HSBC Life (Singapore) Pte. Ltd.
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www.hsbclife.com.sg
GST Reg No. 199903512M
Co. Reg No. 199903512M

Application Form

International Exclusive

Important Notes
1. Under 23(5) of the Insurance Act 1966 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 carefully answering 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 Policyholder (All fields are mandatory)			
Surname ❑Mr ❑Ms ❑Mrs ❑Mdm ❑Dr		Given name	
Other known name/alias			
NRIC / FIN / Passport number	All Nationalities/Citizenships held	Marital status	
Date of Birth (ddmmyyyy)	Height (cm)	Weight (kg)	Gender: ❑ Male ❑ Female
Principal Country of Residence[1] and address		Home Country address if different from principal country of residence	
Residential address (if different from Principal Country of Residence)			Postal code
Mailing address (if different from residential address)			Postal code
Have you been in Singapore for more than 185 days at the time of application ❑ Yes ❑ No			
Telephone number (Home) (Please indicate Country/Region/Territory code)		Telephone number (Mobile) (Please indicate Country/Region/Territory code)	
Email address		Occupation/Profession/Job nature	

[1] The country where you live or intend to live for most of the year being 185 days or more and which will be shown as your address and placed in our records.

Part I – Particulars of insured members			
Is the policyholder one of the persons to be insured? □ Yes □ No			
Details	**1st insured member**	**2nd insured member**	**3rd insured member**
Last name/Surname			
First/Given name			
Other known name/ alias			
Relationship to Policyholder	□ Spouse □ Child	□ Spouse □ Child	□ Spouse □ Child
All Nationalities/ Citizenships held			
Principle Country of Residence[2]			
NRIC / FIN / Passport number			
Date of Birth (dd/mm/yyyy)			
Gender	□ Male □ Female	□ Male □ Female	□ Male □ Female
Occupation (specify nature of duties)			
Height (cm)			
Weight (kg)			

[2] The country where you live or intend to live for most of the year being 185 days or more and which will be shown as your address and placed in our records.

Part I – Additional Particulars of Policyholder

Employment status/Role for Policyholder only

□ *Self-Employed (Sole Proprietor/Freelance) □ *Self-Employed (Business Owner) □ Homemaker □ Unemployed

□ Retired □ *Key Controller (such as CEO, CFO, COO, MD) □ Employed Staff □ Student

Name and Country/Region/Territory of employer:

***Nature of business / industry [applicable only for self-employed (sole Proprietor /Freelance, Business Owner), Key Controller (such as CEO, CFO, COO, MD)]**

□ Money Services Business
□ Involved in production / distribution of military products
□ Casino / other types of gaming / gambling operations
□ Charities, Non-Profit Organisations, Non-Governmental Organisations
□ Government and State-Owned Bodies
□ Others _____

Reason to purchase policy outside of domiciled country **(applicable for non-Singapore resident only):**

Country of Source of Premium (Mandatory to be completed)

□ Singapore
□ Others (please specify the country) _____

Sources of Premium

□ Business Income □ Investment Income □ Savings □ Inheritance □ Deposit & Dividends □ Insurance Proceeds □ Gift □ Lottery □ Salary □ Others (please specify) _____

Payor Details

□ Policyholder
□ Others - please complete below section (Third Party Payor Information) and ID document of third party of payor.

Third party Payor Information

Name of Payor (as per ID/Passport)	Other known name/alias
"Trading as" name (if applicable, only for entities)	All Nationalities / Citizenships held or Country/Region/Territory of Incorporation
Date of Birth/Date of Incorporation (dd/mm/yyyy)	Relationship of Payor to the Policyholder
Contact Number (Please indicate Country/Region/Territory code)	Payor's Occupation
Residential/Registered Address	Payor's Annual Income (S$)
Reason for payment by third party	

Payment Method

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

□ Paynow via payment □ Credit card via payment □ Internet Banking □ AXS station/E-station/M-station

Please complete the following section ONLY if policy is to be issued to your employer who is the payor.

