FWD insurance

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FWD Critical Illness Plus insurance
Policy contract

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +65 6820 8888

Quick reference

About your policy

Thank you for choosing FWD Singapore Pte. Ltd. We're pleased to protect you so that you can focus on living life to the fullest.

Your FWD Critical Illness Plus insurance policy

This is a regular premium payment, non-participating critical illness plan offered by FWD Singapore Pte. Ltd. ("FWD"). This policy does not have any cash surrender value.

'Non-participating' means the person insured does not participate in the insurance company's business. This means that you will not receive any bonuses or dividends which we may declare.

This is not a savings or investment product

Your FWD Critical Illness Plus insurance policy is not a savings or investment product. We will not pay any money under this policy other than the benefits listed in this policy contract.

Your FWD Critical Illness Plus insurance policy is an insurance contract between you and us. Your policy pack is made up of the documents listed below:

- this policy contract,
- the policy schedule,
- your application form and any documents you provided with it, and
- any endorsement to your policy, if applicable.

By reading your policy contract carefully, you'll know exactly what you're covered for, and how to make a claim.

A policy endorsement is the document we provide that records any official change to your policy.

Easy to read

We're here to change the way you feel about insurance – starting with this document. We've made it easy to read, so you can understand your benefits and what you're covered for.

We highlight important information like this. Read these carefully.

We also provide explanations for important details that you need to understand.

Words with special meaning

Some words in this policy contract have special meaning. We show those meanings on page 16 (important words and phrases). Please refer to this section when you need to.

Accident
Activities of daily living
Age
Application form
Benefit effective date
Coverage start date
Coverage end date
Critical illness
Endorsement
Medical practitioner
Owner or policy owner
Period of insurance
Permanent neurological deficit
Person insured
Policy
Policy issue date
Premium
Policy illustration
Policy schedule
Sum insured
We, our, FWD, us
You, and your

Policy information statement

Paying your premium

In return for paying your premiums, we provide the cover you have chosen.

For details about how to pay your premiums, and what happens if you don't pay, see page 13 (your premiums).

You can pay your premiums to us through any of the following methods:

- auto-debit from a credit card, or
- any other payment methods as updated on our website from time to time.

About your policy

Choosing who receives the benefits

Early Cancer, Heart Attack and Stroke Benefit

The Early Cancer, Heart Attack and Stroke Benefit will be paid to you in a lump sum equivalent to 100% of the sum insured, as stated in your policy schedule.

Late-stage Critical Illness Benefit

The Late-stage Critical Illness Benefit will be paid to you in a lump sum equivalent to 100% of the sum insured, as stated in your policy schedule.

Death Benefit

The Death Benefit of S$20,000 will be paid to your nominee in a lump sum.

We will deduct any monies you owe us on your policy before we pay any claim.

When insurance cover begins

This policy starts on the coverage start date as shown in the policy schedule or on the date we receive the first premium, whichever is later.

Coverage renewal option

The coverage renewal option is available on the 10-year renewable plan, where the period of insurance stated in the policy schedule is "10 years".

When each period of insurance ends, your policy (including any add-on rider plans) will automatically renew for 10 more years if your policy (including any add-on rider plans) are active, until:

(i) the person insured turns age 85; or

(ii) we cannot offer another full 10-year term before the person insured turns age 85,

whichever happens first.

You can choose not to renew this policy by writing to us 30 days before the end of the period of insurance. See page 8 (coverage renewal option) for more details.

Nomination

You can choose one or more nominees to receive the benefits. See page 10 (the main people under your policy) for more details on your different choices.

Exclusions and conditions

This policy has certain exclusions, meaning situations where we won't pay a benefit. The specific and general exclusions and/or conditions are set out throughout this policy contract.

Surrendering your policy

If you surrender (cancel) your policy, the person insured:

- will lose the coverage; and
- you will not receive any amount in return.

In addition, any changes to the person insured's health or circumstances in the future may make it more difficult or costly for the person insured to get coverage in the future.

14 calendar days free-look period

If you aren't completely satisfied with your policy and you haven't made a claim under it, you have 14 calendar days from the date you receive your policy to cancel it and receive your premiums back, less any fees we have paid and/or expenses incurred (if any). We consider this policy delivered from the time we email it to you.

You will not be able to make any claim under your policy once it is cancelled.

What you need to do

You must write to us to cancel this policy. We must receive your notice within the 14 calendar days free-look period.

What we will do

After receiving your notice, we will refund you any premiums paid after deducting any fees we have paid and/or expenses incurred (if any). Thereafter, we will cancel your policy, and you will not be able to claim any benefits under it.

You cannot cancel your policy if you have made a claim under your policy during the 14 calendar days free-look period.

Tell us about any changes

You should tell us about any important changes to your personal details (address or contact number) or if you want to change who will receive the Death Benefit. See page 7 (changes to your policy) for more details.

How to contact us if you have any questions or to make a claim

Call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)) if you have any questions about your policy, or if you need to make a claim. See page 11 (how to notify us of a claim) for more details on making a claim.

How to resolve a concern or complaint

We want to resolve any concerns or complaints you may have as quickly as possible. You should follow the steps below to resolve your concerns.

Step 1 Talk to us	The first thing you should do is talk to one of our consultants about your concerns or complaints. Call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)). The consultant may be able to resolve your concerns or complaints. If not, they may refer you to a manager. The consultant will try to resolve your concerns or complaints as soon as possible.
Step 2 Call or write to our Customer Engagement Department	If you feel that your complaint has not been resolved, you can write to: **FWD Singapore Pte. Ltd.** **6 Temasek Boulevard,** **#18-01 Suntec Tower Four,** **Singapore 038986** **Tel: +65 6820 8888** **Email: contact.sg@fwd.com** **Website: www.fwd.com.sg** We will respond to your complaint within 3 working days of us receiving it.
Step 3 Seek an external review from the Financial Industry Dispute Resolution Centre (FIDReC)	If we cannot arrive at a mutual agreement, you may approach the FIDReC, a free, independent and fair dispute resolution centre for resolution of disputes between financial institutions and consumers. You can lodge your concerns or complaints by post, online, or in-person. The FIDReC's details are: **Financial Industry Disputes Resolution Centre** **36 Robinson Road,** **#15-01 City House,** **Singapore 068877** **Tel: +65 6327 8878** **Email: info@fidrec.com.sg** **Website: www.fidrec.com.sg** You need to remember to quote your policy number in any communication with us or with FIDReC.

Quick summary of your benefits

This section describes the main benefits of your policy. It is a guide to your policy coverage. To understand the full details about what we pay and how we pay it, you should go to page 5 (what you're covered for).

