LIA & GIA GUIDELINES ON DISCLOSURE REQUIREMENTS FOR A&H PRODUCTS

INDIVIDUAL BUSINESS

Documents to be presented to client at the pre-sales stage

1 It is compulsory to provide, to all clients or prospective clients, the following two documents:
- "Your Guide to Health Insurance"; and
- "Product Summary".

Further, the titles used for these documents (i.e. "Your Guide to Health Insurance" and "Product Summary") shall be standardised.

2 An existing policyholder need not be provided these documents when he changes his servicing agent at the point of policy renewal. This exemption, however, does not apply where the policyholder is instituting a new policy to replace an existing one.

3 Insurers shall require all proposers to sign the proposal form to confirm that they have been given a copy of the required documents, and that the contents of these have been explained to their satisfaction.

4 Insurer shall reproduce in verbatim the document "Your Guide to Health Insurance"

Specific guidelines for the "Product Summary"

1 The "Product Summary" aims to provide prospective buyers with details on key product information and features, contract provisions or terms and conditions, and other relevant information that may affect their decision to purchase the policy.

2 To ensure proper disclosure and acknowledgement of the information presented, the original signature of the prospective client and the intermediary must be obtained. Both these endorsements should be made on the front page of the "Product Summary".

3a The "Product Summary" shall comprise two sections:
- Product Information
- Key Product Provisions

3b A copy of the duly signed Product Summary must be filed with the Insurer for record purposes.

4 Flexibility in layout is allowed, provided the spirit of the Disclosure guidelines is adhered to.

5 Disclosure of distribution costs, charges & expenses in the "Product Summary" is not mandatory. However, it should be made clear in this document that that such information will be made available at the client's request.

6 Specific guidelines for Product Information

This Product Information section shall include all relevant information on the benefits and coverage, limits of compensation, premium rates and commitment of the health insurance policy. Specifically, the following information shall be covered:

- *Summary of Benefits or Covered Events:* Description of the product, including the covered event(s) and the sum assured (where applicable).
- *Benefits Schedule Table (where applicable):*
  (a) Limits on the benefits claimable for each covered event, in the form of a table featuring the limits of compensation and amount of coverage e.g. Limits of Compensation table or Benefits Schedule table.
  (b) The minimum amount of the claim that must be borne by the policyholder, per policy year or per claim made – in percentage terms or as a fixed sum of the amount claimed e.g. deductible or co-insurance.
  (c) The maximum amount which will be reimbursed per policy year or per lifetime of the insured e.g. annual limits or lifetime limits of the policy.
- *Premium Rates or Premium Rates Table:* The premium rate at entry age that is payable for each premium instalment, or a premium rates table where the premium is not level.
- *Premium Payment Duration:* The number of years premiums are payable for.
- *Duration of Policy Cover:* Duration of policy coverage in terms of number of years, expiry date of cover or age of cessation of cover.
- *Definition of Activities of Daily Living (where applicable):* If Activities of Daily Living (ADL) is a listed claims criteria, their definitions should be in the document.

7 Specific guidelines for Key Product Provisions

The Key Product Provisions section shall include relevant information on the following contract provisions, on other terms and conditions that would affect the premium, coverage or benefits of the policy. Specifically, the following information (where applicable) should be covered:

- *Cancellation/Termination Clause:* Stating explicitly that the policy may be unilaterally cancelled or terminated by the insurer.
- *Renewability of the Policy or Terms of Renewal:* Information on the terms relating to policy renewal (for example, whether policy renewal is guaranteed by the payment of renewal premium or is subject to fulfilment of a limited premium payment period). The last age of policy renewal should also be specified.
- *Premium Guarantee:* Where premium rates are not guaranteed or can be increased at the insurer's discretion, this must be clearly indicated.
- *Waiting Period:* Where policy benefits are payable only a specified length of time after policy inception, this must be clearly stated.

- *Benefit Limitations:* Conditions under which benefits of the policy will not be payable.
  (a) The following standard statement must be highlighted in the document:

"There are certain conditions whereby the benefits under this plan will not be payable. These are stated as exclusions in the contract. You are advised to read the policy contract for the full list of exclusions."

(b) In addition to the standard statement above, if any of the following three conditions are excluded from the contract, they shall be highlighted:
- Pre-existing conditions;
- Limits of Compensation; and
- Congenital Anomalies or Defects.

(c) The list shall be extended to include exclusions that may influence the prospective client's decision in the prevailing environment. For example, the exclusion on communicable disease was once considered a redundant exclusion. However, this exclusion may now be an important factor in light of the heightened concern over SARS.

