



redefining / insurance

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 GST Reg No. 199903512M
 Co. Reg No. 199903512M

Application Form

SmartCare Executive

A. Application Details

Important Notes

- Under Section 25(5) of the insurance Act Cap 142 or any subsequent amendment thereof, you are to disclose in this Application form, fully and faithfully, all the facts which you know or ought to know, otherwise the policy issued may be void.
- Please complete this form by answering carefully all questions. It is important that a complete answer be given to every question including dates where applicable in order to avoid unnecessary delay in the processing of this application. Any question not answered on this form will be taken as an answer in the negative. Please complete in BLOCK LETTERS and tick the appropriate boxes.

Part I – Particulars of Applicant

Surname <input type="checkbox"/> Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/> Mdm <input type="checkbox"/> Dr				Given name			
NRIC No. / FIN		Nationality		Marital Status		Age Next Birthday	
Date of Birth: (ddmmyyyy)		Height (m)	Weight (kg)	Gender <input type="checkbox"/> Male / <input type="checkbox"/> Female		Smoker <input type="checkbox"/> Yes / <input type="checkbox"/> No No. of sticks / day: Yrs of smoking:	
Mailing Address							Postal Code
Have you been in Singapore for more than 182 days at the time of application? <input type="checkbox"/> Yes / <input type="checkbox"/> No							
Tel (H)		(O)			(Mobile/Pager)		
Email				Occupation/Profession/Job nature			

Part II – Particulars of Family Members to be Insured

	Full name	NRIC/FIN/ BC No.	Date of birth (ddmmyyyy)	Gender	Height (m)	Weight (kg)	Smoker (Y/N)
Applicant	Applicant as named under Part I						
Spouse							
Child 1							
Child 2							
Child 3							

Occupation/Profession of Spouse: _____ For Smoker only – No. of sticks/day: _____ Yrs of smoking: _____

Note: Proposal for children must include at least one parent (If more space is required, please write on separate sheet of paper and attach herewith).

Part III – Details of Employer

Please complete this section **ONLY** if policy is to be issued to your employer.

Name of Employer: _____

Address of Employer: _____

Nature of Employer's Business: _____

Part IV – Details of Insurance (Please tick the appropriate box)

PERIOD OF INSURANCE From (ddmmyyyy) To (ddmmyyyy)

CHOICE OF PLAN & OPTIONAL DEDUCTIBLE &/OR CO-PAYMENT

Private Hospital Plan			Public Hospital Plan		
<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E	<input type="checkbox"/> Plan F
Premium Discount	Deductible	Co-payment	Premium Discount	Deductible	Co-payment
<input type="checkbox"/> 10%	S\$0	10%	<input type="checkbox"/> 10%	S\$0	10%
<input type="checkbox"/> 30%	S\$2,000	0%	<input type="checkbox"/> 30%	S\$1,000	0%
<input type="checkbox"/> 45%	S\$2,000	10%	<input type="checkbox"/> 45%	S\$1,000	10%

Note: The deductible & co-payment apply to Hospital & Surgical Benefits except Emergency Outpatient Treatment (due to accident only) and Major Organ Transplant.

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

Part V – Individual Take Over

(Applicable only if the applicants are currently insured under an individual Health insurance plan with other insurance company in Singapore. Please provide a copy of your renewal invitation and previous policy documents including terms and conditions of the policy contract.)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Has any one of the applicants had treatment in hospital or consulted a specialist in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does any of the applicants have any consultation, treatment, investigation or test planned or pending (this applies whether it is to be provided by a Specialist or General Practitioner)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any one of the applicants suffered from any form of heart disease, renal failure, cancer, diabetes, any alcohol or drug problems or mental illness including depression? | <input type="checkbox"/> | <input type="checkbox"/> |

If all the above answer is NO, please skip "Part VI – Questionnaire". Please complete "Part VI - Questionnaire" if any of the above answer is YES.