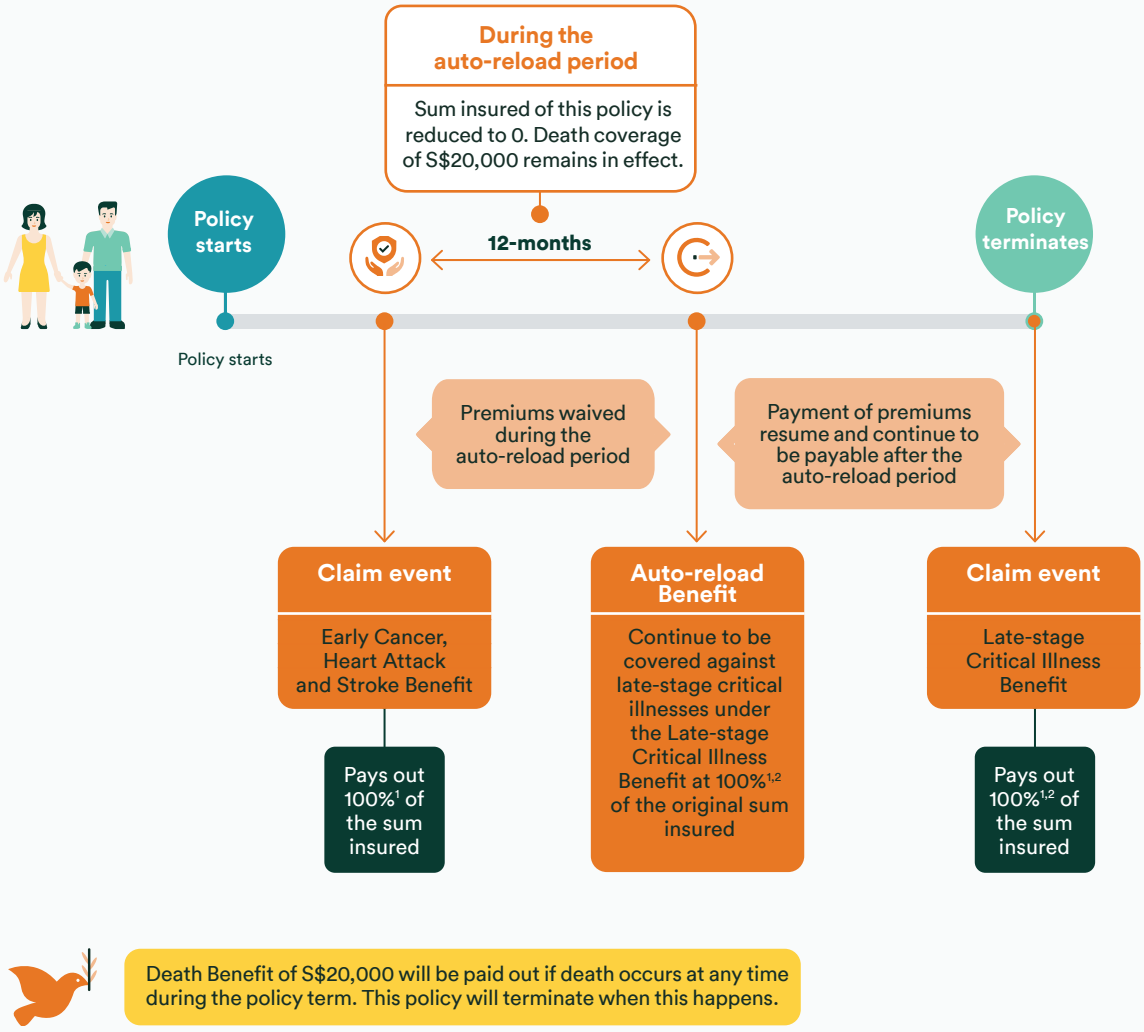
Your benefits at a glance

You can claim the following benefits while the policy is active.

What we pay

We will pay the benefit amount shown in your policy schedule, after taking off any amounts you owe us.

How the policy works



Death Benefit of S$20,000 will be paid out if death occurs at any time during the policy term. This policy will terminate when this happens.

[1] Less any claims paid for angioplasty & other invasive treatment for coronary artery.

[2] Payment for 'angioplasty & other invasive treatment for coronary artery' is limited to 10% of the sum insured under this policy, subject to a S$25,000 maximum sum payable.

What you're covered for

In this section, we explain what benefits you are covered for, and any specific exclusions or conditions that apply to those benefits. General exclusions may also apply.

Detailed benefits

Your policy provides the amount of cover stated in your policy schedule for the person insured. Any successful claim made by the person insured under the policy will be paid from the sum insured.

The person insured is covered for the following benefits while the policy is active.

Critical Illness Benefit

(i) Early Cancer, Heart Attack and Stroke Benefit

If the person insured is diagnosed with any early or intermediate stages of cancer, heart attack or stroke as listed and defined on page 18 (definitions of conditions covered under the Early Cancer, Heart Attack and Stroke Benefit) within the policy term while this policy is active, 100% of the sum insured under this policy, as stated in the policy schedule, will be payable in one lump sum (less any claims paid for angioplasty & other invasive treatment for coronary artery).

This benefit is payable once only and will end when it is paid.

The person insured must be alive at the point of diagnosis in order for a claim to be made under the Early Cancer, Heart Attack and Stroke Benefit.

If you have added the ICU Benefit to the policy, the Early Cancer, Heart Attack and Stroke Benefit will end when it is paid or when payment of 100% of the sum insured is accelerated under the ICU Benefit, whichever is earlier.

For more details on how the ICU Benefit works, please refer to the ICU Benefit add-on rider policy contract.

(ii) Late-stage Critical Illness Benefit

If the person insured is diagnosed with any of the late-stage critical illnesses listed (except angioplasty & other invasive treatment for coronary artery) and defined on page 22 (definitions of conditions covered under the Late-stage Critical Illness Benefit) within the policy term while the policy is active, 100% of the sum insured under this policy, as stated in the policy schedule, will be payable in one lump sum (less any claims paid for angioplasty & other invasive treatment for coronary artery). This policy will terminate once this benefit is fully paid out.

Payment for 'angioplasty & other invasive treatment for coronary artery' is limited to 10% of the sum insured under this policy, subject to a S$25,000 maximum sum payable. This benefit is payable once only and shall be deducted from the amount of this policy contract, thereby reducing the amount of sum insured which may be payable herein. We will also reduce all future premiums in proportion to this revised sum insured.

The person insured must be alive at the point of diagnosis in order for a claim to be made under the Late-stage Critical Illness Benefit.

What you're covered for

Auto-reload Benefit

If the person insured has successfully made a claim under the Early Cancer, Heart Attack and Stroke Benefit, the sum insured under this policy will be reduced to 0 for a period of 12 months from the date of diagnosis of the claim. This 12-month period is called the "auto-reload period". You will not be able to make any claims on this policy during this auto-reload period (apart from claims for the Death Benefit). However, this policy will remain active until the cover ends and premiums payable during the auto-reload period will be waived.

What happens after the auto-reload period

Once the auto-reload period has passed and if the policy is still active, assuming that there was no claim made under the Death Benefit, the person insured will continue to be covered against late-stage critical illnesses under the Late-stage Critical Illness Benefit at 100% of the original sum insured (less any claims paid for angioplasty & other invasive treatment for coronary artery).

Payment of premiums under the policy will resume and continue to be payable after the auto-reload period.

The Auto-reload Benefit can only be activated once.

If you have added the ICU Benefit to the policy, the Auto-reload Benefit can be activated when the person insured has successfully made a claim under the Early Cancer, Heart Attack and Stroke Benefit or the ICU Benefit.

For more details on how the ICU Benefit works, please refer to the ICU Benefit add-on rider policy contract.

Death Benefit

If the person insured dies within the policy term while this policy is active, S$20,000 is payable in one lump sum. This policy will terminate once this benefit is paid out.

Waiting period

For the following critical illnesses, the benefits described in this policy are only available 90 days after the issue date or the last reinstatement date (if your policy has been reinstated), whichever is later:

- heart attack of specified severity;
- major cancer;
- other serious coronary artery disease;
- coronary artery by-pass surgery;
- angioplasty & other invasive treatment for coronary artery;
- early cancer;
- early heart attack; and
- early stroke.

No such waiting period will apply to other critical illness conditions not covered in the above list, and death.

The above applies even if the signs or symptoms of these critical illnesses were not apparent to the person insured, if they would have been apparent to a reasonable person in the same position.

When we won't pay

We won't pay the benefits if any of the following happens:

- your policy has ended. See page 9 (when your policy ends).
- an exclusion applies. See page 12 (when we will not pay any benefit).

Starting, changing or ending your policy

This section explains when your policy starts and ends, and how to make changes to your policy. We also outline when you can reinstate your policy after it has ended.

When your policy starts

The policy cover starts on the coverage start date shown in your policy schedule or the date we receive the first premium, whichever is later.