- *Other Circumstances that Affect Premium Rates or Policy Benefits:* Other provisions stated in the contract that may affect premium rates or the benefits payable, and which require continued disclosure by the insured after policy inception. Examples of such provisions are Change of Occupation or Change of Country of Residence.
- *Deferment Period/Pre-Benefit Period:* Where the policy benefits are payable only a certain period after the occurrence of the covered event, this must be clearly stated.
- *Survival Period:* Where the insured must survive for a certain length of time after the occurrence of the covered event before the policy benefits are payable, this must be clearly stated.

8 The following appendices provide the format for the presentation of the Product Summary for the respective A&H plans and the specimen wordings to be used for Key Product Provisions:
- Appendix I – Specimen wordings for Key Product Provisions.
- Appendix II – Format for Product Summary for hospital and surgical plans.
- Appendix III – Format for Product Summary for critical illness plans.
- Appendix IV – Format for Product Summary for long-term care plans.
- Appendix V – Format for Product Summary for disability income plans.

Application of the guidelines to direct marketing and telemarketing channels

1 This section relates to situations where there is no face-to-face contact at all between the client and the insurer/intermediary throughout the sales process (for example, when a sale is concluded through direct marketing or telemarketing channels without clients being referred to a financial advisor or insurance broker). Where a financial advisor or insurance broker is subsequently involved in the sales process as a result of a referral, the standard guidelines previously discussed shall apply.

2 For the purpose of this section,

- "direct marketing" shall be defined as marketing through the use of direct response advertising communications of any medium, including mail, print, TV, radio, and electronic media; and
- "telemarketing" shall be defined as marketing through the use of a call centre of any description.

3 In the case of direct marketing, the insurer must have control over the entire process, from publication and distribution of promotional materials to delivery of the policy document. For telemarketing, the

insurer must have sufficient control over its telemarketing staff or, where the function is outsourced, over the telemarketing firm, such that it is able to ensure that the information conveyed on product features is accurate.

4 Where, in communications made through direct marketing or telemarketing channels, a piece of advice (or a recommendation) is made to an intending insured to purchase a health insurance product, such advice (or recommendation) shall only be made if it has a reasonable basis. To establish such reasonable grounds, the advisory process requirements shall be adhered to.

5 For direct marketing that only involves the presentation of product information without making recommendations,

- the following statements need to be highlighted in the marketing materials:
  "This is only product information provided by us. You should seek advice from a qualified advisor if in doubt. Buying health insurance products that are not suitable for you may impact your ability to finance your future healthcare needs."
- the following clause must be highlighted to the proposer and should be included in the proposal form before the proposer's signature column, :
  "I am aware that I can seek advise from a qualified advisor before I sign this application/proposal form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives."

6 The above statements should also be emphasised to the client before the contract is made when the product is sold through telemarketing and no advice has been given to the client. A verbal acknowledgement of these statements from the client should be sought.

7 The insurers must make adequate arrangements to provide appropriate post-sales disclosures to policyholders who have purchased health insurance products through direct marketing or telemarketing channels. Such post-sales disclosures include a "follow-up letter" which:

- advises the proposer to read the two compulsory disclosure documents enclosed;
- highlights to the proposer that he or she is entitled to a "14-day Free Look" period and can decide to cancel his coverage without penalty within this period if he deems the product unsuitable; and
- requests the proposer to return the enclosed pre-paid reply card to the insurer to confirm his receipt of the disclosure documents.

8 With such procedures in place, the following standard disclosure requirements will not apply to direct marketing and telemarketing:

- Having the proposer sign on the proposal form stating that he or she has been given the two compulsory disclosure documents, and that the contents of these have been explained to his or her satisfaction; and
- Having the proposer sign on the first page of the Product Summary.

Disclosure requirements for personal accident products

1 In all pre-sales marketing materials and in the application forms, the insurer is required to highlight to prospective clients that the benefits of the policy will only be payable upon an accident occurring. There must not any misleading statements to give prospective clients the impression that the policy covers events arising from causes other than an accident.

2 In addition, to discourage insureds from switching personal accident policies without considering whether the switch is detrimental to them, the insurer is required to highlight to clients the potential disadvantages of switching.

Post-sales disclosure

1 Insurers are required to make continual disclosures to policyholders after policy inception whenever there are modifications to the Product Information or Key Policy Provisions specified in the Product Summary. The documents required for continual disclosure will not be prescribed as long as they disclose the pertinent information recommended in the guidelines.