Part VI – Questionnaire

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Has any one of the applicants ever had any physical defects or infirmity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has any one of the applicants ever, | | |
| (a) had a surgical operation? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Has any one of the applicants ever had or been told to have, or currently undergoing any medical treatment for, ever been treated for, under observation for, | | |
| (a) any nervous or mental disorders (e.g. epilepsy/fits, prolonged headache or depression)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) any lung trouble, eg. asthma, bronchitis? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) any heart trouble, stroke or circulatory disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) any stomach, bowel, kidney, liver or bladder trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) any form of rheumatism, arthritis or back trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) any enlarge glands or any form of cancer, tumor or disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) any condition requiring treatment, eg. raised blood pressure, diabetes or used drugs for any other reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) any medical or surgical advice or treatment other than those already stated? | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) any alcohol or drug problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any one of the applicants during the past 5 years, had any treatment, examination or advice for a complaint by a physician or other medical practitioners, at a clinic, hospital, dispensary, or sanitorium? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If the answer to any of the above questions is YES, please provide details below. If surgery is undertaken, please provide name/nature of surgical procedure. (If more space is required, please write on a separate sheet of paper and attach herewith.) | | |

Name of Person	Nature of Illness/ Disability	Date & Duration of Disability	Type & Result of Treatment/ Surgery	Name & Address of Doctor, Clinic/Hospital

- | | Yes | No |
|--|--------------------------|--------------------------|
| 6. Has any one of the applicants ever, | <input type="checkbox"/> | <input type="checkbox"/> |
| (a) had an Accident or Health insurance policy cancelled or its renewal refused? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) had a Life, Accident or Health insurance policy declined, postponed, withdrawn or subject to special terms and conditions? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) made a claim against any Insurer in respect of bodily injury or sickness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If the answer to any of the questions is YES, please give details: _____ | | |
| 7. Has any one of the applicants experienced any symptoms but not consulted a medical practitioner in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If the answer to any of the questions is YES, please give details: _____ | | |
| 8. Is there any known or foreseeable need to consult any doctor or other health professional? | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please give details: _____ | | |
| 9. In the last 1 year, has any one of the applicants experienced unexplained weight loss, or recurring symptoms for more than 2 weeks (e.g. giddiness, breathlessness, abnormal growth or enlargement, persistent fever, diarrhea, bodily discomfort or pain?) | <input type="checkbox"/> | <input type="checkbox"/> |
| If YES, please give details: _____ | | |
| 10. When did you including your dependents last consult a doctor for any illness? | | |

Name of Person	Nature of Illness /Disability	Date of Last Visit	Type & Result of Treatment received	Date of follow up (if any)	Name & address of Doctor, Clinic/Hospital

Part VII – Raised Blood Pressure / Hyperlipidaemia (high cholesterol)

Applicable only to applicants who have ever had or been told to have, or currently undergoing any medical treatment for, ever been treated for, under observation for, Raised Blood Pressure/ Hyperlipidaemia (high cholesterol).

1. Please provide the latest blood pressure and cholesterol reading and date.
(If more space is required, please write on a separate sheet of paper and attach herewith.)

A. Raised Blood Pressure

Name of Person	Systolic & Diastolic Reading	Date of Reading	Are you receiving medical treatment for Raised Blood Pressure?	Has your Raised Blood Pressure been managed and under the control* of a medical practitioner for at least twelve months?
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

* By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Raised Blood Pressure.

B. Hyperlipidaemia (high cholesterol)

Name of Person	Total Cholesterol Level (Tchol)	Date of Reading	Are you receiving medical treatment for Hyperlipidaemia (high cholesterol)?	Has your Hyperlipidaemia (high cholesterol) been managed and under the control* of a medical practitioner for at least twelve months?
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

* By 'control' we mean that for the last one year, you have been and is currently, under the supervision of your physician to monitor your Hyperlipidaemia (high cholesterol).

2. Please provide name and address of the treating doctor and clinic.

Part VIII – Personal Data

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

By providing this information, I understand and give my consent for AXA Insurance Singapore and AXA Life Insurance Singapore (collectively “AXA”) and their respective representatives or agents to:

- (a) Collect, use, store, transfer and/ or disclose the information, to or with all such persons (including any member of the AXA Group or any third party service provider, and whether within or outside of Singapore) for the purpose of enabling AXA to provide me with services required of an insurance provider, including the evaluating, processing, administering and/ or managing of my relationship and policy(ies) with AXA, and for the purposes set out in AXA’s Data Use Statement which can be found at <http://www.axa.com.sg> (“Purposes”).
- (b) Collect, use, store, transfer and/ or disclose personal data about me and those whose personal data I have provided from sources other than myself for the Purposes.
- (c) Contact me to share with me information about products and services from AXA that may be of interest to me by post and e-mail and