You are not covered before the coverage start date.

Your policy anniversary

When we refer to a policy anniversary, we mean the same date and month as the coverage start date, in the next year (i.e. counted 12 months from the coverage start date).

Changes to your policy

You can ask us to make the following changes to your policy, and we will make the changes by providing an official written change confirmation (called an endorsement).

We are not bound by any change until we have issued such written confirmation.

Changing your address, contact details or who will receive the death benefit

You can change your address, contact details, or who you have chosen to receive the Death Benefit.

It is important that you tell us immediately about any of these changes, so that you keep enjoying the benefits of your policy cover.

What you need to do

- Contact us.
- Fill in the required form and pass it to us.
- Complete your change request using our customer portal.

What we will do

- Review your request.
- Make the change, and tell you in writing, along with the date the change will take effect from.

Changing your premium payment method or frequency

You can change:

- how often you pay your premiums (your premium payment frequency); or
- the method of paying your premiums,

by telling us in writing.

What you need to do

- Contact us.
- Fill in the required form and pass it to us.
- Complete your change request using our customer portal.

What we will do

- Review your request.
- Make the change, and tell you in writing, along with the date the change will take effect from.

Changing your nominees

You may nominate one or more persons to receive the benefits under your policy. See page 10 (the main people under your policy) for more details on your different choices.

Changing your sum insured

You can decrease the sum insured under your policy at any time. The new sum insured will be effective on your policy (including any add-on rider plans) from the next premium payment due date.

The decrease in sum insured should be in multiples of S$50,000.

You cannot increase the sum insured of your policy.

What you need to do

- To decrease your sum insured, you need to contact us.
- Fill in the required form and pass it to us.

Starting, changing or ending your policy

What we will do

- Review your request and decide if we accept it.
- If we agree to the change, we will provide an endorsement, and we will advise you of your new premium amounts.
- We will not decrease the sum insured below the minimum offered under this policy.

Cancelling your policy

You can cancel (terminate) your policy at any time. If you choose to cancel your policy early and you have paid your premiums, your cover will end on the day before the next due date for the premium payment.

After you inform us to cancel your policy, we will not charge you any further for the premiums due.

You will not be able to reinstate (restart) your policy after you cancel it.

What you need to do

- Contact us.
- Fill in the required form and pass it to us.

What we will do

- Review your request and cancel your policy.
- We will write to you to confirm the cancellation.

If you tell us to cancel your policy within the 14 calendar days free-look period, we will give you a full refund (less any fees and expenses incurred, such as payments for medical examinations and reports) - see page 2 (14 calendar days free-look period) for more details.

Coverage renewal option

The coverage renewal option is available on the 10-year renewable plan, where the period of insurance stated in the policy schedule is "10 years".

When each period of insurance ends, your policy (including any add-on rider plans) will automatically renew for 10 more years if your policy (including any add-on rider plans) are active, until:

(i) the person insured turns age 85; or

(ii) we cannot offer another full 10-year term before the person insured turns age 85,

whichever happens first.

The premiums due upon each renewal will be based on the prevailing premium rates at the attained age of the person insured and will stay level throughout the renewed term.

We will not take into account any changes in the person insured's health to allow your policy renewal, but any conditions we made when we first approved this policy (such as charging higher premiums or adding exclusion(s) because of a health condition the person insured had) will apply to your policy renewal.

You can choose not to renew this policy by writing to us 30 days before the end of the period of insurance.

Reinstatement

If your policy ends because of non-payment of policy premiums, you can reinstate it within two years of it ending if we agree. You cannot reinstate your policy for any other reason (for example, if you had ended the policy cover).

To reinstate your policy, you have to provide us with evidence of health of the person insured, and you will need to pay us a lump sum premium made up of the following amounts:

- any amounts you owe us up to your next premium due date; and
- any medical costs that we need to pay in order to assess the health of the person insured.

What you need to do

- Contact us.
- Provide a completed service request form. You need to select the reinstatement service option on the form.
- Confirm that the health of the person to be insured still qualifies for cover (by answering the questions in the service request form).
- Pay us the required premiums.

What we will do

- We will review your request, and if we are satisfied that you have met our requirements, we will reinstate your policy on the same or adjusted terms. Otherwise, we will not reinstate your policy.
- If we reinstate your policy, the person insured's cover will be reinstated from the date we tell you.

Important note
The person insured will not be covered for any event that took place before the policy is reinstated.

You can download the relevant form from our website **www.fwd.com.sg** or call our hotline at **+65 6820 8888** for assistance.

When your policy ends

Your policy ends on the earliest of the following dates:

- the policy coverage end date shown in your policy schedule;
- when this policy has reached the coverage end date and is not or cannot be renewed if you have chosen a 10-year renewable option;
- on the date of the person insured's death;
- the date when 100% of the sum insured under the Late-stage Critical Illness Benefit is paid out;
- 60 days after a premium due date, if we do not receive your due premium before then;
- the day before the next premium due date if you request to cancel (terminate) your policy cover; or
- the date we are told to cancel your policy cover by law or regulation.

The main people under your policy

This section explains who the main people under your policy are, what rights they have, and how they are treated.

Person insured

This is the person insured under your policy. A person insured (other than the policy owner) cannot make changes to your policy.

Policy owner

The policy owner (or policyholder) owns the policy. Details of the policy owner are shown in the policy schedule or any endorsement. The policy owner is the only person who may make changes to or enforce any rights under this policy.

Under this policy, you are the policy owner and person insured, unless there were changes made to your policy through an assignment of benefits. See page 10 (assignment of benefits).

You may choose a person to receive the benefits payable under this policy.

Age requirements for policy owner and person insured

Age requirements apply for the policy owner and person insured, which are shown in the following table.

Policy owner / person insured	
Minimum age at time of application	Must be at least 18 years old.
Maximum age at time of application	Must be younger than 66 years old.

Nominees

Nomination of beneficiaries

If you (policy owner) are also the person insured under this policy, you can choose to nominate another person (or people) to receive the benefits under this policy, and you can decide how much of the benefits each nominee will receive.

Trust or revocable nomination

You have a choice of either a trust nomination or a revocable nomination under the Insurance Act 1966. Depending on your choice, the nominees may have certain rights under the policy.

For a trust nomination, you will lose all rights to the ownership of the policy. You can only revoke a trust nomination if all nominees consent to the change.

For a revocable nomination, you are free to change, add or remove nominees at any time without their consent.

To make a trust or revocable nomination under this policy, you will have to complete the required form and pass it to us.

You should regularly check if your nominees are still appropriate.

Changing your nominees

Only you (the policy owner) can change the nominees. However, depending on the type of nomination you have selected, the nominees may need to consent to the change.

Assignment of benefits

You can transfer the benefits under your policy to someone else, through an assignment. For us to record this assignment of benefits, you need to provide us with the completed required form and necessary documents. We will not be responsible for checking the validity of the assignment.

Making a claim

Need to make a claim? Read this section to find out what you need to do.

How to notify us of a claim

You can notify us of a claim online by visiting our website or by contacting our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)) and we'll be pleased to assist you.

Tell us as soon as possible

We should be informed as soon as possible if a claim is to be made under this policy.

To make sure we are able to assess claims quickly, we ask that you or the nominee(s) let us know that a claim will be made under the policy and by whom. Claim forms do not have to be sent at this time.

Claims won't be affected if there were good reasons why you or the nominee could not notify us of a claim immediately.

Filling-in your claim form

We will provide the forms that need to be filled in to make a claim once you notify us that you need to make a claim.

Claims must be made on forms provided by us and submitted together with the supporting documents and any other information and documents that we ask for. The information may include original receipts, proof that treatment was medically necessary or proof of the country where the person insured lives. We will not be able to process a claim until we receive this information and the filled-in claim form.

