

APPLICATION FOR FLEXILINK PLAN

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP. 142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You must disclose all facts as you know or ought to know which may affect the insurance cover being applied for. Otherwise, the insurance policy issued may not be valid.

For Official Use

Adviser's Name	Adviser's Code	Source Code	Delivery Mode <input type="checkbox"/> Mail <input type="checkbox"/> Hand
----------------	----------------	-------------	--

Particulars of Proposer/Insured

Name (as shown in NRIC)			NRIC No.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (dd/mm/yyyy)	Height (m)	Weight (kg)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Residential Address				Nationality <input type="checkbox"/> Singaporean <input type="checkbox"/> Singapore PR <input type="checkbox"/> Others (Please specify) _____
Contact No. (O) _____ (H) _____ (Hp) _____		Email _____		
Name of Company/School	Occupation/Position		Annual Income (\$\$)	
Exact Nature of Work				

Details of Plan

Plan Type FlexiLink - IB4	Premium Payable (\$)
Please specify fund allocation (Please note that fund allocation must add up to 100%)	
Please note that any distributions from Fund(s) which units are purchased using CPFIS will be reinvested and will not be paid into the policyholder's CPFIS Account.	

Payment Method

Payment by CPFIS OA (If you have not signed a Standing Instruction with your bank, please complete a copy and submit it directly to your bank)
I authorise NTUC Income Insurance Co-operative Limited ("NTUC Income") to bill my CPF account once the proposal is accepted by NTUC Income.

Name of Agent Bank	Investment Account No.	CPF Account No.
--------------------	------------------------	-----------------

Please note that your bank will levy a charge, as determined by them, for every premium deduction attempt or refund made on your CPFIS OA.

Payment by CPFIS SA (Please fill "CPF Special Account" section on Page 6)

CPF Account No.

Regular Single Premium Top-up

Amount of Premium	Premium Payment Mode <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Half-yearly <input type="checkbox"/> Yearly	Period From year _____ to year _____
-------------------	--	---

Declaration/Replacement of Existing Policy(ies)

	Proposer	Insured
1. Do you have any existing policy(ies)? If "Yes", please provide details below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Proposer

Name of Company	Year Issued	Sum Assured			Total & Permanent Disability	Accident & Hospitalisation	Others
		Life	Critical Illness	Term			

Insured

Name of Company	Year Issued	Sum Assured			Total & Permanent Disability	Accident & Hospitalisation	Others
		Life	Critical Illness	Term			

2. Has any proposal or application for a Life or Accident or Hospital Assurance Policy ever been declined, postponed and accepted at special rates or terms with this or any other office? If yes, please provide details of company(ies) and why.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you making or have you made any claims, including hospitalization claims, or any policy with this or any other office?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the assurance now applied for intended to replace any existing policy(ies) with this or any other office? Warning: It is disadvantageous to replace an existing life insurance policy with a new one. Some of the disadvantages are: i. Insurance may not be granted on standard terms; ii. A higher premium may have to be paid in view of increased age; iii. The financial benefits accumulated over the years may be lost. In your own interest, we would advise that you consult your present insurer (s) before making a final decision. Do hear out both sides and make a careful comparison so that you can be sure that you are making a decision that is in your best interest.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your answer is "Yes" to Questions 2-4, please provide details below:

Proposer

Question No.	Details

Insured

Question No.	Details

Lifestyle

	Insured
1. Do you consume beer, alcohol, or any other stimulants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you smoke cigarettes, cigar, etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have any intention of residing abroad for more than 3 months other than for holidays or studies? If "Yes", please provide details below including country, duration and reason.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you engage or have you any prospect or intention of engaging in military or private flying other than as a passenger on a regular airline or any other hazardous occupation or pursuits such as scuba diving, mountain/rock climbing, free fall parachuting, sky diving, motor racing etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been taking narcotics, any habit formed drugs or have you been ever treated for drug or alcohol addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If your answer is "Yes" to the above questions, please provide details below:

Question No.	Details
1	Type (e.g. beer, wine or other alcoholic beverages): _____ Quantity per week: _____
2	_____ sticks per day for _____ years

Family History

	Insured				
Has either of your natural parents or any 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Family Record	Living	Deceased			
	Age	Medical Condition	Age at Onset	Age at Death	Cause of Death & Details

Particulars of Regular Doctor

	Insured
Do you have a regular doctor? If "Yes", please provide details below:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Doctor	Address of Regular Doctor
Date, Reasons and Details of Last Consultation	

Questions On Health

For Total Single Premium below S\$200,000

	Insured
1. Have you ever suffered from or received treatment for disease of the heart or circulatory system, stroke, high blood pressure, diabetes, cancer, growth or other malignancy, kidney or bladder disorders, asthma, other respiratory disorders, liver disease such as Hepatitis, epilepsy, hereditary diseases and eye disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you suffered from physical or mental impairment or deformity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you undergone or are you undergoing any medical treatment/surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Total Single Premium S\$200,000 and above

	Insured
1. Have you ever had or been told to have or been treated for:	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) epilepsy, fits, stroke, paralysis, weakness of limb, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diabetes, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) double vision, impaired sight, hearing or speech, ear discharge, nose bleeds or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other long diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapsed or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) jaundice, hepatitis B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(k) anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or your spouse received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS Related Complex or any other AIDS related conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had HIV testing done (please state reason and results), 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past five years, have you had any test done such as X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine test? If "Yes", please provide details of any abnormalities detected.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Questions on Health (Continued)

Additional Health Questions for Female only (For age 10 and above)

	Insured
5. (a) Have you had or received any treatment for or intend to be treated for any disease or disorder of the breast including breast lump, cyst, fibroadenoma, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ, cancer or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Have you had or received any treatment for or intend to be treated for any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, abnormal enlargement of the abdomen, carcinoma in situ or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Have you at any time undergone a PAP smear, mammogram or ultrasound of the breasts or pelvis, cone biopsy or colposcopy for which the results were abnormal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Have you had any complications during your pregnancy or as a result of your pregnancy? (E.g. ectopic pregnancy, diabetes, high blood pressure or protein in urine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) Have any of your children suffered from hereditary disorders? (E.g. Spina bifida or Down's Syndrome)	
(f) Have any of your children suffered from congenital disorders? (E.g. Club foot, Hole-in-heart or Cleft lip/palate)	
(g) Are you now pregnant? If "Yes", how many months?	

