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 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 Applicant (All fields are mandatory)

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
Principal Country of Residence* and address:		Home Country address if different from principal country of residence	
Mailing Address (if different from Principal Country of Residence)		Postal code	
Have you been in Singapore for more than 182 days at the time of application ❑ Yes ❑ No			
Tel (H)	(O)	(Mobile)	
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	Nationality	Principal country of residence*	Home Country	Height (m)	Weight (kg)
Spouse									
Child 1									
Child 2									
Child 3									

Occupation/Profession of Spouse: _____

Note: Policyholder must be aged 18 years and above.

*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 III – Details of Employer

Please complete this section <u>ONLY</u> 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 (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 Applicant	Please refer to page 24 to 35 of the brochure for the premium.			Please refer to page 23 of the brochure for your applicable zone.									Please refer to page 36 of the brochure for the Annual Deductible and Co-insurance options.		
Applicant	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
	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).														
Spouse	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
	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).														
Child 1	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Child 2	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Child 3	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

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

^ Asia: Afghanistan, Australia, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, 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 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.

	Name of Doctor / Clinic / Hospital	Address of Doctor / Clinic / Hospital	Telephone No. 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/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.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(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.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

	Applicant		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
(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?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(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.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

	Applicant		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
(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.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(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?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

	Applicant		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
(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):

(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?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
(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)			
Applicant							
Spouse							
Child 1							
Child 2							
Child 3							

		Yes	No
7.	Has anyone named in this form ever,		
	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 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 its 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 or our 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, the Life Assured and those whose personal data I have provided from sources other than myself for the Purposes.

(c) Contact me to share information about products and services offered by 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 insurance advisor 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 effective following full annual premium payment and subject to the acceptance and approval of this application by HSBC Life (Singapore) Pte. Ltd.
4. 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 (Singapore) Pte. Ltd. issues the policy, I/we shall immediately notify HSBC Life (Singapore) Pte. Ltd. of the changes, otherwise, HSBC Life (Singapore) Pte. Ltd. reserves the right to void the policy.
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 HSBC Life (Singapore) Pte. Ltd., 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 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 (Singapore) Pte. Ltd. or on termination of the policy.
8. I/We understand that HSBC Life (Singapore) Pte. Ltd. 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.
9. 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.

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 methods, please visit www.hsbclife.com.sg/payment/how-to-pay to consult the various payment modes.

Our Note to You:
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 name of Scheme member) 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: International Exclusive

Plan	Plan A / Plan B / Plan C
Area of Cover	Worldwide / Worldwide excluding USA / Asia
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.