If you cannot exercise proper judgment

If you are not able to exercise proper judgment regarding your policy or your claim, we may require additional documentation from the courts or appropriate authorities to make sure your interests are protected.

Required proof

We must be provided with the following proof to support the claim:

- supporting evidence from a medical practitioner;
- confirmatory investigations including but not limited to clinical, radiological, histological and laboratory evidence;
- evidence that any medical procedure performed is (or was) medically necessary; and
- any other documents that we may require.

When we will not pay any benefit

This policy has certain exclusions, meaning situations where we won't pay a benefit under your policy. We list below the exclusions that apply to all benefits under your policy.

We may also apply specific exclusions to your policy when we offer to issue your policy. If any specific exclusion applies to certain benefits, we will record the details in a policy endorsement.

Suicide or self-inflicted act	We will not pay any benefit under this policy if the claim arises from suicide, attempted suicide or an intentional self-inflicted act, within one year of the start of your policy cover, or the date we last reinstate (restart) your policy. This applies regardless of the mental state of the person insured. If this happens, the policy will be cancelled.
Unlawful acts	We will not pay any benefit under this policy if the claim arises because you or the person insured deliberately participated in an unlawful act or failed to act in accordance with the law.

We won't pay any benefit if the signs or symptoms leading to diagnosis and claim became apparent to the person insured:

- before the policy issue date; or
- before the policy reinstatement date (if the policy cover was reinstated).

The above applies even if the signs or symptoms were not apparent to the person insured, if they would have been apparent to a reasonable person in the same position.

We check the age and gender before paying

We will not pay any benefits under your policy until we have checked that the age and gender of the person insured matches the information we have been given by you.

Costs of preparing claims

We are not responsible for any of the costs of filling in any form or getting any documents, such as diagnosis of the disability or other certification. We may ask the person insured to get diagnosed by our appointed medical practitioner, but we will not pay for these costs.

We will deduct any monies you owe us on your policy before we pay any claim.

Who do we pay your claim to?

We pay the Critical Illness Benefit to you.

We pay the Death Benefit to the nominees.

Your premiums

This section explains your premiums and what happens when you miss paying a premium.

Paying your premium

It is important to pay your premiums on time, so your policy stays active and the person insured continues to be covered. Below we outline how you can pay your premiums and what happens if you don't pay.

Amount and due date

Your policy schedule shows the amount and the period you need to pay your premiums.

Any amount due to us under this policy will be deducted from any benefit that becomes payable within the grace period.

Payment frequency options

You have the following payment frequency options:

- annually in one lump sum; or
- by monthly instalments.

You can change your chosen method any time and we will inform you of the date the change will take effect from. See page 7 (changing your premium payment method or frequency) to find out how to do so.

Payment method options

You can pay using any of the following options.

- auto-debit from a credit card, or
- any other payment methods as updated on our website from time to time.

Premium rates are not guaranteed

The premium rates stated in your policy schedule are not guaranteed. This means we can change the premium rates by giving you at least 30 days' notice in writing.

Premium rates upon renewal of the policy are not guaranteed

If you have chosen the 10-year renewable plan then the premium rates stated in your policy illustration for future renewals are not guaranteed. This means that we may change these rates, which will be based on the person insured's attained age, by giving you at least 30 days' notice in writing.

What happens if you don't pay on time

Your premiums are due on the due date. We give you a 60-day grace period after the due date to pay your premium. Your policy will continue if you pay your overdue premium within this 60-day grace period. If we do not receive your premium within this period, we will cancel your policy.

First premium	Your first premium is due on the coverage start date.
Annual or monthly premiums	Due at the frequency you choose. You need to keep paying your premiums until the coverage end date as shown in the policy schedule.
If you miss your premium payment	We give you a 60-day grace period after the due date to pay your premium. Your policy ends from the date the premium was due if we do not receive your premium within this period.

If your policy ends because you missed a premium payment, you can apply to reinstate it. See page 8 (reinstatement) for more details.

Keeping it legal

In this section, we explain the important legal rights and obligations under your policy.

Governing law

Your policy is an insurance contract between you and us and is governed by the laws of the Republic of Singapore. If there is any dispute or disagreement relating to this policy, we and you agree to submit to the exclusive jurisdiction of the Singapore courts.

Changes to your policy to comply with the law

We have the power to make any changes to your policy required to comply with any law (not just Singapore laws). If we need to make a change, we will write to you 30 days in advance.

We rely on your information

Read all parts of your policy to make sure they are correct

This policy is issued based on the information you gave us during the application process. It is important that the information is correct, and you were truthful and accurate with all of the information you provided. This information helped us to decide if you were eligible for the policy, and how much you need to pay.

The law as per Section 23(5) of the Insurance Act 1966 requires that we inform you of your duty to fully and faithfully tell us everything you know or could reasonably be expected to know that is relevant to our decision to insure you. Otherwise, we have the right to either decline your claims or terminate this policy and treat it as never having existed. In the event that we decide to maintain your cover, we may charge an additional premium.

You should let us know immediately if the information you gave us during the application was inaccurate, misleading, or exaggerated. You should also let us know immediately if the information you have given us changes after your policy is active.

Change in residential address:
You must inform us within 60 days if you change your residential address.

You need to provide correct and complete information

You and the person insured are responsible for:

- providing us correct and complete information; and
- being careful when answering our questions, or when you confirm or amend any information you have given to us.

If you don't, we may not pay your claim, and your benefits under your policy may be affected. In some cases, we may cancel the policy. See page 15 (disputing payments) for more details.

If we were given the wrong age and gender

If we discover that we were given the wrong age or gender, we may adjust the amount of the benefit or premiums to reflect what the benefit or premiums should have been if we were provided with the correct age or gender in the first place.

If we would not have issued this policy if we had known the correct age, gender or any other details, we can declare your policy void. If we do, we will cancel your policy and treat it as never having existed. We will refund any premiums paid without interest, after deducting any benefits we have paid.

If you need to change your information, or if you have any questions, please call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)).

Disputing payments

We can declare your policy void if you or the person insured:

- made an inaccurate or untrue statement on a material matter; or
- suppressed or omitted a material fact,

within your application.

How we define material matters and facts

A material matter or material fact is one that would have caused us to:

- refuse to issue the policy to you; or
- offer you a policy on different terms,

if you or the person insured had told us about it.

Unless there was fraud, material non-disclosure and/or misrepresentation of a material fact, non-payment of premium or any applicable policy exclusion, we will not declare your policy void 2 years after the issue date or the last reinstatement date (if your policy has been reinstated), whichever is later.

However, we may not pay a claim if you or the person insured:

- did not provide accurate and truthful information;
- gave us misleading or exaggerated information; or
- made any false statements,

at the time of purchase or reinstatement of this policy.

What we will do

- If we dispute your policy, we will review your policy and decide if we have any reason to declare it void. If we do, we will cancel it and treat it as never having existed.
- We will refund the premiums paid without interest, after deducting any amounts owed. If a benefit has been paid, we will recover that benefit.

Anti-Money Laundering, Anti-Terrorism Financing and proceeds of unlawful activities

We may need to freeze or seize any monies received or payable under your policy:

- at the order of the relevant authorities; or
- if we discover, or if we have reasonable suspicion that you are sanctioned under any competent authorities recognised by us, for money laundering activities or activities relating to financing terrorism.

If this happens, we will end your policy and the cover under it immediately. We will deal with all premiums paid and all amounts payable under your policy in any manner we deem fit, which may include handing it over to the relevant authorities.

Policy owners' protection scheme

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 needed 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 us or visit the Life Insurance Association or SDIC websites (www.lia.org.sg) or (www.sdic.org.sg).

