LIA & GIA GUIDELINES
DISCLOSURE REQUIREMENTS FOR ACCIDENT & HEALTH (A&H) INSURANCE PRODUCTS

Introduction

1 **MAS Notice 120** (Disclosure and Advisory Process Requirements for Accident and Health (A&H) Insurance Products) sets out both mandatory requirements and best practice standards on the disclosure of information and provision of advice to policy owners for accident and health policies and life policies that provide accident and health benefits.

2 The objective of this set of Guidelines is to set out **industry standards on the disclosure of information** to policy owners, to be carried out by the A&H insurance intermediary for A&H insurance policies and life policies that contain A&H benefits. The definitions of the respective terms used in this document take reference from the MAS Notice 120.

3 This guideline is intended to complement and supplement the MAS Notice. It does not repeat the requirements in the Notice. In the event of conflict, the regulatory provision shall apply.

Pre-sales disclosure documents

4 The below table lists the mandatory pre-sales disclosure documents that must be provided to intending policy owners of individual policies (who are individuals) and individual members of voluntary plans under group policies when advice is given:

Types of products	Your Guide to Health Insurance*	Product Summary
Individual Health Policies	√	√
Individual Accident Policies	X	X (see point 6)
Individual Life Policies with health benefits	√	√
Individual Life Policies with accident benefits	X	√
Group Policies with voluntary health benefits**	√	X (see point 6)
Group Policies with voluntary accident benefits**	X	X (see point 6)

*Includes Infographic "Evaluating my Health Insurance Coverage", and Insurers shall reproduce in verbatim the document "Your Guide to Health Insurance".

**Group Policies with voluntary benefits means group policies where individual members of the group have a choice to participate in the group policy, or adjust their level of coverage (such as upgrading or downgrading) and are responsible for paying the premium (where applicable), whether in monetary form or otherwise. This is commonly known as a voluntary plan.

5 An existing policy owner need not be provided these documents at the point of policy renewal or when he changes his servicing agent. This exemption, however, does not apply where the policy owner is replacing an existing policy with a new one.

6 For **individual accident policies and group policies with voluntary accident and/or health benefits (also known as voluntary plan)**, while product summaries are not mandatory, specific information listed under Point 15 below must be disclosed. It can be presented in other form of written disclosures where the form of Product Summary as a standalone single document is not used. For example, a document that combines the proposal form, benefit tables and listed specific information in a pamphlet form is acceptable.

7 A&H Insurance intermediary shall require intending policy owners to acknowledge that they have read and understood the pre-sales disclosure documents. Insurers must keep a record of these acknowledgements.

8 For Integrated Plans (IP), where applicable, the above information is presented in mandatory wordings and in a format as per the regulations issued by the Ministry of Health and Monetary Authority of Singapore.

9 The final proposed terms for **group policies** must be signed/acknowledged by the client or a legally appointed representative of the client (e.g. when letter of authorisation clearly states that the broker is allowed to sign binding insurance contracts on the client's behalf).

10 For policies related to **Foreign Worker Medical Insurance**, to include disclosure of whether the hospital and surgical plans provide coverage that complies with Ministry of Manpower's (MOM) enhanced Medical Insurance requirements for S Pass and Work Permit holders. Insurers have the flexibility in how they disclose this information. It can be included in the Product Summary, proposal form, quotation slip / renewal invitation (for renewal cases only) or by adding a link to the insurer's website (whichever applicable) for the disclosure information.

11 Requirements stated in Point 15 may also be contained in a Policy Illustration (PI) and are presented together with the Product Summary. In such cases, such information need not be duplicated in the Product Summary.

12 Where applicable, for group policies, insurers must specify the period of validity of a proposal (or a quote) to all intending policy owners; as well as other key policy terms and conditions that includes eligibility for coverage, and obligations to be met by client and rights of insurers when these are not met (e.g. any individual underwriting requirements, declaration on named basis, etc.).

Specific guidelines for the "Product Summary"

13 The "Product Summary" aims to provide intending policy owners with details on key product information that may affect their decision to purchase the policy.

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

15 The following information shall be disclosed in the "Product Summary":

a. *Name and the business address of Insurer underwriting the Product.*

b. *Nature and objective of the policy*

   i. whether the policy is a health policy or a personal accident policy; and

   ii. whether the policy seeks to reimburse health services costs incurred by the insured, provide continuous income during disability or sickness, provide lump sum benefits on the occurrence of specified events, or a combination of these.

c. *Benefits Schedule Table (where applicable):*

   i. Summary of Benefits or Covered Events: Description of the product, including the covered event(s), key definition of covered event(s) and the sum assured (where applicable).

   ii. 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.

   iii. The minimum amount of the claim that must be borne by the policy owner, 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.

   iv. 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.

d. *The amount and timing of the payment of the policy moneys:* Where the policy moneys are not guaranteed, it should be mentioned explicitly including the terms and conditions for policy moneys to be paid.

e. *Premium Rates or Premium Rates Table:*

   i. Individual policy – The premium rate at entry age that is payable for each premium instalment, or a premium rates table where the premium is not level.

   ii. Group policy – The unit premium rate and/or total premiums, along with the basis by which these figures were derived from, where applicable.