2 Circumstances that would require continual disclosure include, but are not limited to, modifications to policy provisions in the following areas:

- Premium rates or premium rates table
- Policy benefits or coverage
- Exclusion clauses
- Change in definition of contract provision

3 Both the existing and the modified benefits/terms need to be shown. In cases where some original benefits are withdrawn or new exclusions are added with no change in premium rates, this must be highlighted to policyholders.

4 Insurers are required to give policyholders advance written notice of at least 30 days before the modifications take effect.

5 To modify any of the original terms of the policy contract, insurers may:

- obtain written acceptances of the modified terms from policyholders; **OR**
- where no written acceptances of the modified terms is sought, the insurer must ensure that all of the following conditions are fulfilled:
  - i) policyholders are given the option to reject the modified terms and cease cover;
  - ii) in the notification letter to policyholders:
    - a) the modified terms must be conspicuously indicated on the front page of the notification letter,
    - b) the modified terms must be highlighted in bold print on the notification letter, and
    - c) the print size of the modified terms should not be smaller than the rest of the text on the notification letter.
  - iii) the following standard statement (wherever applicable) must be highlighted on the notification letter:

"Please be informed that unless otherwise advised by the Owner of the policy, receipt of the renewal premium by the Company shall be construed as an acceptance of the modified terms and the modified terms shall take effect from the date of policy renewal".

OR

"Please be informed that unless otherwise advised by the Owner of the policy by DD/MM/YY (expiry date of the advance notice), the modified terms shall take effect from DD/MM/YY (effective date of the modified terms)".

CORPORATE BUSINESS

Information to be disclosed to clients at the pre-sales stage

1 A list of the information it is mandatory for insurers to disclose to corporate clients at the pre-sale stage is given below. The format and wording of such disclosure will not, however, be prescribed. The responsibility of communicating A&H product features to members of the corporate client will rest on the shoulders of the company itself.

- Name of insurer underwriting the product
- Duration of coverage
- Premium rates per person/total premiums and bases by which these figures were arrived at
- Benefit schedules, including details on coinsurance, deductibles, waiting period, restriction to panels or hospitals, etc.
- Period of validity of a proposal (or a quote)
- Other key policy terms and conditions
  - Eligibility for coverage
  - Exclusions & limitations (including exclusions for pre-existing conditions)
  - Provisions relating to termination of coverage (e.g. when insured attains age 65, short–period rates, grace period, etc.)
  - Obligations to be met by client and rights of insurers when these are not met (any individual underwriting requirements, declaration on named basis, etc.)
- Whether premium rates are guaranteed and, if so, for how long
- Whether renewals are guaranteed and, if so, for how long
- Whether the product is a qualified plan under the Transferable Medical Insurance Scheme (TMIS)
- Whether or not the free look period is applicable
- Upon request by client, commission amounts must be disclosed (as per CESGI requirements)

2 The final proposed terms are to be signed by the client or a legally appointed representative of the client. (e.g. when letter of authorization clearly states that the broker is allowed to sign binding insurance contracts on the client's behalf).

3 Additional disclosure to individual members of a corporate client is required where participation in the plan is, in full or in part, at the discretion of the members themselves (commonly known as a voluntary plan).

Such disclosure shall be as follows:

Insurers shall make available (through the corporate client) to persons who are eligible to be insured members of voluntary plans the following two documents:

- "Your Guide to Health Insurance"; and
- "Product Summary".

The title used in these documents (i.e. "Your Guide to Health Insurance" and "Product Summary" shall be standardised.

Further, the document "Your Guide to Health Insurance" shall be reproduced in verbatim.

The "Product Summary" shall comprise of two sections: Product Information and Key Product Provisions. Specific guidelines for these two sections shall follow the rules prescribed for INDIVIDUAL BUSINESS.

Insurers shall require all persons applying for insurance under voluntary plans to sign on the Policy Health Declaration form (or any equivalent document, e.g. option or selection form) to confirm that they have read and understood the contents of these two documents ("Your Guide to Health Insurance" and "Product Summary").

APPENDIX I

Specimen wordings for Key Product Provisions

1) Cancellation clause (relating to insurers' rights to unilaterally terminate policies)
"The Company reserves the right to terminate the coverage at any time by giving <number of days> days' notice in writing to the Owner. Whenever such cancellation occurs, the Company shall return the unearned portion of premiums paid. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination."

2) Terms of renewal
"Coverage may be renewed on the Policy Anniversary Date by the payment of the annual premium."