Third party's rights

Unless it is clearly stated in this policy contract, no one other than you (as the policy owner) can enforce or rely on any terms in this policy or have any rights under the Contracts (Rights of Third Parties) Act 2001.

Important words and phrases

The list below explains the meanings of important words and phrases shown in your policy.

Accident	An accident is the sudden, violent, unexpected and unintentional visible contact between the person insured and another object or substance. It does not include an illness, degenerative process or any other naturally occurring condition.
Activities of daily living	**Washing:** the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances. **Transferring:** the ability to move from a bed to an upright chair or wheelchair and vice versa. **Mobility:** the ability to move indoors from room to room on level surfaces. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene. **Feeding:** the ability to feed oneself once food has been prepared and made available.
Age	Refers to age last birthday.
Application form	Refers to the information you or the person insured (or both) provided to us when applying for this policy. Our decision to issue this policy is based on the information in the application form.
Benefit effective date	Refers to the date the first premium is due for the benefit and the date your benefit starts. This date is shown in your policy schedule.
Coverage start date	Refers to the date the first premium is due, and is the date cover starts under your policy. This date is shown in your policy schedule.
Coverage end date	Refers to the date the coverage under the policy ends as shown in your policy schedule.
Critical illness	Means that the person insured is diagnosed and certified by a medical practitioner to be suffering from any of the conditions listed under page 18 (definitions of covered critical illnesses under the Critical Illness Benefit).
Endorsement	Refers to an extra document attached to your policy or which we may issue later that outlines any changes to your policy.
Medical practitioner	Refers to a person who has a medical degree and is legally licensed or registered to practise western medicine in Singapore or such other countries as approved by us. We reserve the right to request that the person insured be examined by a medical practitioner appointed by us. A medical practitioner cannot be any of the following people unless we agree in writing. ▪ A person insured ▪ A person insured's spouse, relative or business partner ▪ You ▪ Your spouse, relative or business partner

Owner or policy owner	The person who owns this policy. Your details are shown in the policy schedule or endorsement. We also use the term 'you' or 'your' in this policy contract.
Period of insurance	Refers to the period of time between the coverage start date and coverage end date (both inclusive) as shown in your policy schedule.
Permanent neurological deficit	Permanent means expected to last throughout the lifetime of the person insured. Permanent neurological deficit means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the person insured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.
Person insured	The person insured by this policy and shown on the policy schedule.
Policy	All of the documents listed below: ▪ this policy contract; ▪ the policy schedule; ▪ the application form and any documents you provided with it; and ▪ any endorsement to your policy, if applicable.
Policy issue date	Refers to the date your policy is issued. This date is shown in your policy schedule.
Premium	Refers to the scheduled premium payments for this policy as shown in the policy schedule or endorsement.
Policy illustration	Refers to the document attached to the policy when you bought this policy. It provides a summary of this product, its benefits, and the premiums that you will need to pay.
Policy schedule	Refers to the document attached to your policy. It shows important information about your policy, including the following: ▪ Policy number; ▪ Details of policy owner and person insured; ▪ Your premium details; and ▪ The benefits of your policy and the sum insured.
Sum insured	Refers to the amount you or the nominees will receive if the Critical Illness Benefit or Death Benefit is paid. The sum insured is shown in the policy schedule.
We, our, FWD, us	Refers to FWD Singapore Pte. Ltd., the issuer of this insurance policy.
You, and your	Refers to the person who is the owner of this policy as shown in the policy schedule and endorsement.

Definitions of covered critical illnesses under the Critical Illness Benefit

Definitions of conditions covered under the Early Cancer, Heart Attack and Stroke Benefit

Early cancer means a diagnosis of any of the following conditions:

a. Carcinoma in-situ	A focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. For carcinoma-in-situ of cervix uteri, it must be at a grading of CIN III. We do not cover all neoplasms or tumours which are classified as pre-malignant, having borderline malignancy, having any degree of malignant potential, having suspicious malignancy or of uncertain or unknown behaviour.
b. Early prostate, thyroid or urinary bladder cancer	Must be histologically described using the TNM Classification as T1N0M0 (TNM Classification).
c. Early chronic lymphocytic leukaemia	Must be diagnosed at RAI Stage 1 or 2.
d. Neuroendocrine tumours	Must be histologically classified as T1N0M0 (TNM Classification).
e. Early invasive melanoma	Must have not invaded beyond the epidermis.
f. Gastro-intestinal stromal tumours	Must be histologically classified as Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual.
g. Bone marrow malignancies	Must not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment.

All tumours and malignancies in the presence of HIV infection will be excluded.

Early heart attack means a diagnosis of any of the following conditions:

a. Cardiac defibrillator insertion	Insertion of a permanent cardiac defibrillator as a result of cardiac arrhythmia which cannot be treated via any other method. The surgical procedure must be certified to be absolutely necessary by a specialist in the relevant field. Cardiac defibrillator insertion in the presence of HIV infection is excluded.
b. Cardiac pacemaker insertion	Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be absolutely necessary by a specialist in the relevant field. Cardiac pacemaker insertion in the presence of HIV infection is excluded.

c. Coronary artery disease	The narrowing of the lumen of two coronary arteries by a minimum of 60%, as proven by coronary arteriography, regardless of whether any form of coronary artery surgery has been recommended or performed. Coronary arteries herein refer to right coronary artery, left main stem, left anterior descending and left circumflex, but not their branches. Note that any non-invasive method of determining coronary artery stenosis is not acceptable.
d. Early cardiomyopathy	The unequivocal diagnosis of cardiomyopathy which has resulted in the presence of permanent physical impairments to at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment. The diagnosis must be confirmed by a specialist in the relevant field. Cardiomyopathy that is directly related to alcohol misuse is excluded. The NYHA classification of cardiac impairment: **Class I** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain. **Class II** Slight limitation of physical activity. Ordinary physical activity results in symptoms. **Class III** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms. **Class IV** Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest. Early cardiomyopathy in the presence of HIV infection is excluded.
e. Increased pulmonary blood pressure	Primary or secondary pulmonary hypertension with established right ventricular hypertrophy leading to the presence of permanent physical impairment of at least Class III of the New York Heart Association (NYHA) classification of cardiac impairment. The diagnosis must be established by cardiac catheterisation by a specialist in the relevant field.
f. Keyhole coronary bypass surgery or coronary artery atherectomy or myocardial laser revascularisation or enhanced external counter pulsation	The actual undergoing for the first time for the correction of the narrowing or blockage of one (1) or more coronary arteries via "keyhole" surgery, atherectomy, myocardial laser revascularisation or enhanced external counterpulsation. All other surgical procedures will be excluded from this benefit.
g. Large asymptomatic aortic aneurysm	Asymptomatic abdominal or thoracic aortic aneurysm or dissection greater than 55mm in diameter as evidenced by appropriate imaging technique, and confirmed by a specialist in the relevant field.

Definition of covered critical illnesses under the Critical Illness Benefit

h. Minimally invasive surgery to aorta	The actual undergoing of surgery via minimally invasive or intra-arterial techniques to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta, as evidenced by a cardiac echocardiogram and confirmed by a specialist in the relevant field. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.
i. Percutaneous valvuloplasty, valvotomy, percutaneous valve replacement or device repair	The actual undergoing of valvotomy or valvuloplasty or percutaneous valve replacement necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram. The procedure should be performed totally via intravascular catheter based techniques. Any procedure on heart valves that involves opening or entering the chest by any thoractotomy incision is excluded.
j. Pericardectomy	The undergoing of a pericardectomy or undergoing of any surgical procedure requiring keyhole cardiac surgery as a result of pericardial disease. Both these surgical procedures must be certified to be absolutely necessary by a consultant cardiologist. Pericardectomy in the presence of HIV infection is excluded.

