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SmartCare Executive

A. Know Your Client

Confidential Fact Find for	By your Insurance Advisor	
(Client's Name)	(Name of Advisor)	(Account Code)

Important Notice to Clients

For General Agents/Banks
Your insurance adviser is a representative with **AXA Insurance** and can advise you on the products of:

1) AXA Insurance Singapore Pte Ltd 2) _____ 3) _____

For Insurance Brokers/Financial Advisers/Banks
Your insurance advisory is a broker with _____ .
As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he/she sources the products.

Standard Statement Applicable to All Advisors:
Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given.

A policy purchased without the proper completion of a "Know Your Client" form may not be appropriate to your needs.

Application Type

Client's Choice

1. ❑ I/We wish to disclose all information requested for in this Form. (Please complete and sign "Know Your Client" and all sections of "Our Advice and Reasons Why")
2. ❑ I/We wish to receive product advice only. (Please complete and sign "Know Your Client" and sections 2 & 3 of "Our Advice and Reasons Why")
3. ❑ I/We do not wish to receive any advice from my/our advisor. (Please complete and sign "Know Your Client")

I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.

Advisor's Declaration:
I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.

_____ _____
Signature of client (on behalf of all applicants) Signature of Advisor
Date: Date:

B. Our Advice and Reasons Why

Section 1 - Analysis and Calculation Worksheet

(a) Personal Priorities (Please tick)

Your Health Insurance Concerns	Level of Concerns		
	Low	Medium	High
Cover for hospitalisation expenses	o	o	o
Cover for outpatient medical expenses	o	o	o
Cover for major illnesses (e.g. cancer, kidney dialysis)	o	o	o
Cover for loss of income due to illness or sickness	o	o	o

(b) Medical Expenses (also known as Hospital / Surgical Expenses)

(i) Which type of hospital do you or your family members prefer in the event of hospitalisation? **Private / Public***

(ii) What type of hospital ward do you or your family members prefer in the event of hospitalisation? **1 / 2 / 4 / 6 bedded***

(iii) Do you have an existing hospitalisation insurance plan? **Yes / No***

(iv) Is your existing policy an Individual policy or Group Employee Benefits policy? **Individual / Group***

Section 2 - Advisor Analysis and Recommendations

Total Health Insurance Budget : _____ per year

Advisor's recommendations	Reasons for recommendations	Remarks
Hospital/Surgical Expense Protection o **Smart***Care Executive*		Replacement **Y/N***

Note: If this product is intended to replace any existing health insurance policy, advisor should state the reasons for recommending a replacement

Section 3 - Acknowledgement

Client's Declaration:

I/We understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I/we **agree / do not agree*** with the proposed recommendation(s).

If I/we should decide to switch from one health insurance product to another health insurance product, I/we understand that:

(a) I/We may not be insurable at standard terms
(b) I/We may have to pay a different premium
(c) Terms and conditions may defer

(*Circle as appropriate.)

Statement by Advisor:

The recommendations in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the "Know Your Client" Form.

_____ _____

Signature of client (on behalf of all applicants) Signature of Advisor
Date: Date:

C. Declaration For Product Summary

I hereby confirm that the following documents were given and the contents have been explained to me satisfactorily;
(a) Your Guide to Health Insurance and;
(b) Product Summary

_____ _____

Signature of Client (on behalf of all applicants) Signature of Advisor
Date: Date:

For Office Use Only – INTERNAL

I understand that the recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I **agree /do not agree*** with the proposed recommendation(s).

Comments (necessary if in disagreement with recommendation) :			
Remedial Action			
Signature	Name	Position	Date

D. Application Details

Important Notes

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

Part I - Particulars of Person to be Insured

Surname			Given name	
NRIC No. / FIN	Nationality		Marital Status	Age Next Birthday
Date of Birth (ddmmyyyy)	Height (m)	Weight (kg)	Gender: ❑ Male ❑ Female	Smoker: ❑ Yes / ❑ No No. of sticks / day: Yrs of smoking:
Mailing Address				
				Postal code
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)
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: ❑ A (1-bedded) ❑ B (2-bedded) ❑ C (4-bedded) ❑ D (6-bedded)
❑ Public Hospitals Only ❑ Public & Private Hospitals Only

OPTIONAL CO-PAYMENT
Please tick the appropriate box if you wish to include a co-payment per claim in return for a premium discount.