By telephone By fax By text message

Part IX – Declaration

1. I/We declare that the above answers are full, complete and true and agree that they shall form part of my/our application which shall be the basis of the contract of insurance.
2. I/We are aware that I/we can seek advice from a qualified insurance advisor before I/we sign this proposal form. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.
3. I/We understand that this Policy shall only be effective following full annual premium payment and subject to the acceptance and approval of this application by AXA Insurance Singapore.
4. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
5. I/We also agree that in case of any claims, I/we authorise any hospital, physician or other person who has attended to us, or examined us or is authorised to maintain medical records to disclose when requested to do so by AXA Insurance Singapore, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorisation shall be considered as effective and valid as the original.
6. I/We also understand that membership cards issued for the policy are to be used only for admissions to hospitals for treatment falling under the scope of the policy and in the event the charges incurred are not claimable from the policy for any reason, I/we shall undertake to pay AXA Insurance Singapore within 30 days from the receipt of all expenses that are not claimable under the policy including the interest, if any levied by the hospital. I/We further agree to sign the MediSave Authorisation form at the hospital notwithstanding the production of the membership card. I/We also agree to return the membership card upon request from AXA Insurance Singapore or on termination of the policy.
7. I/We understand that AXA Insurance Singapore reserves the right to request for a copy of the latest medical report from me/us at my/our own expense should further medical information be required.

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

Name of Client

Date (ddmmyyyy)

Part X – Payment Mode

Please choose only ONE payment mode

Cash/Nets

Make your payments at our AXA Customer Centre at AXA Tower during our office hours (Monday to Friday, 9.00am to 5.30pm).
Please do not send cash by post.

Cheque

Crossed and made payable to AXA Insurance Pte Ltd.
Please indicate the Product, Applicant’s Name, NRIC and Contact Number clearly on the back of the cheque. Please do not send us post-dated cheques.

Bank: _____ Cheque Number: _____

Credit Card

Make payment:-

- by downloading the AXS app to make payments online from the comfort of your home anytime, any day; or
- at AXS stations located island-wide; or
- by completing the Credit Card Authorisation Form and email it to us at creditcardpayment@axa.com.sg

B. Product Summary for SmartCare Executive

PRODUCT INFORMATION

This is an annual hospital & surgical plan that helps to relieve the financial burden of the family while you or your covered family member is hospitalized. Subject to the full terms and condition, we will pay expenses according to the benefits set out in the benefits schedule, depending on the plan you have chosen.

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

Benefits Table	Private Hospital Plan			Public Hospital Plan		
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
ANNUAL LIMIT <small>Applicable to All Benefits (S\$)</small>	70,000	55,000	40,000	70,000	40,000	25,000
Hospital and Surgical Benefits (S\$)						
Bed Type (Standard Types)	1-Bedded	2-Bedded	4-Bedded	1-Bedded	4-Bedded	6-Bedded
Room & Board Includes meal & general nursing care						
Intensive Care Unit						
Hospital Miscellaneous Expenses <small>Prescription drugs, Inpatient Diagnostic Procedures, Operating Theatre Fees, Ancillary Charges</small>						
Inpatient Physiotherapy						
Ambulance Services	As charged up to	As charged up to	As charged up to	As charged up to	As charged up to	As charged up to
Surgeon's Fee Includes Inpatient Surgery & Day Surgery	20,000	15,000	10,000	20,000	10,000	5,000
Anesthetist's Fee	Per disability	Per disability	Per disability	Per disability	Per disability	Per disability
In-Hospital Physician's Visit						
Pre-Hospitalisation/Surgery Specialist's Consultation (Up to 90 days)						
Pre-Hospitalisation/Surgery Diagnostic Services (Up to 90 days)						
Post-Hospitalisation/Surgery Treatment (Up to 90 days)						
Emergency Outpatient Treatment (due to accident only)						
Outpatient Benefits (S\$)						
Outpatient Cancer Treatment Per Year	20,000	15,000	10,000	20,000	10,000	5,000
Outpatient Kidney Dialysis Per Year	20,000	15,000	10,000	20,000	10,000	5,000
Emergency Outpatient Dental Treatment (due to accident only)	2,000	1,500	1,000	2,000	1,500	1,000
Extended Benefits (S\$)						
Major Organ Transplant	As charged	As charged	As charged	As charged	As charged	As charged
Miscarriage due to accident Per Occurrence	3,000	2,000	1,000	3,000	2,000	1,000
Ectopic Pregnancy Per Occurrence	3,000	2,000	1,000	3,000	2,000	1,000
Surgical Implants Per Disability	3,000	2,000	1,000	3,000	2,000	1,000
Medical Report Fees	As charged	As charged	As charged	As charged	As charged	As charged
Daily Recovery Benefits Per Day <small>After 7 days of hospitalisation, up to 20 days</small>	200	150	100	200	100	50
Special Grant	5,000	3,000	3,000	5,000	3,000	3,000