Early stroke means a diagnosis of any of the following conditions:

a. Amyotrophic lateral sclerosis	Unequivocal diagnosis by a medical practitioner who is a neurologist confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centres in the brain and with spastic weakness and atrophy of the muscles of the extremities. Claims shall only be admitted if the condition is confirmed by a medical practitioner who is a neurologist as progressive and resulting in irreversible damage to the nervous system.
b. Bacterial meningitis with full recovery	Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord which requires hospitalisation. This diagnosis must be confirmed by: ▪ the presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and ▪ a consultant neurologist. Bacterial meningitis in the presence of HIV infection is excluded.
c. Brain aneurysm surgery (via craniotomy)	The actual undergoing of surgical repair of an intracranial aneurysm or surgical removal of an arteriovenous malformation via craniotomy. The surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
d. Brain aneurysm surgery (via endovascular procedure)	The actual undergoing of surgical repair of an intracranial aneurysm or surgical removal of an arteriovenous malformation via endovascular procedures. The surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
e. Carotid artery surgery	The actual undergoing of endarterectomy of the carotid artery which has been necessitated as a result of at least 80% narrowing of the carotid artery as diagnosed by an arteriography or any other appropriate diagnostic test that is available. Endarterectomy of blood vessels other than the carotid artery are specifically excluded. Percutaneous carotid angioplasty is excluded.

f. Cavernous sinus thrombosis surgery	The actual undergoing of a surgical drainage for cavernous sinus thrombosis. The presence of cavernous sinus thrombosis as well as the requirement for surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
g. Cerebral shunt insertion	The actual undergoing of surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid. The need of a shunt must be certified to be absolutely necessary by a specialist in the relevant field.
h. Polio induced muscle weakness	Unequivocal diagnosis of infection with the poliovirus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. In respect of this definition, claims shall only be admitted if poliomyelitis causes neurological deficit resulting in paralysis in limbs that is permanent. The unequivocal diagnosis must be made by a specialist in the relevant medical field.
i. Primary lateral sclerosis	A progressive degenerative disorder of the motor neurons of the cerebral cortex resulting in widespread weakness on an upper motor neuron basis. Clinically it is characterised by progressive spastic weakness of the limbs, preceded or followed by spastic dysarthria and dysphagia, indicating combined involvement of the corticospinal and corticobulbar tracts. The unequivocal diagnosis must be made by a neurologist and confirmed by appropriate neuromuscular testing such as electromyogram (EMG). The condition must result in the permanent inability to perform, without assistance, at least 3 of the 6 “activities of daily living”. These conditions have to be medically documented for at least 3 consecutive months.
j. Progressive supranuclear palsy	A degenerative neurological disease characterised by supranuclear gaze paresis, pseudobulbar palsy, axial rigidity and dementia. The unequivocal diagnosis of progressive supranuclear palsy must be confirmed by a medical practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least 3 of the 6 “activities of daily living”. These conditions have to be medically documented for at least 3 consecutive months.
k. Severe progressive bulbar palsy	Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be unequivocally diagnosed by a medical practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least 3 of the 6 “activities of daily living”. These conditions have to be medically documented for at least 3 consecutive months.

Definition of covered critical illnesses under the Critical Illness Benefit

Definitions of conditions covered under the Late-stage Critical Illness Benefit

1. Alzheimer's disease/severe dementia	Deterioration or loss of cognitive function as confirmed by clinical evaluation and imaging tests, arising from alzheimer's disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the person insured. This diagnosis must be supported by the clinical confirmation of an appropriate consultant and supported by the company's appointed doctor. The following are excluded: ▪ non-organic diseases such as neurosis and psychiatric illnesses; and ▪ alcohol related brain damage.
2. Angioplasty & other invasive treatment for coronary artery	The actual undergoing of balloon angioplasty or similar intra-arterial catheter procedure to correct a narrowing of minimum 60% stenosis, of one or more major coronary arteries as shown by angiographic evidence. The revascularisation must be considered medically necessary by a consultant cardiologist. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. Diagnostic angiography is excluded.
3. Benign brain tumour	Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges or cranial nerves where all of the following conditions are met: ▪ it has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and ▪ its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques. The following are excluded: ▪ cysts; ▪ abscess; ▪ angioma; ▪ granulomas; ▪ vascular malformations; ▪ haematomas; and ▪ tumours of the pituitary gland, spinal cord and skull base.
4. Blindness (irreversible loss of sight)	Permanent and irreversible loss of sight in both eyes as a result of illness or accident to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in both eyes using a Snellen eye chart or equivalent test, or visual field of 20 degrees or less in both eyes. The blindness must be confirmed by an ophthalmologist. The blindness must not be correctable by surgical procedures, implants or any other means.

5. Coma	A coma that persists for at least 96 hours. This diagnosis must be supported by evidence of all of the following: ▪ no response to external stimuli for at least 96 hours; ▪ life support measures are necessary to sustain life; and ▪ brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma. For the above definition, medically induced coma and coma resulting directly from alcohol or drug abuse are excluded.
6. Coronary artery by-pass surgery	The actual undergoing of open-chest surgery or minimally invasive direct coronary artery bypass surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist. Angioplasty and all other intra-arterial, catheter-based techniques, 'keyhole' or laser procedures are excluded.
7. Deafness (irreversible loss of hearing)	Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by audiometric and sound- threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist. Total means "the loss of at least 80 decibels in all frequencies of hearing". Irreversible means "cannot be reasonably restored to at least 40 decibels by medical treatment, hearing aid and/or surgical procedures consistent with the current standard of the medical services available in Singapore after a period of 6 months from the date of intervention."
8. End stage kidney failure	Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.
9. End stage liver failure	End stage liver failure as evidenced by all of the following: ▪ permanent jaundice; ▪ ascites; and ▪ hepatic encephalopathy. Liver disease secondary to alcohol or drug abuse is excluded.
10. End stage lung disease	End stage lung disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following: ▪ FEV1 test results which are consistently less than 1 litre; ▪ permanent supplementary oxygen therapy for hypoxemia; ▪ arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO_2 \leq 55mmHg$); and ▪ dyspnea at rest. The diagnosis must be confirmed by a respiratory physician.

Definition of covered critical illnesses under the Critical Illness Benefit

11. Fulminant hepatitis	A submassive to massive necrosis of the liver by the hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following: ▪ rapid decreasing of liver size as confirmed by abdominal ultrasound; ▪ necrosis involving entire lobules, leaving only a collapsed reticular framework; ▪ rapid deterioration of liver function tests; ▪ deepening jaundice; and ▪ hepatic encephalopathy.
12. Heart attack of specified severity	Death of heart muscle due to ischaemia, that is evident by at least three of the following criteria proving the occurrence of a new heart attack: ▪ history of typical chest pain; ▪ new characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block; ▪ elevation of the cardiac biomarkers, inclusive of CKMB above the generally accepted normal laboratory levels or Cardiac Troponin T or I at 0.5ng/ml and above; ▪ imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. The imaging must be done by cardiologist specified by the company. For the above definition, the following are excluded: ▪ angina; ▪ heart attack of indeterminate age; and ▪ a rise in cardiac biomarkers or Troponin T or I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. Explanatory note: 0.5ng/ml = 0.5ug/L = 500pg/ml
13. HIV due to blood transfusion and occupationally acquired HIV	A. Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met: ▪ the blood transfusion was medically necessary or given as part of a medical treatment; ▪ the blood transfusion was received in Singapore after the issue date, date of endorsement or date of reinstatement of this policy, whichever is the later; and ▪ the source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood. B. Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the issue date, date of endorsement or date of reinstatement of this policy, whichever is the later whilst the person insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to the company's satisfaction:

	▪ proof that the accident involved a definite source of the HIV infected fluids; ▪ proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and ▪ HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded. This benefit is only payable when the occupation of the person insured is a medical practitioner, housemen, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic (in Singapore). This benefit will not apply under either section A or B where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.
14. Idiopathic parkinson's disease	The unequivocal diagnosis of idiopathic parkinson's disease by a consultant neurologist. This diagnosis must be supported by all of the following conditions: ▪ the disease cannot be controlled with medication; and ▪ inability of the person insured to perform (whether aided or unaided) at least 3 of the 6 "activities of daily living" for a continuous period of at least 6 months. For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.
15. Irreversible aplastic anaemia	Chronic persistent and irreversible bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following: ▪ blood product transfusion; ▪ bone marrow stimulating agents; ▪ immunosuppressive agents; or ▪ bone marrow or haematopoietic stem cell transplantation. The diagnosis must be confirmed by a haematologist.
16. Irreversible loss of speech	Total and irreversible loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist. All psychiatric related causes are excluded.
17. Loss of independent existence	A condition as a result of a disease, illness or injury whereby the person insured is unable to perform (whether aided or unaided) at least 3 of the 6 "activities of daily living", for a continuous period of 6 months. This condition must be confirmed by the company's approved doctor.

Definition of covered critical illnesses under the Critical Illness Benefit

	Non-organic diseases such as neurosis and psychiatric illnesses are excluded. For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.
18. Major burns	Third degree (full thickness of the skin) burns covering at least 20% of the surface of the person insured's body.

19. Major cancer	A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.
	The term major cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.
	Major cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.
	For the above definition, the following are excluded:
	▪ all tumours which are histologically classified as any of the following:
	  ▪ pre-malignant;
	  ▪ non-invasive;
	  ▪ carcinoma-in-situ (Tis) or Ta;
	  ▪ having borderline malignancy;
	  ▪ having any degree of malignant potential;
	  ▪ having suspicious malignancy;
	  ▪ neoplasm of uncertain or unknown behaviour; or
	  ▪ all grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
	▪ any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans unless there is evidence of metastases to lymph nodes or beyond;
	▪ malignant melanoma that has not caused invasion beyond the epidermis;
	▪ all prostate cancers histologically described as T1N0M0 (TNM Classification) or below; or prostate cancers of another equivalent or lesser classification;
	▪ all thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
	▪ all neuroendocrine tumours histologically classified as T1N0M0 (TNM Classification) or below;
	▪ all tumours of the urinary bladder histologically classified as T1N0M0 (TNM Classification) or below;
	▪ all gastro-intestinal stromal tumours histologically classified as Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
	▪ chronic lymphocytic leukaemia less than RAI Stage 3;
	▪ all bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
	▪ all tumours in the presence of HIV infection.

20. Major head trauma	Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist and supported by relevant findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques. "Accident" means an event of violent, unexpected, external, involuntary and visible nature which is independent of any other cause and is the sole cause of the head injury. The following are excluded: ▪ spinal cord injury; and ▪ head injury due to any other causes.
21. Major organ/bone marrow transplantation	The receipt of a transplant of: ▪ human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or ▪ one of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ. Other stem cell transplants are excluded.
22. Motor neurone disease	Motor neurone disease characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. This diagnosis must be confirmed by a neurologist as progressive and resulting in permanent neurological deficit.
23. Multiple sclerosis	The definite diagnosis of multiple sclerosis, and must be supported by all of the following: ▪ investigations which unequivocally confirm the diagnosis to be multiple sclerosis; and ▪ multiple neurological deficits which occurred over a continuous period of at least 6 months. Other causes of neurological damage such as SLE and HIV are excluded.
24. Muscular dystrophy	The unequivocal diagnosis of muscular dystrophy must be made by a consultant neurologist. The condition must result in the inability of the person insured to perform (whether aided or unaided) at least 3 of the 6 "activities of daily living" for a continuous period of at least 6 months. For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.
25. Open chest heart valve surgery	The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.
26. Open chest surgery to aorta	The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

Definition of covered critical illnesses under the Critical Illness Benefit

27. Other serious coronary artery disease	The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by invasive coronary angiography, regardless of whether or not any form of coronary artery surgery has been performed. Diagnosis by Imaging or non-invasive diagnostic procedures such as CT scan or MRI does not meet the confirmatory status required by the definition. Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. The branches of the above coronary arteries are excluded.
28. Paralysis (irreversible loss of use of limbs)	Total and irreversible loss of use of at least 2 entire limbs due to injury or disease persisting for a period of at least 6 weeks and with no foreseeable possibility of recovery. This condition must be confirmed by a consultant neurologist. Self-inflicted injuries are excluded.
29. Persistent vegetative state (apallic syndrome)	Universal necrosis of the brain cortex with the brainstem intact. This diagnosis must be definitely confirmed by a consultant neurologist holding such an appointment at an approved hospital. This condition has to be medically documented for at least one month.
30. Poliomyelitis	The occurrence of poliomyelitis where the following conditions are met: ▪ poliovirus is identified as the cause, ▪ paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months. The diagnosis must be confirmed by a consultant neurologist or specialist in the relevant medical field.
31. Primary pulmonary hypertension	Primary pulmonary hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterisation, resulting in permanent physical impairment of at least Class IV of the New York Heart Association (NYHA) classification of cardiac impairment. The NYHA Classification of Cardiac Impairment: **Class I** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain. **Class II** Slight limitation of physical activity. Ordinary physical activity results in symptoms. **Class III** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms. **Class IV** Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

32. Progressive scleroderma	A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally confirmed by a consultant rheumatologist and supported by biopsy or equivalent confirmatory test, and serological evidence, and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys. The following are excluded: ▪ localised scleroderma (linear scleroderma or morphea); ▪ eosinophilic fascitis; and ▪ CREST syndrome.
33. Severe bacterial meningitis	Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. This diagnosis must be confirmed by: ▪ the presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and ▪ a consultant neurologist. Bacterial meningitis in the presence of HIV infection is excluded.
34. Severe encephalitis	Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) and resulting in permanent neurological deficit which must be documented for at least 6 weeks. This diagnosis must be certified by a consultant neurologist, and supported by any confirmatory diagnostic tests. Encephalitis caused by HIV infection is excluded.
35. Stroke with permanent neurological deficit	A cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis resulting in permanent neurological deficit. This diagnosis must be supported by all of the following conditions: ▪ evidence of permanent clinical neurological deficit confirmed by a neurologist at least 6 weeks after the event; and ▪ findings on magnetic resonance imaging, computerised tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke. The following are excluded: ▪ transient ischaemic attacks; ▪ brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease; ▪ vascular disease affecting the eye or optic nerve; ▪ ischaemic disorders of the vestibular system; and ▪ secondary haemorrhage within a pre-existing cerebral lesion.
36. Systemic lupus erythematosus with lupus nephritis	The unequivocal diagnosis of Systemic Lupus Erythematosus (SLE) based on recognised diagnostic criteria and supported with clinical and laboratory evidence. In respect of this contract, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class VI Lupus Nephritis, established by renal biopsy, and in accordance with the RPS/ISN classification system). The final diagnosis must be confirmed by a certified doctor specialising in rheumatology and immunology.

Definition of covered critical illnesses under the Critical Illness Benefit

	The RPS/ISN classification of lupus nephritis: **Class I** Minimal mesangial lupus nephritis **Class II** Mesangial proliferative lupus nephritis **Class III** Focal lupus nephritis (active and chronic; proliferative and sclerosing) **Class IV** Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global) **Class V** Membranous lupus nephritis **Class VI** Advanced sclerosis lupus nephritis
37. Terminal illness	The conclusive diagnosis of an illness that is expected to result in the death of the person insured within 12 months. This diagnosis must be supported by a specialist and confirmed by the company's appointed doctor. Terminal illness in the presence of HIV infection is excluded.