   Note: If the policy is purchased by an employer specifically for and complies with MOM's enhanced Medical Insurance requirements for S Pass and Work Permit holders, the premium rates table shall be provided in age bands according to MOM's requirements.

f. *Premium Payment Duration:* The frequency and number of years premiums are payable for.

g. *Premium Guarantee:* Where premium rates are not guaranteed or can be increased at the insurer's discretion, this must be clearly indicated.

h. *Duration of Policy Cover:* Duration of policy coverage in terms of number of years, expiry date of cover or age of cessation of cover.

i. *Total Distribution Costs* (TDC): Total cost that the Insurer may expect to incur, including any commission, fee and other benefit that an insurance intermediary has received or will be receiving for providing advice on, or arranging insurance contracts or both. It can be expressed as a range if TDC is different for the same product due to sales via different distribution channels.

j. *Risks to be borne by policy owner, including:*
   i. *Cancellation/Termination Clause by the insurer:* Stating explicitly that the policy may be unilaterally cancelled or terminated or not renewed by the insurer.

   ii. Whether Insurer may alter the terms of contract, and if so, what are the terms that may be altered and under what conditions would alterations be allowed.

k. *Renewability of the Policy or Terms of Renewal:* Information on the terms relating to policy renewal (e.g. 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.

l. *Waiting Period:* Where policy benefits are payable only a specified length of time after policy inception, this must be clearly stated.

m. *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.

n. *Benefit Limitations, Exclusions & Lien:* Conditions under which benefits of the policy will not be payable or reduced.

o. *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 policy owner after policy inception. Examples of such provisions are Change of Occupation or Change of Country of Residence.

p. *Deferment Period/Pre-Benefit Period:* Where the policy benefits are payable only after a certain period upon the occurrence of the covered event, this must be clearly stated.

q. *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.

r. *Free-look period:* Where rights are granted to the policy owner to cancel the policy within the free-look period without penalty, the free-look period, the terms and procedures for exercising the rights must be clearly stated.

s. *Claims procedures and relating restrictions and charges:* Restrictions and charges relating to claims should be stated in the Product Summary. The insurer may provide greater details on claims procedures by using references (e.g. company's website).

t. *Termination procedures and relating restrictions and charges*: Restrictions and charges relating to termination should be stated in the Product Summary. The insurer may provide greater details on termination procedures by using references (e.g. company's website).

u. *Warnings and disclaimers*, including warning of switching between A&H policies without considering the switch is detrimental to them.

v. *Contractual rights and obligations:*

i. the party against which the policy owner may take action to enforce his rights with respect to the policy he has purchased;

ii. that the applicant is responsible for the accuracy and completeness of the information given to the insurer when applying for the policy and when making a claim under the policy; and

iii. that any mis-statement or non-disclosure of material facts may affect the validity of the policy.

w. *If the policy is not a Medisave-approved policy, this statement has to be included as stipulated in Appendix C of the MAS Notice 120:* "This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy."

x. *Statement to be included in the product summary of the policy (for renewable short-term accident and health policies).* Please refer to Appendix VII below.

y. *Additional statement to be included in the product summary of the policy if impose exclusions or require additional premiums to cover existing medical conditions (for renewable short-term accident and health policies).* Please refer to Appendix VII below.

16 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:

- Appendix I – Specimen wordings for Product Summary
- 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
- Appendix VI – Format for Pre-contract Disclosure
- Appendix VII – Disclosure for non-guaranteed renewability of short-term A&H policies

17 For a group policy, where any person insured under the policy is liable to pay any premium (whether in monetary form or otherwise), in other words participating in a voluntary plan, the A&H insurance intermediary shall disclose to every person in the group information as if it is dealing with them individually, with key product information that may affect their decision to participate, upgrade or downgrade the coverage set out in the product summary (or an equivalent document) as per Point 15.

Application of the guidelines to direct marketing and telemarketing channels

18 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, insurance agent or insurance broker). Where a financial advisor, insurance agent or insurance broker is subsequently involved in the sales process as a result of a referral, the standard guidelines previously discussed shall apply.

19 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.

20 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.

21 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.

22 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 advice 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."