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 II – Details of Insurance (Please tick the appropriate box)

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

	International Exclusive	**Zone**	**Area of Cover**			**(Optional) Annual deductible & Co-insurance**
Plan	**A B C**	**1 2 3 4 5 6**	**1) Worldwide**	**2) Worldwide excluding USA #**	**3) Asia ^**	**1 2 3**
All persons to be insured can select different plans but cannot be higher than the Policyholder	Please refer to the Product Summary for the premium.	Please refer to the Product Summary for your applicable zone.				Please refer to the Product Summary for the Annual Deductible and Co-insurance options.
Policyholder	❑ ❑ ❑ **Optional Add-On Benefit:** ❑ Please tick/check the box to add Normal (Routine) pregnancy and childbirth benefit (Available for Plan A and for female more than 18 years old only).	❑ ❑ ❑ ❑ ❑ ❑	❑	❑	❑	❑ ❑ ❑
1st insured member	❑ ❑ ❑ **Optional Add-On Benefit:** ❑ Please tick/check the box to add Normal (Routine) pregnancy and childbirth benefit (Available for Plan A and for female more than 18 years old only).	❑ ❑ ❑ ❑ ❑ ❑	❑	❑	❑	❑ ❑ ❑
2nd insured member	❑ ❑ ❑ **Optional Add-On Benefit:** ❑ Please tick/check the box to add Normal (Routine) pregnancy and childbirth benefit (Available for Plan A and for female more than 18 years old only).	❑ ❑ ❑ ❑ ❑ ❑	❑	❑	❑	❑ ❑ ❑
3rd insured member	❑ ❑ ❑ **Optional Add-On Benefit:** ❑ Please tick/check the box to add Normal (Routine) pregnancy and childbirth benefit (Available for Plan A and for female more than 18 years old only).	❑ ❑ ❑ ❑ ❑ ❑	❑	❑	❑	❑ ❑ ❑

Worldwide excluding USA: Worldwide excluding USA and US Minor Outlying Islands

^ **Asia:** Australia, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Nepal, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam.

ANNUAL PREMIUM DUE (inclusive of GST): S$ _____

10% family discount is applicable when 3 or more family members sign up under the same policy.

Part III – Questionnaire

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

	Name of Doctor / Clinic / Hospital	Address of Doctor / Clinic / Hospital	Telephone number of Doctor / Clinic / Hospital
Policyholder			
1st insured member			
2nd insured member			
3rd insured member			

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:

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	No	Yes	No	Yes	No	Yes	No
(a) Brain, nervous system or mental disorders? eg. dementia, migraine, repeated headaches, unconsciousness, epilepsy/fits, 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.	❑	❑	❑	❑	❑	❑	❑	❑

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(d) Stomach, intestines, bowel or liver or gall bladder problems? eg. gastro-esophageal reflux disease, gastritis, stomach inflammation/ulcers, duodenal ulcers, diverticulitis, irritable bowel, Crohn's disease, colitis, change in bowel habits, abdominal pain, fistula, haemorrhoids / piles, rectal bleeding or blood in stools, pancreatitis, Hepatitis B Carrier or any forms of hepatitis, liver inflammation, 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 inflammatory 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, etc.	❑	❑	❑	❑	❑	❑	❑	❑
(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?	❑	❑	❑	❑	❑	❑	❑	❑

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(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, fingernails, 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.	❑	❑	❑	❑	❑	❑	❑	❑

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(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, fibroids, 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 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. For **females** to be insured (aged above 18 years old):

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
(a) Has anyone named in this form ever had symptoms, or been advised, or been diagnosed, or treated for Pregnancy/Childbirth or any Complications of Pregnancy/Childbirth?	❑	❑	❑	❑	❑	❑	❑	❑

	Policyholder		1st insured member		2nd insured member		3rd insured member	
	Yes	No	Yes	No	Yes	No	Yes	No
(b) Were any past pregnancies and/or current pregnancy conceived by assisted conception/assisted pregnancy^?	❑	❑	❑	❑	❑	❑	❑	❑
(c) Does any person had/intend to have her baby delivered by caesarean section or intend to undergo any fertility treatment or assisted conception/ assisted pregnancy reproduction?^ If yes, please state the reasons for the caesarean in the space provided under Q6.	❑	❑	❑	❑	❑	❑	❑	❑
(d) Is anyone named in this form currently pregnant? If so how many months?_____	❑	❑	❑	❑	❑	❑	❑	❑

^ *Assisted Conception/Assisted Pregnancy*

Refers to the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to intra-uterine insemination (IUI), in vitro fertilisation (IVF), intracytoplasmic sperm injection (ICSI) or the use of any form of treatment to induce or increase ovulation. This will include baby conceived via surrogacy.