If you answered "Yes" to Questions 1-5, please provide details below:

- Name of condition and date of diagnosis;
- Name and address of each doctor/hospital;
- Duration of illness/injury and date of recovery as appropriate; and
- Nature of tests done, dates, results and reasons for tests
- Copy of the above test(s), if any

Declaration of Beneficial Ownership

If you are not the beneficial owner*, please provide the details such as Name and NRIC/Passport No. of the beneficial owner(s) and your personal relationship(s) with them and submit a copy of their NRIC/Passport to us.

Please provide relevant details here : _____

* "Beneficial Owner" as defined in the MAS Notice on Prevention of Money Laundering and countering the Financing of Terrorism means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over a body corporate or unincorporate.

For the avoidance of doubt, completion of this section is not a nomination of beneficiary (ies) under the policy.

Declaration and Authorisation

I/We agree to inform NTUC Income as soon as possible if there is any change in the state of my health and/or Insured's health or if I and/or Insured plan to seek any medical consultation, investigation or treatment between the date of this application and before the date the policy is issued by NTUC Income. I/We understand that NTUC Income may impose special terms according to the information provided by me/us.

I/We declare and warrant that the answers given in this application are true, correct and complete and I/We accept full responsibility for them, whether written by me/us or by anyone else on my/our behalf. I/We have not withheld any information. I/We agree that this application and other written answers, statements, information or declarations made by me/us or on my/our behalf shall form the basis of the contract of insurance between me/us and NTUC Income and if anything untrue, incorrect or incomplete is stated, the insurance policy issued shall not be valid.

I/We agree that there shall be no liability upon NTUC Income until a policy has been issued and delivered to me and the first premium has been paid in full. And I/We agree and authorise:

(a) Any medical source, insurance office, or organisation to release to NTUC Income, and

(b) NTUC Income to release to any medical source or insurance office,

any relevant information concerning me/us at the time, irrespective of whether the application is accepted by NTUC Income or not. A photocopy is valid as an original copy.

I/We understand that it is usually disadvantageous to replace an existing investment product e.g. unit trust, with a new investment product, whether from the same/different financial institution.

I/We have been given the following documents, the contents of which were explained to my satisfaction:

(a) Your Guide to Life Insurance or Your Guide to Health Insurance or both, (b) Products Summary, and (c) Benefit Illustration.

I/We confirm that the entire marketing and selling process in respect of my/our proposed insurance application has been conducted in Singapore.

I/We agree that the policy will be entered in the Register of the Singapore policies.

I/We further declare that I/we am/are not (an) undischarged bankrupt and that I/we have committed no act of bankruptcy within the last twelve months and that no receiving order or adjudication in bankruptcy has been made against me/us during that period.

I/We also wish to apply for admission as a member of NTUC Income and if accepted, I/We agree to be bound by the By-Laws of NTUC Income.

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

Signed in Singapore on the _____ day of _____ 20____

Signature of Proposer/Insured

Signature of Witness

Name & NRIC No. of Witness

CPFIS Special Account

TO: THE CENTRAL PROVIDENT FUND BOARD

I hereby irrevocably authorise the Board to:

1. Debit my CPF Special Account the sum of monies specified by NTUC Income or the amount determined by the Board for the purchase/placement of the life insurance policy(ies) approved under the CPFIS-SA including any related fees, expenses and charges under the CPF Investment Scheme = Special Account (CPFIS-SA).
2. Credit my CPF Special Account with any income or any proceeds from the liquidation of the life insurance policy(ies) approved under the CPFIS-SA that are received from NTUC Income.
3. Disclose any particulars or information whatsoever relating to or in connection with my investment with NTUC Income to facilitate any transactions that cannot be settled due to data discrepancies, insufficient funds or any other reasons that the board deems fit.

I understand that the above transactions shall be made, subject to the provisions of the Central Provident Fund Act and the Central Provident Fund (Investment Schemes) Regulations as may be amended from time to time and also to all such terms and conditions as may be imposed by the Board from time to time.

I hereby agree to indemnify the Board and shall keep the Board indemnified against all actions, proceedings, liabilities, claims, damages, expenses or legal costs whatsoever arising out of in connection with the Board accepting and acting upon this authorisation.

Signature of Proposer

Name (as shown in NRIC)

Date (dd/mm/yyyy)

Adviser's Declaration

1. I declare that all the answers given to me by the Proposer/Insured are declared in the application. I have not withheld any information which may influence the acceptance of this application by NTUC Income.
2. I am aware that NTUC Income takes a serious view of non-disclosure and action will be taken against me if I am deemed a party to the non-disclosure.
3. I have personally SEEN the Proposer/Insured and have explained the terms of the policy to the Proposer.
4. I have seen the original identification documents and attached a photocopy herewith. I confirm that the attached is a copy of the original.

Signature of Adviser

Date

5. Is the application intended to replace an existing policy? If "Yes", please provide details.

Yes No