23 The above statements listed in Point 22 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 must be sought and recorded.

24 The insurers must make adequate arrangements to provide appropriate post-sales disclosures to policy owners 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; and
- highlights to the proposer that he or she is entitled to a "XX-day Free Look" period and can decide to cancel his coverage without penalty within this period if he deems the product unsuitable.

25 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.

Post-sales disclosure

26 Insurers must make continuing disclosures to policy owners whenever there are changes to the product information and/or policy terms and conditions specified in the Product Summary. The documents required for continuing disclosure is at the discretion of insurers as long as they disclose the pertinent information recommended in the guidelines.

27 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

28 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 policy owners.

29 Insurers are required to give policy owners advance written notice of at least 30 days before the modifications take effect, as stipulated in Paragraph 29 (d) of the MAS Notice 120.

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

- obtain written acceptances of the modified terms from policy owners; or
- where no written acceptance of the modified terms is sought, the insurer must ensure that all of the following conditions are fulfilled:

i) policy owners are given the option to reject the modified terms and cease cover;
ii) in the notification letter to policy owners:

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:

"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)".

Specimen wordings for Product Summary

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 paying of the premium."

3) **Non-guaranteed premium**
"Premiums payable for this coverage are not guaranteed and may be adjusted 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 <*the insurer can independently determine the suitable waiting periods in their insurance policies*>.**

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 <XX> 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 <XX> 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 <XX> days of being diagnosed as suffering from a critical illness."

9) **Free-look period**

"You have a free-look period of <XX> days to review the policy from the date you receive it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you without interest after deducting the expenses incurred in issuing this policy. This option of free-look period shall not apply to renewals of your policy with us."

10) **Medical Insurance for S Pass and Work Permit Holders**

"This hospital and surgical plan <meet/do not meet> the Ministry of Manpower's minimum requirements for S Pass and Work Permit holders."

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 Adviser Representative:_____

Age & Gender: _____ Date: _____

(Age last birthday & Gender of Insured)

Plan Name: _____ Expiry Date of Cover: _____

Name and the business address of Insurer underwriting the Product.

This product is underwritten by <insurer name>, <Insurer business address>.

Nature and objective of the policy

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.

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

Benefits Schedule :

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 Limit per lifetime	110,000 330,000	85,000 250,000
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 Adviser Representative 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 paying of the premium.

c) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be adjusted 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 <XX> days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later.

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

You can visit or contact us at the following designations:

Website: <website>
Telephone: +65 XXXX XXXX

g) Free-look period
You have a free-look period of <XX> days to review the policy from the date you receive it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you without interest after deducting the expenses incurred in issuing this policy. This option of free-look period shall not apply to renewals of your policy with us.

h) 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.

i) Medical Insurance for S Pass and Work Permit Holders
This hospital and surgical plan does not meet the Ministry of Manpower's minimum requirements for S Pass and Work Permit holders.

Important Note

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

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

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

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 Adviser Representative: _____

Age & Gender: _____ Date: _____

(Age last birthday & Gender of Insured)

Plan Name: _____ Sum Assured ($): _____

Premium Rate: _____ Expiry Date of Cover: _____

Name and the business address of Insurer underwriting the Product.

This product is underwritten by <insurer name>, <Insurer business address>.

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 37 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. Major Cancer
2. Heart Attack of Specified Severity
3. Stroke with Permanent Neurological Deficit
4. Coronary Artery By-pass Surgery
5. End Stage Kidney Failure
6. Irreversible Aplastic Anaemia
7. End Stage Lung Disease
8. End Stage Liver Disease
9. Coma
10. Deafness (Irreversible Loss of Hearing)
11. Open-Heart Heart Valve Surgery
12. Irreversible Loss of Speech
13. Major Burns
14. Major Organ/Bone Marrow Transplantation
15. Multiple Sclerosis
16. Muscular Dystrophy
17. Idiopathic Parkinson's Disease
18. Surgery to Aorta
19. Alzheimer's Disease / Severe Dementia
20. Fulminant Hepatitis
21. Motor Neurone Disease
22. Primary Pulmonary Hypertension
23. HIV Due to Blood Transfusion and Occupationally Acquired HIV
24. Benign Brain Tumour
25. Severe Encephalitis
26. Severe Bacterial Meningitis
27. Angioplasty & Other Invasive Treatment for Coronary Artery
28. Blindness (Irreversible Loss of Sight)
29. Major Head Trauma
30. Paralysis (Irreversible Loss of Use of Limbs)
31. Terminal Illness
32. Progressive Scleroderma
33. Persistent Vegetative State (Apallic Syndrome)
34. Systemic Lupus Erythematosus with Lupus Nephritis
35. Other Serious Coronary Artery Disease
36. Poliomyelitis
37. Loss of Independent Existence

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 Adviser Representative should you require further explanation.