3) Non-guaranteed premium
"Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company."

4) List of standard 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:
- Pre-existing condition
- Congenital anomalies or defect
- Pregnancy, miscarriage or child birth

You are advised to read the policy contract for the full list of exclusions.*"*

5) Waiting period
   a) For hospital and surgical plans
   "No benefits will be payable if the illness or disorder, which results in the Insured's hospitalisation or having to undergo surgery, is diagnosed within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later"
   b) For critical illness, long term care or disability income plans
   "No benefits will be payable if the Insured has been <diagnosed as suffering from a critical illness/unable to perform any activities of daily living/deemed disabled> within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later"

6) Change of occupation
"In the event of a change in occupation of the Insured, the Insured shall notify the Company in writing of the new occupation. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation. "

7) Deferment period
"This is the period following the onset of disability before the benefits under this policy will be payable."

8) Survival period

"No benefits under this policy shall be payable if the Insured dies within 30 days of being diagnosed as suffering from a critical illness."

APPENDIX II

Format for Product Summary for Hospital & Surgical Plan

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

Plan Name: _____ Expiry Date of Cover: _____

Premium Rates Table:

The annual premium rates for this plan are as set out below. Please note that the premium rates are not guaranteed and the Company may, at its sole discretion, increase the premium rates from time to time depending on its claims experience. The annual premium is based on the Insured's age last birthday and the renewal premium rates as determined by the Company at the time of renewal, based on the attained age of the Insured. This plan will terminate immediately following the 80th birthday of the insured.

	Plan A Plus	**Plan B Plus**
Age Group (Attained age last birthday)	1st Year Premium* (S$)	1st Year Premium* (S$)
30 & below	95	57
31 to 40	143	86
41 to 50	285	171
51 to 55	476	285
56 to 60	491	295
61 to 65	812	488
66 to 70	1167	700
71 to 73	1673	1004
74 to 75	1964	1178
76 to 80 (renewal Premium)	2730	1649

Product Information:

This is a hospital & surgical plan that helps to reduce the financial burden on the family while you or your covered family member is hospitalised. We will pay for the expenses according to the limits of compensation set out in the Benefits Schedule, depending on the plan you have chosen.

Schedule of Benefits (Limits of Compensation)	**PLAN A PLUS (S$)**	**PLAN B PLUS (S$)**
Hospitalisation Benefits		
Daily Room & Board*	650	400
Daily Intensive Care Unit*	1,000	625
Surgical Benefits		
Surgery Limits**	480 to 7,200	390 to 6,500
Surgical Implants/ Approved Medical Consumables (per year)	3,500	2,500
Gamma Knife (per procedure)	12,600	9,600

Out-Patient Hospital Benefits		
Radiotherapy for cancer (per day)	280	240
Stereotactic Radiotherapy for cancer per treatment	2,500	2,000
Chemotherapy for cancer (per month)	1,000	800
Immunotherapy for cancer(per month)	800	600
Renal Dialysis (per month)	2,500	2,000
Erythropoietin (per month)	500	400
Cyclosporin (per month)	500	400
Extra Cancer Coverage #		
• Per Policy Year	30,000	30,000
• Per Lifetime	100,000	100,000
Final Expenses Benefit ##	5,000	3,000
Limit per policy year	110,000	85,000
Limit per lifetime	330,000	250,000
Deductible per policy year	2,500	1,500
Co-insurance	15%	15%

* Inclusive of meals, prescriptions, professional charges, investigations & other miscellaneous charges

** Limits vary according to the level of complexity of the surgical operation

The extra cancer coverage is provided over and above the Policy Year and Lifetime Limits and can be claimed for hospitalisation following diagnosis of Cancer. Cancer is defined as a histologically confirmed malignant tumour exhibiting invasion of adjacent tissues. Tumours classified as carcinoma in situ and localised skin cancers are specifically excluded.

This benefit is a waiver of the deductible and co-insurance amounts, up to the limits stated, upon death occurring during hospitalisation or within 30 days of discharge of the hospitalisation and provided death occurs as a result of the cause of the hospitalisation.