	❑	❑	❑	❑
Co-payment:	5%	10%	15%	20%
Premium Discount:	5%	10%	15%	20%

Note: The co-payment does not apply to outpatient cancer treatment and kidney dialysis benefit.

ANNUAL PREMIUM DUE (inclusive of GST): S$

Part V - Questionnaire

	Yes	No
1. Has any one of the Applicants proposed for Insurance hereunder been suffering from or receiving medical advice, counselling or treatment, in connection with:		
(a) any lung trouble, eg. asthma, bronchitis?	❑	❑
(b) any heart trouble, stroke or circulatory disease?	❑	❑
(c) any stomach, bowel, kidney, liver or bladder trouble?	❑	❑
(d) any form of rheumatism, arthritis or back trouble?	❑	❑
(e) any enlarge glands or any form of cancer, tumor or disorder of the blood?	❑	❑
(f) any condition requiring treatment, eg. raised blood pressure, diabetes or used drugs for any other reason?	❑	❑
(g) any medical or surgical advice or treatment other than those already stated?	❑	❑
2. Has any one of the Applicants proposed for Insurance hereunder ever been declined, postponed or accepted on special terms for medical insurance plans?	❑	❑

3. If the answer to any of the above questions in Part V 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 disability | Date & Duration of disability | Type & Result of treatment/surgery | Name & address of doctor/hospital

_____

_____

_____

_____

4. Please give your family or regular doctor's name, address and telephone number:

_____

_____

Part VI - 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 declare that all persons proposed for insurance are in good health and are free from any form of physical defect or infirmity.
3. I/We understand that no coverage will be granted due to any illness or condition for which treatment or medication or advice has been sought or received prior to my/our enrolment in the Policy.
4. 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.
5. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
6. I/We also agree that in case of any claims, I/we authorise any hospital, physician or other person who has attended to us, or examined us or is authorised to maintain medical records to disclose when requested to do so by AXA Insurance, any and all information with respect to any illness or injury, medical history or treatment. A photocopy of this authorisation shall be considered as effective and valid as the original.
7. I/We also understand that membership cards issued for the policy are to be used only for admissions to hospitals for treatments 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 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 or on termination of the policy.
8. I/We understand that AXA Insurance reserves the right to request for a copy of the latest medical report from me/us at my/our own expense should further medical information be required.
9. I/We have been given a copy of "Your Guide to Health Insurance" and "Product Summary" and their contents have been explained to my/our satisfaction.

_____ _____

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

Part VII - Payment Method

❑ VISA ❑ MasterCard ❑ AMEX ❑ Diners

Credit card no. | | | | | | | | | | | | | | | |

Expiry date | | | | |

Cardholder's Name / Signature _____

_____

❑ Cash - Please do not send cash via mail

❑ Cheque - Crossed and made payable to AXA Insurance Singapore Pte Ltd

Bank _____ Cheque No. _____

E. Product Summary for **Smart***Care Executive*

PRODUCT INFORMATION

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

BENEFITS (S$)	PLAN A	PLAN B	PLAN C	PLAN D
ANNUAL POLICY LIMIT PER PERSON (shall apply to all benefits)	60,000	45,000	30,000	15,000
Limit Applicable to Section A.1-10 below, in aggregate	20,000 Per Disability	15,000 Per Disability	10,000 Per Disability	5,000 Per Disability
A. Hospital & Surgical				
1. Daily Hospital Room & Board (Bed Type) (include meals and general nursing services)	Single	Two	Four	Six
2. Intensive Care Unit	As Charged	As Charged	As Charged	As Charged
3. Hospital Miscellaneous Expenses(includes Ambulance fees, prescription drugs, operating theatre fees, inpatient diagnostic procedures and other ancillary charges)				
4. Surgeon's Fees				
5. Anesthetist's Fee				
6. In-Hospital Physician's Visit				
7. Pre-Hospitalisation Surgery/Specialist's Consultation (Up to 30 days before admission)				
8. Pre-Hospitalisation Surgery/Diagnostic Services (Up to 30 days before admission)				
9. Post Hospitalisation/Surgery Treatment (Upto 60 days)				
10. Emergency Out-patient Treatment (due to Accident)				
B. Outpatient Kidney Dialysis (Annual Limit)	20,000	15,000	10,000	5,000
C. Outpatient Cancer Treatment (Annual Limit)	20,000	15,000	10,000	5,000
D. Miscarriage due to Accident (Per occurrence)	1,000	1,000	1,000	1,000
E. Special Grant	3,000	3,000	3,000	3,000

Please note:

(a) Per disability shall mean all medical conditions resulting from an Illness arising from the same cause, including any and all complications arising therefrom or closely related thereto, except that after fourteen (14) days following the latest discharge from Hospital or Surgery, any subsequent disability from the same cause shall be considered as a new disability.