Please note:

- Per Disability shall mean all medical conditions resulting from an Illness or Injury arising from the same cause, including any and all complications arising therefrom or closely related thereto as well as concurrent medical conditions from different causes during the same hospital confinement, except that after fourteen (14) days following the latest discharge from Hospital or Day Surgery, any subsequent Illness or Injury from the same cause shall be considered as a new Illness or Injury.
- Special Grant benefit is payable upon death due to,
 - Injury
 - Illness during or after treatment for such illness, at a Hospital or in Day Surgery;
 - Critical illness
- Deductible is the amount out of an eligible claim which has to be borne by the Insured Person before the relevant benefits are payable under this Policy.
- Co-payment is the percentage of the Covered Expenses in excess of any Deductible, which is borne by you.
- We will pay up to a percentage of the Covered Expenses as per the following Pro-ratio Table if you are treated and/or stay in a different type of:
 - Ward; and/or
 - Hospital (i.e. Private Hospital or Public Hospital) from that stated on the Schedule or Endorsement.

My Plan is	I am warded in the Standard Room of the Hospital	I will receive _____% of the Covered Expenses	My Plan is	I am warded in the Standard Room of the Hospital	I will receive _____% of the Covered Expenses
A	Private or Public Hospital 1, 2, 4 or 6-Bedded	100%	D	Private Hospital : 1-bedded Private Hospital : 2 or 4-bedded Public Hospital : 4 or 6-bedded	50% 60% 100%
B	Private Hospital : 1-bedded Private Hospital : 4-bedded Public Hospital : 1, 4 or 6-bedded	60% 100% 100%	E	Private Hospital : 1, 2 or 4-bedded Public Hospital : 1-bedded Public Hospital : 6-bedded	50% 60% 100%
C	Private Hospital : 1-bedded Private Hospital : 2-bedded Public Hospital : 1-bedded Public Hospital : 4 or 6-bedded	50% 60% 60% 100%	F	Private Hospital : 1, 2 or 4-bedded Public Hospital : 1 or 4-bedded	50% 60%

ANNUAL PREMIUM RATE TABLE (INCLUSIVE OF GST)

The annual premium rates for this plan are set out below. Please note that the premium rates are not guaranteed and subjected to change without prior notice. The annual premium is based on the insured's age next birthday and the applicable rates at the time of renewal. All benefits and premiums shown are in Singapore dollars and are inclusive of GST. The plan will terminate immediately following the 80th birthday of the insured.

Private Hospital Plan

Age Next Birthday	1-17	18-29	30-39	40-44	45-49	50-54	55-59	60-65	66-69*	70-74*	75-80*
Plan A	334	440	545	619	692	966	1,088	1,528	2,188	3,288	5,046
Plan B	282	366	450	513	577	798	910	1,278	1,823	2,736	3,836
Plan C	240	303	387	440	482	682	757	1,087	1,527	2,187	3,177

Public** Hospital Plan

Age Next Birthday	1-17	18-29	30-39	40-44	45-49	50-54	55-59	60-65	66-69*	70-74*	75-80*
Plan D	261	313	387	471	524	734	878	1,208	1,747	2,715	3,782
Plan E	176	219	271	324	366	513	587	822	1,208	1,884	2,625
Plan F	92	113	134	166	187	261	292	408	586	955	1,318

Please note:

* For renewal only

** Public Hospitals refer to Government and Restructured Hospitals

The Total Distribution Cost of this product is between 0% - 19% of the premium. Such costs include cash payments in the form of commission, costs of benefits and services paid to the distribution channel. We assure you that the Total Distribution Cost is not an additional cost to you, as it was already accounted in the calculation of your premium.