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 advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

a) Cancellation Clause
The Company reserves the right to terminate coverage at any time by giving 30 days' notice in writing to the Owner. Whenever such cancellation occurs, the Company shall return the unearned portion of premiums paid. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination.

b) Terms of Renewal
Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

c) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

d) 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 3 conditions. You are advised to read the policy contract for the full list of exclusions.**

- **Pre-existing condition** – This is defined as any known medical condition from which the Insured is suffering on or before the issuance of the policy, including those for which treatment, medication or advice have been received before the issuance of the policy. **This plan does not cover any hospitalisation or surgical charges incurred if the condition resulting in the hospitalisation or surgery existed on or before the issuance of the policy contract.**

- **Congenital Anomalies or Defect** – This plan does not cover any hospitalisation or surgical charges incurred directly or indirectly for the treatment for congenital abnormalities and physical defects that have been in existence since birth.

- **Reasonable & Customary Charges** – This is defined as the general level of charges applicable in Singapore when furnishing similar or comparable treatment, services or supplies to individuals of the same sex and comparable age, for similar disease or injury. **The benefits payable under this plan shall be the lower of the Reasonable and Customary Charges in Singapore and those in the foreign country in which the Insured seeks similar medical treatment.**

e) Waiting Period
This plan shall not apply or no benefits will be payable if the illness or disorder, which results in the Insured's hospitalisation or having to undergo surgery, is diagnosed within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later.

f) Change of Occupation
In the event of a change in occupation of the Insured, the Insured shall notify the Company in writing of the new occupation. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation.

APPENDIX III

Format for Product Summary for Critical Illness Plan

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

Plan Name: _____ Sum Assured ($): _____

Premium Rate: _____ Expiry Date of Cover: _____

Please note that the premium rates are not guaranteed and the Company may at its sole discretion increase the premium rates from time to time depending on its claims experience.

Product Information:

This policy will pay the lump sum benefit (sum assured) when the Insured is diagnosed as suffering from any one of the 30 covered Critical Illnesses listed below, as defined in the policy contract. With effect from DD/MM/YY, the Insurance Industry has adopted common definitions for all critical illnesses. This means that each illness covered will be defined the same way by all insurance companies. You are advised to refer to the policy contract for definitions of the covered Critical Illnesses.

1. First Heart Attack (Excludes coverage within 90 days)
2. Stroke
3. Coronary Artery Surgery (Excludes coverage within 90 days and excludes angioplasty, laser or other intra-arterial procedures)
4. Occupationally Acquired HIV and HIV due to blood transfusion (Excludes HIV infection from other means including sexual activity and use of intravenous drugs)
5. Angioplasty and Other Invasive Treatments for Coronary Artery Disease
6. Cancer (Excludes coverage within 90 days, includes leukaemia other than chronic lymphocytic leukaemia but excludes non-invasive cancers in situ, tumours in the presence of HIV and any skin cancer other than Malignant Melanoma)
7. Fulminant Viral Hepatitis
8. Pulmonary Arterial Hypertension
9. Kidney Failure
10. Major Organ Transplant
11. Multiple Sclerosis
12. Blindness
13. Paralysis (Excludes self-inflicted injuries)
14. Muscular Dystrophy
15. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (Excludes neurosis, psychiatric illness and any drug or alcohol related organic disorder)
16. Coma (Excludes illness resulting from drug or alcohol abuse)
17. Loss of Hearing
18. Heart Valve Replacement
19. Loss of Speech (Excludes all psychiatric causes)
20. Major Burns
21. Surgery to Aorta
22. Terminal Illness

23. End-stage Lung Disease
24. Chronic Liver Disease (Excludes illness resulting from drug or alcohol abuse)
25. Motor Neurone Disease
26. Parkinson's Disease (Excludes drug-induced or toxic causes)
27. Aplastic Anaemia
28. Bacterial Meningitis (Excludes illness resulting from HIV infection)
29. Benign Brain Tumour (Excludes cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas and tumours in the pituitary or spine)
30. Encephalitis (Excludes illness resulting from HIV infection)

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 advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

a) Terms of Renewal
Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) 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 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

Pre-existing condition –This plan shall not apply or no benefits will be payable if the Insured has been diagnosed with the Critical Illness before the issuance of the policy. This includes those for which treatment, medication, or advice had been received before the issuance of the policy.

Congenital Anomalies or Defect – This plan shall not apply or no benefits will be payable if the Critical Illness is due to any congenital abnormalities and physical defects that have been in existence since birth.

d) Waiting Period
This plan shall not apply or no benefits will be payable if the Insured is diagnosed as suffering from a Critical illness within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later.

e) Survival Period
This plan shall not apply or no benefits will be payable if the Insured dies within 30 days from the day on which the Insured is diagnosed as suffering from a Critical Illness.

