgical assistants.

For medical treatment and services incurred in Singapore, we shall also reference the guidelines and published fee benchmarks provided by Singapore Ministry of Health (MOH). In the event that the particular eligible treatment or service is not stated on the MOH published fee benchmark, we reserve the right to base the reference charge or proportionately reduce any claim to reflect the average charge of 2 physicians in the same specialty for the same surgical intervention or treatment. In the event of any differences in opinions between our medical advisers or physicians and your physicians, our medical advisers or physicians opinion shall prevail.

9. 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.

Our Note to You:

When switching from one health insurance product to another, you should consider carefully as there may be disadvantages in doing so. The new policy may cost more or have fewer benefits at the same cost.

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/LIA or SDIC web-sites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

HSBC Life

Pre-contract disclosure for medical insurance plans for Work Permit and S Pass Holders

Product Name: SmartCare Executive

Plan	Plan A / Plan D
Deductible and Co-Insurance option	Not selected

This product provides coverage for the following features that comply with the Ministry of Manpower's (MOM) enhanced Medical Insurance requirements[1]:

	Yes/No
Annual claim limit of at least $60,000, inclusive of a first-dollar cover of $15,000	Yes
For portion of the bill above $15,000, the employer must co-pay up to 25% (to the hospital)	No
Exclusions are in line with MOM's list of allowable exclusions[2]	No
Age-differentiated premiums are in 2 age bands: (1) ≤50 years old and (2) >50 years old	No
Insurers will reimburse our portion of the hospital bill to hospitals directly upon admissibility of the medical claim	No, except for the LOG cases

[1] Scan the QR code for MOM's press release on the enhanced medical insurance.

[2] Refer to Annex of the press release for the list of allowable exclusions.