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

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be adjusted 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 <XX> 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 <XX> days from the day on which the Insured is diagnosed as suffering from a Critical Illness.

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

You can visit or contact us at the following designations:

Website: <website>
Telephone: +65 XXXX XXXX

g) Free-look period
You have a free-look period of <XX> days to review the policy from the date you receive it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you without interest after deducting the expenses incurred in issuing this policy. This option of free-look period shall not apply to renewals of your policy with us.

Important Note (for adoption where applicable only)

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

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

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

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 Adviser Representative: _____

Age & Gender: _____ Date: _____

(Age last birthday & Gender of Insured)

Plan Name: _____ Premium Rate ($): _____

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

Death Benefits ($): _____

Name and the business address of Insurer underwriting the Product.

This product is underwritten by <insurer name>, <Insurer business address>.

Please note that the premium is not guaranteed and the Company may at its sole discretion adjust 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 wash 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 or medical appliances;
- **Transferring** - the ability to move from a bed to an upright chair or wheelchair, and vice versa;
- **Walking or Moving Around** - the ability to move indoors from room to room on level surfaces;
- **Toileting** - the ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments or surgical appliances if appropriate;
- **Feeding** - the ability to feed oneself food after it 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 Adviser Representative should you require further explanation.

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

b) Non-Guaranteed Premium
   Premiums payable for this coverage are not guaranteed and may be adjusted 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 <XX> days before the benefits under this plan are payable by the Company. No benefits will be paid during the waiting period.

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

You can visit or contact us at the following designations:

Website: <website>
Telephone: +65 XXXX XXXX

f) Free-look period
You have a free-look period of <XX> days to review the policy from the date you receive it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you without interest after deducting the expenses incurred in issuing this policy. This option of free-look period shall not apply to renewals of your policy with us.

Important Note (for adoption where applicable only)

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

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

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

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 Adviser Representative: _____

Age & Gender: _____ Date: _____

(Age last birthday & Gender of Insured)

Plan Name: _____ Premium Rate ($): _____

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

Deferment Period: _____ Death Benefits ($): _____

Name and the business address of Insurer underwriting the Product.

This product is underwritten by <insurer name>, <Insurer business address>.

Please note that the premium is not guaranteed and the Company may at its sole discretion adjust 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 Adviser Representative should you require further explanation.

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

b) Non-Guaranteed Premium

Premiums payable for this coverage are not guaranteed and may be adjusted 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.

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

You can visit or contact us at the following designations:

Website: <website>
Telephone: +65 XXXX XXXX

f) Free-look period
You have a free-look period of <XX> days to review the policy from the date you receive it. If you decide that this policy does not suit your needs, you may request to cancel it by giving us clear, written instructions within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you without interest after deducting the expenses incurred in issuing this policy. This option of free-look period shall not apply to renewals of your policy with us.

Important Note (for adoption where applicable only)

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

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

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

Pre-contract Disclosure Form

[Insurer corporate header – each insurer will manage this]

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

PRODUCT NAME:

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

[Stage 1] Applies to policies with start date effective on or after 1 July 2023	Yes/No
Annual claim limit of at least $60,000, inclusive of a first-dollar cover of $15,000	
For portion of the bill above $15,000, the employer must co-pay up to 25% (to the hospital)	
[Stage 2] Applies to policies with start date effective on or after 1 July 2025	Yes/No
Exclusions are in line with MOM's list of allowable exclusions[2]	
Age-differentiated premiums are in 2 age bands: (1) ≤50 years old; and (2) >50 years old	
Insurers will reimburse our portion of the hospital bill to hospitals directly upon admissibility of the medical claim	

[Note: Insurers need to comply with the enhanced Medical Insurance requirements under Stage 2 on or after 1 July 2025.]

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

2. Refer to https://www.mom.gov.sg/-/media/mom/documents/work-passes-and-permits/standardised-allowable-exclusions-for-medical-insurers.pdf for the list of allowable exclusions.

Disclosure for non-guaranteed renewability of short-term A&H policies

The below disclosure statement must be included for non-guaranteed renewable short-term accident and health policies in its product summary.

This is a short-term accident and health policy[i] and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you ___[ii] notice in writing.

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

[i]The insurer shall use in the above statement the same term that is used in the product summary to refer to the short-term accident and health policy.

[ii]The insurer shall set out the relevant notice period, whether in days, weeks or months.

* The insurer shall include this statement only if it imposes exclusions or require additional premiums to cover existing medical conditions under the short-term accident and health policy at renewal.