APPENDIX IV

Format for Product Summary for Long Term Care Plan

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

Plan Name: _____ Premium Rate ($): _____

Expiry Date of Cover:_____ Monthly Benefit ($): _____

Death Benefits ($): _____

Please note that the premium is not guaranteed and the Company may at its sole discretion increase the premium from time to time depending on its claims experience.

Product Information:

This plan will provide the following benefits when the Insured is diagnosed to have suffered a Qualifying Loss of Functional Capacity.

1) Monthly Cash Benefit
The monthly benefit will be paid to the Applicant for as long as the Insured suffers from a Qualifying Loss of Functional Capacity. Should the Insured recover from the Qualifying Loss of Functional Capacity, the Company will stop further monthly benefit payments and the Policy will terminate.

2) Waiver of Premium
Premium for this plan will be waived during the period the Insured suffers a Qualifying Loss of Functional Capacity.

Upon the death of the Insured, the death benefit will be payable.

Qualifying Loss of Functional Capacity:
The Insured is considered to have suffered from a Qualifying Loss of Functional Capacity if the Insured is unable to perform (with or without assistance) at least 3 out of 6 Activities of Daily Living, or if the Insured suffers from Advanced Dementia (including Alzheimer's Disease), as defined in the Contract.

Activities of Daily Living:
The 6 Activities of Daily Living covered under this plan are defined as follows:

- **Washing** - the ability to wash in the bath or shower (including getting into and out of the bath or shower), or to wash satisfactorily by other means;
- **Dressing** - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- **Transferring** - the ability to move from a bed to an upright chair or wheelchair and vice versa;
- **Mobility** - the ability to move indoors from room to room on level surfaces;
- **Toileting** - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- **Feeding** - the ability to feed oneself once food has been prepared and made available.

Advanced Dementia:

Advanced Dementia, including Alzheimer's disease, is defined as a medically confirmed diagnosis of dementia which is solely responsible for the inability of the Insured to perform unassisted any two of the Activities of Daily Living.

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 advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

a) Terms of Renewal
Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) 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 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

Pre-existing condition – **This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to a medical condition that occurred or was diagnosed before the issuance of the policy. This includes conditions for which treatment, medication, or advice was received before issuance of the policy.**

Self-inflicted Injury – This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to any injury or illness, caused directly or indirectly, by self-destruction or intentional self-inflicted injury, drugs or alcohol abuse, or because of injuries sustained as a direct result of a criminal act or attempted suicide, whether the Insured is sane or insane.

d) Waiting Period
The Insured must suffer from a Qualifying Loss of Functional Capacity for a continuous period of at least 90 days before the benefits under this plan are payable by the Company. No benefits will be paid during the waiting period.

APPENDIX V

Format for Product Summary for Disability Income Plan

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

Plan Name: _____ Premium Rate ($): _____

Expiry Date of Cover:_____ Monthly Benefit ($): _____

Deferment Period: _____ Death Benefits ($): _____

Please note that the premium is not guaranteed and the Company may at its sole discretion increase the premium from time to time depending on its claims experience.

Product Information:

This plan will provide the following benefits in the event of disability due to illness or injury resulting in inability of the Insured to perform all the duties of his/her occupation or any other occupation after the onset of disability.

1) Monthly Cash Benefit
In the event of total disability, the Monthly Benefit will be paid to the Insured for as long as the Insured is unable to perform his/her occupation or any other occupation after the onset of disability. In the case of partial disability, if the monthly earned income of the Insured falls by at least 25%, a pro-rated amount of the monthly benefit will be paid to the Insured. Payment of the Monthly Benefit will commence after the Deferment Period.

2) Waiver of Premium
Premium for this plan will be waived for the period the monthly benefit is paid to the Insured.

Upon the death of the Insured, the death benefit will be payable.

Total Disability:
The Insured is considered to be totally disabled if he/she is unable to perform his/her usual occupation, or any occupation or profession to earn or obtain any wages for compensation or profit.

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 advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

a) Terms of Renewal
Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

b) Non-Guaranteed Premium

Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) 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 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

Pre-existing condition – **This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to a medical condition that occurred or was diagnosed before the issuance of the policy. This includes conditions for which treatment, medication, or advice was received before the issuance of the policy.**

Self-inflicted Injury – This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to any injury or illness caused directly or indirectly by self-destruction or intentional self-inflicted injury, drugs or alcohol abuse, or because of injuries sustained as a direct result of a criminal act or attempted suicide, whether the Insured is sane or insane.

d) Deferment Period

The deferment period is the period of time after becoming disabled during which no benefits will be paid despite being under insurance coverage