6. 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 on the tick box.

	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)			
Policyholder							
1st insured member							
2nd insured member							
3rd insured member							

7. Has anyone named in this form ever,	**Yes**	**No**
i. had an application, reinstatement or renewal of a Health, Critical Illness, Life or Disability insurance declined, postponed, withdrawn, cancelled, or accepted on special terms and conditions?	❑	❑
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_____

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

If yes to Question 8, your Financial Planner is required to explain the following to you. Please tick both and confirm the below declaration.

❑ I confirm that my Financial Planner has explained to my satisfaction the implications associated with this switch/ replacement and based on his/her recommendation, I agree to proceed with the switch/ replacement of my existing Health Plan.

❑ 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 lose coverage 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 IV – Personal Data

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

I/We understand that HSBC Life's Data Privacy Policy (which may be found at https://www.insurance.hsbc.com.sg/privacy-and-security/) forms a part of the terms and conditions governing my/our relationship with HSBC Life.

I/We understand and acknowledge that the personal data which I am/we are submitting is being collected for the purposes stated in the Data Privacy Policy and I/we consent to the collection, use and disclosure of my/our personal data for the purposes set out in the Data Privacy Policy.

Part V – Declaration

1. I/We declare to the best of my/our knowledge and belief, the information given by me/us or on my/our behalf to HSBC Life (Singapore) Pte. Ltd ("HSBC Life") or the medical examiner whether in this application form or in any other form, document or questionnaire relating to this application is true and complete and that no material facts (i.e. facts that are likely to influence the assessment and acceptance of the proposal) have been withheld. I/We understand that such other forms, documents and questionnaire shall constitute and form part of this application and the policy I applied for i.e. HSBC Life International Exclusive policy ("Policy").
2. I/We understand that if anything is incomplete, untrue, incorrect, or a material fact is not disclosed in this application form, any Policy issued may be void.
3. 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.
4. I/We declare that I/we have received a copy of "Product Summary", and I/we have fully read and understand the product benefits and general exclusions applicable to Policy. I/We further understand that a sample copy of the Policy Terms and Conditions is available upon request.
5. 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 HSBC Life.
6. I/We confirm that there has been no change in my/our health since the completion of the application and all additional declarations made in connection with the application. I/We agree to inform HSBC Life if there is any change in my/our state of health, occupation or activity between the date of the application or medical examination and the issuance of my/our Policy. On receiving this information, HSBC Life is entitled to accept or reject my/our application.
7. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
8. I/We understand that I/we will be receiving my/our Policy document directly from HSBC Life by e-mail. I/We have been made aware that I/we shall be deemed to have received my/our policy document on the business day immediately following the date the policy document is e-mailed by HSBC Life. I/We am/are aware that the 14-days free look period for my/our Policy shall commence on the business day immediately following the date the policy document is e-mailed to me/us. I/We further understand that if I/we wish to exercise my/our right to free Look and cancel the Policy, and receive a refund of premium without interest after deducting any medical and underwriting expenses incurred, I/We shall notify HSBC Life in writing and return the policy document for the cancellation within the 14-days free look period. I/We authorise any medical source, insurance office or organization, to release to HSBC Life any relevant information concerning me/ourselves, at any time, irrespective of whether the application is accepted by HSBC Life or not.
9. I/We further 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.
10. 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.
11. I/We understand that HSBC Life reserves the right to request for a copy of the latest medical report of an insured member from me/us at my/our own expense should further medical information be required.
12. 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.
13. I/We am/are aware that the product that I/we am/are applying is authorised for sale in Singapore. I/We acknowledge that I/we am/are responsible for ensuring, and I/we represent and warrant, that I/we am/are in compliance with all the laws and regulations applicable to my/our nationality(ies) and country(ies)/region(s)/territory(ies) of residence and that such laws and regulations allow my/our purchase of this Policy. I/We understand that no liability can or will be accepted by HSBC Life for any consequences under the laws of any country/region/territory other than Singapore or any tax implications that may arise in connection with my/our purchase of this Policy.
14. Applicable only where applications are signed outside of Singapore:
    I/We declare that I/we have initiated the purchase of this Policy.
15. Applicable only to Indonesian Residents / Foreigners residing in Indonesia:
    My/Our decision to purchase this Policy in Singapore is due to some or all of the following reason(s):
    To the best of my/our knowledge,
    - I/We am/are unable to purchase a Singapore Dollar denominated insurance product in Indonesia and/or
    - I/We am/are unable to get a similar insurance product from Indonesia and/or
    - I/We am/are unable to get the same level of local underwriting capacity for the sum insured I/we am/are seeking in respect of the insurance risk from.
16. Applicable only to Japanese Nationals residing outside Japan:
    I/We agree to complete the Declaration of Non-Japanese Residency in the Supplementary Proposal Form as part of my/our application for this Policy.
17. Compliance with US laws and regulations and other laws having extra-territorial effect:
    - I/We am/are not (and will not be) physically located in US throughout the entire policy application process through to policy insurance;
    - I/We am/are aware of and understand the policy servicing restrictions* applicable to any and all persons residing temporarily or permanently in the US; and
    - I/We will inform HSBC Life should I/we decide to reside in the US either temporarily or permanently.