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 required to refer to full actual terms and conditions in the contract. Please consult your insurance advisor should you require further explanation.

1. Waiting Period

No benefit will be payable for any illness suffered by an Insured Person that commence within thirty (30) days from the date an Insured Person is first Covered under the Policy except for Injuries sustained during an Accident which occurs after the date an Insured Person is Covered under the Policy.

2. 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 conditions.

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

- (a) Pre-existing conditions, which refers to an injury or an illness which, prior to the date on which an Insured Person is first Covered under the Policy:
 - (i) existed (or symptoms or manifestations of which existed) with respect to an Insured Person based on normal medically accepted pathological development of the injury or illness; or
 - (ii) the Insured Person was aware or should reasonably have been aware irrespective of whether treatment was actually received.
- (b) Congenital conditions, which refers to congenital anomalies as well as neo-natal physical abnormalities developing within six (6) months of birth.

3. Policy Renewal / Renewal Premium

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.

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.

- (a) On or before the expiry of your Policy, and subject to our acceptance, you may renew this Policy by paying the premium applicable at the time of renewal. This shall not apply in the event that the Policy expires, or is terminated or cancelled in accordance with the terms of this Policy and you should subsequently wish to reapply for insurance cover under this Policy.
- (b) The premium rates payable shall be determined at each renewal based on the Insured Persons' Age Next Birthday, the table of premium rates then in effect, and any other factors which may materially affect the risks insured. We reserve the right to change the table of premium rates on a class basis for our Individual **SmartCare Executive** and all similar policies.

4. Cancellation Clause

We have the right to cancel this Policy in the event that we decide to cease offering our **SmartCare Executive** Individual plan (i) totally; or (ii) to any particular groups of persons insured with us or proposing to be insured with us. We will give you at least thirty (30) days' written notice of such cancellation and upon such cancellation you will be granted a pro-rated refund of the total premium paid corresponding to the unexpired Period of Insurance.

5. Claims Conditions

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

- i) We require written notice us as soon as possible and in any event, within thirty (30) days after the occurrence of any event which may give rise to a claim under this Policy.
- ii) A claim form is obtainable from us upon request and we will require all necessary supporting documents covering the nature and extent of loss, within sixty (60) days after the occurrence of the event giving rise to the claim.
- iii) Costs related to obtaining the necessary certificates, receipts, information and evidence required for assessing the claim, are to be borne by the policyholder, and given to us in the form we require.

For further information, you can visit or contact us at the following designations:

Website: <https://www.axa.com.sg/customer-care/file-a-claim>

Telephone: (+65) 6880 4888

6. Changes in Circumstances

If there is any change in circumstances affecting the risk, the Insured must give the Company immediate written notice. In particular, the Insured must notify the Company of any changes in occupation/business or health.

7. Country of Residence

In the event the Insured intends to remain outside Singapore for more than 90 days, the Insured shall notify the Company in writing prior to the departure. The Company will advise the Insured as to whether the Insured will be covered while outside Singapore, and the Company's terms and conditions for extending such cover.

8. Reasonable & Customary Charges

The benefits payable under this plan shall be the lower of the actual charge incurred or the Reasonable and Customary Charges. This is defined as the charges for medical treatment which do not exceed the general level of fees or charges made by others of similar professional standing in the same locality where the charges are incurred, when furnishing like or comparable treatment, services or supplies for a similar Illness or Injury and which in accordance with accepted medical standards, could not have been omitted without adversely affecting the Insured Person's medical condition.

9. Free look period

You have a free-look period of 14 business days from the date that you receive this Policy to review it. You are deemed to have received the Policy within 3 days after we have dispatched it. If you decide that this Policy does not suit your needs, you may request to cancel it by giving us clear, written instructions and returning the Policy documents to us within the free-look period. Provided that no claims have been made during this period, we shall refund the premiums paid by you in full without interest. This free-look period shall not apply to policies with terms of less than 1 year. It will also not apply to policy renewals.

Our Note to You:

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 protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