(b) For Section A.1. to A.10, we will pay the amount as charged up to per disability limit, but if the Insured Person choose to stay at a higher class of ward, we will ONLY pay the Room & Board and all related/eligible expenses based on the Bed Type chosen.

(c) Special Grant benefit is payable upon death due to,
- (i) injury,
- (ii) illness during or after treatment for such illness, at a Hospital or in Day Surgery;
- (iii) critical illness and it refers to Major Cancers, Heart Attack, Stroke, Coronary Artery By-pass Surgery, Kidney Failure, Aplastic Anaemia, End Stage Lung Disease, End Stage Liver Failure, Coma, Heart Valve Surgery, Major Burns, Major Organ / Bone Marrow Transplantation, Multiple Sclerosis, Parkinson's Disease, Surgery to Aorta, Alzheimer's Disease / Severe Dementia, Fulminant Hepatitis, Motor Neurone Disease, Primary Pulmonary Hypertension, Terminal Illness, Benign Brain Tumour Encephalitis, Poliomyelitis, Bacterial Meningitis, Major Head Trauma, Apallic Syndrome, Other Serious Coronary Artery Disease, Angioplasty & Other Invasive Treatment For Coronary Artery, Progressive Scleroderma, Systemic Lupus Erythematosus with Lupus Nephritis.

(d) The Insured can opt for a co-payment in order to pay a lower premium. Co-payment means the percentage out of a claim which has to be borne by the Insured Person before the relevant benefits are payable under the Policy.

PREMIUM RATE TABLE (INCLUSIVE OF 5% GST)

The annual premium rates for this plan are set out below. Please note that the premium may be revised at each renewal date, based on the profile of all persons insured under the **Smart***Care Executive* plan. The annual premium is based on the Insured's age next birthday and the applicable rates at the time of renewal. The plan will terminate immediately following the 72nd birthday of the insured.

For Males

Age band / Hospital Type	Plan A		Plan B		Plan C		Plan D
	Public *	Private	Public*	Private	Public*	Private	Public*
0-17	266	306	226	268	202	262	94
18-29	284	323	240	284	211	275	99
30-39	297	339	252	300	225	294	103
40-49	462	528	395	466	352	453	170
50-59	853	969	734	856	651	835	323
60-65	1,395	1,585	1,197	1,402	1,064	1,368	534

For Females

Age band / Hospital Type	Plan A		Plan B		Plan C		Plan D
	Public *	Private	Public*	Private	Public*	Private	Public*
0-17	426	490	365	434	319	422	150
18-29	453	520	386	458	337	444	159
30-39	475	545	404	481	357	466	170
40-49	480	549	407	485	361	471	173
50-59	706	809	605	715	534	693	263
60-65	1,044	1,197	898	1,054	797	1,026	393

*Public Hospitals refer to Government and Re-structured Hospitals.

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

1. **Waiting Period**
   No benefits will be payable for any Illness which commences within thirty (30) days of the commencement date of the Policy or from the time an Insured is first Covered under the Policy. (This does not apply to accidental injuries).

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 means an injury or an illness which existed (or symptoms or manifestations of which existed) prior to the effective date of cover with respect to an Insured based on normal medically accepted pathological development of the illness, or of which the Insured was aware or should reasonably have been aware, irrespective of whether treatment was actuallyreceived.
   (b) Congenital Conditions means Congenital anomalies as well as neo-natal physical abnormalities developing within six (6) months of birth.

3. **Terms of renewal**
   Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

4. **Premium upon renewal**
   The premium rates will be determined at each renewal based on the profile of all persons insured under the **Smart***Care Executive* plan.

5. **Cancellation Clause**
   The Company reserves the right to terminate coverage, in the event that it decides to cease offering the **Smart***Care Executive* plan altogether. At least 30 days' notice in writing of such termination shall be given to the Policyholder. Whenever such cancellation occurs, the Company shall return the unearned portion of the premiums paid subject to minimum premium of S$50 + GST. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination.

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 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.