    * List of policy servicing restrictions is set out in our website https://www.insurance.hsbc.com.sg/help/useful-information/

18. I/We acknowledge and agree that:
    a. HSBC Life is authorised to accept my/our signature(s) in electronic form including electronically scanned and transmitted versions of an original signature ("Electronic Signature") in electronic form (which may include my/our click off on check boxes contained in the document) I/we have submitted or will be submitting to HSBC Life – such document referred to as the "Electronic Document";
    b. my/our electronic signature(s) on the Electronic Documents is/are attached by me/us and I/we have not and will not permit any other person to assist me/us in attaching my/our signature(s) to the Electronic Documents;
    c. my/our Electronic Signature(s) on the Electronic Documents is/are reflected clearly and accurately on the Electronic Documents and my/our signature(s) received shall be deemed to be equivalent to my/our wet-ink signature(s) in hard copy for all purposes provided that HSBC Life verifies (whether before or after such signature is taken) my/our identity in a manner which complies with the internal requirements of HSBC Life;
    d. any electronic data or images of the Electronic Documents submitted to HSBC Life by me/us shall be valid, accurate and authentic, and the signed Electric Documents maintained by HSBC Life on my/our behalf shall have the same effect as though the Electronic Documents were written and had been signed by me/us in hard copy; and
    e. I/we will not dispute the validity, accuracy or authenticity of the contents of any such Electronic Documents or any evidence in the form of activity or transaction logs, computer or electronic records, computer printouts or any other form of computer or electronic data or information storage or system (collectively referred to as "Electronic Records") and other than in the case of the HSBC Life's manifest or clerical error, such Electronic Records shall be final and conclusive of the information and your instructions, consents, acknowledgements and agreements of any matter set out in the Electronic Documents and the Electronic Records can be used as evidence in any court proceedings as proof of their concerns.
19. I/We confirm that the information provided in this form is correct and complete. By providing my signature, I authorize HSBC Life to update my particulars according to this form.
20. I, the Policyholder, confirm that I am authorised by each insured member to complete this form on their behalf (where applicable).

Part V – Marketing Consent to be completed by the Policyholder

How would you like to receive marketing and promotional materials from the HSBC Group*?

□ Email
□ Mobile Message
□ Call
□ Post

*HSBC Life (Singapore) Pte. Ltd., its holding companies, affiliates, subsidiaries and associated entities and their respective agents, authorized service providers and third parties.

Note: Please complete Section 1 - Particulars of Policyholder.

Non-Disclosure

If a material fact is not disclosed in this proposal, any policy issued may be void. If you are in doubt whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the financial consultant but was not included in the proposal. Please check to ensure that you are fully satisfied with the information declared.

Signature of Policyholder

(for and on behalf of all persons to be insured)

Name of Policyholder

Signed at (city, Country/Region/Territory)

Date signed

(ddmmyyyy)