FWD insurance

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ICU Benefit add-on rider
Policy contract

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +65 6820 8888

Quick reference

ICU Benefit

Thank you for choosing FWD Singapore Pte. Ltd. We're pleased to protect you so that you can focus on living life to the fullest.

Part of your policy

This rider becomes part of your FWD Critical Illness Plus insurance policy ("base plan") if we have agreed to provide it to you. The details of your rider cover will be shown in this ICU Benefit add-on rider policy contract attached to your base plan.

The terms and conditions of the base plan apply to this rider, unless stated otherwise.

Who's covered under your rider

Person insured

The person insured under this rider has to be the same person insured under the base plan. The person insured cannot receive any benefit under this rider, and cannot make changes to this rider, unless the person insured is also the policy owner.

Words with special meaning

The section below explains the meanings of words and phrases used in this document.

Accident	An accident is the sudden, violent, unexpected and unintentional visible contact between the person insured and another object or substance. It does not include an illness, degenerative process or any other naturally occurring condition.
Admitted to the ICU	Means admittance to the ICU for medically necessary treatment due to an illness or accident, and where such ICU stay is for a duration of at least 5 continuous days with invasive life support. **ICU** (intensive care unit) refers to a class of rooms within a hospital dedicated to treating acutely or critically ill patients which: (a) has additional services and equipment on a 24-hour operating basis, including full facilities for resuscitating patients; (b) is equipped for constantly monitoring vital bodily functions of patients; and (c) has different charges from non-ICU rooms and typically cost more per night. **Medically necessary treatment** refers to medical service or procedure ordered by a medical practitioner which is: (a) provided for the direct treatment of a medical condition due to an illness or accident; (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of that medical condition; (c) provided in accordance with generally accepted medical practices; (d) the most appropriate supply or level of service which can be provided on a cost-effective basis; and (e) not of an experimental nature or investigative nature, and not in the nature of research. Accidents caused by alcohol or drug abuse will be excluded.

Your rider benefits

Summary of your rider benefits

This section describes the main benefits of your rider. To understand the full details about what we pay and how we pay it, you should read the following section (detailed rider benefits).

You are covered for the following benefit while the base plan and this rider are active.

ICU benefit

If the person insured is admitted to the ICU, 100% of the sum insured under the policy as stated in the policy schedule will be accelerated and become payable. This rider will end when payment of 100% of the sum insured is accelerated under this ICU Benefit, or when 100% of the sum insured under the base plan's Early Cancer, Heart Attack and Stroke Benefit has been paid, whichever is earlier.

Please refer to the 'Early Cancer, Heart Attack and Stroke Benefit' in your base plan contract for more details on how this benefit works.

The person insured must be alive at the point of diagnosis in order for a claim to be made under this benefit.

What we pay
We will pay the benefit amount shown in your policy schedule, after taking off any amounts you owe us.

Detailed rider benefits

This is a regular premium payment, non-participating accelerating rider and it provides the following benefits. You need to pay a separate premium to keep this rider active. This rider does not have any cash surrender value.

How an accelerating rider works

Your base plan provides the amount of cover ("sum insured") for critical illness and death, as stated in your policy schedule. Any claim made by the person insured under the base plan or the rider will be paid from such sum insured. We will pay the benefits until the base plan's sum insured is reached.

Your coverage under accelerating rider

The sum insured for this rider is equal to the sum insured under the base plan.

If you have made a claim for this benefit, 100% of the sum insured under the base plan will be accelerated and this rider will terminate automatically.

If you have made a claim for other benefits under the base plan which pays out 100% of the sum insured under the base plan, this rider will terminate automatically when such benefit is paid.

If you have made a claim for other benefits which reduces part of the sum insured under the base plan to be less than the ICU Benefit sum insured, we will cap the amount payable for the ICU Benefit at the reduced sum insured under the base plan and this rider will terminate automatically when payment of the sum insured under the base plan is accelerated under this ICU Benefit.

Waiting period

For the following critical illnesses, the benefit described in this rider is only available 90 days after the issue date of this rider or the last reinstatement date of this rider (if your rider has been reinstated), whichever is later:

- heart attack of specified severity;
- major cancer;
- other serious coronary artery disease;
- coronary artery by-pass surgery;
- angioplasty & other invasive treatment for coronary artery;
- early cancer;
- early heart attack; and
- early stroke.

No such waiting period will apply to other critical illness conditions not covered in the above list.

The above applies even if the signs or symptoms of these critical illnesses were not apparent to the person insured, if they would have been apparent to a reasonable person in the same position.

When we won't pay
We won't pay the benefit if any of the following happens:

- your rider has ended. See page 6 (when your rider cover ends); or
- an exclusion applies. See page 5 (what we don't cover).

Your premiums

Your premiums are the amounts you pay for protection. It is important to pay your premiums on time, so your rider stays active and the person insured continues to be covered. Below we outline how you can pay your premiums and what happens if you don't pay.

Amount

Your current policy schedule shows the amount and the period you need to pay your premiums for this add-on rider.

When you need to pay premiums for your rider

You need to pay your premiums for this rider at the same time that you pay your premiums for your base plan (annually or monthly). You can change your chosen method any time – if you do, then your premiums for both base plan and rider will be changed. Please refer to 'changing your premium payment method or frequency' in your base plan policy contract to find out how to do so.

Premium rates are not guaranteed

The premium rates stated in your policy schedule are not guaranteed. This means we can change the premium rates by giving you at least 30 days' notice in writing.

Premium rates upon renewal of the rider are not guaranteed

If you have chosen the 10-year renewable plan, we will automatically renew this rider for 10 more years from each rider expiry date if your base plan and rider are active, until

(i) the person insured reaches age 85; or

(ii) we cannot offer another full 10-year term before the person insured turns age 85,

whichever happens first.

In either case, the rider cover will not be renewed beyond the base plan coverage term.

You can choose not to renew this rider by writing to us 30 days before the end of the period of your existing rider cover. The premiums due upon each renewal will be based on the prevailing premium rates at the attained age of the person insured and will stay level throughout the renewed term.

What happens if you don't pay on time?

Your rider premiums are due on the due date. We give you a 60-day grace period after the due date to pay your premium. Your rider coverage will continue if you pay your overdue premium within this 60-day grace period. If we do not receive your premium within this period, we will cancel your rider coverage.

If your rider ends because you missed a premium payment, you can apply to reinstate it. See page 6 (reinstating your rider) for more details.

Refund of premiums after we approve a claim

If we accept a claim for the benefit, we will refund premiums paid to us after the confirmed diagnosis.

Any refunded premium amount will be paid on top of the other amounts due to be paid under your rider.

Premiums must be paid until we approve the claim

All premiums due under the base plan and any riders must be paid until we approve the claim for the benefit.

What we don't cover

What we don't cover

This rider has certain exclusions, meaning situations where we won't pay a benefit under your rider. We list below the exclusions that apply to the benefit under your rider.

We may also apply specific exclusions to your rider when we offer to issue your rider. If any specific exclusion applies, we will record the details in a rider endorsement.

Suicide or self-inflicted act	We will not pay any benefit under this rider if the claim arises from attempted suicide or an intentional self-inflicted act, within one year of the start of your rider cover, or the date we last reinstate (restart) your rider. This applies regardless of the mental state of the person insured. If this happens, this rider will be cancelled.
Unlawful acts	We will not pay any benefit under this rider if the claim arises because you or the person insured deliberately participated in an unlawful act or failed to act in accordance with the law.

We won't pay any benefit if the signs or symptoms leading to diagnosis and claim became apparent to the person insured:

- before the rider issue date; or
- before the rider reinstatement date (if the rider cover was reinstated).

The above applies even if the signs or symptoms were not apparent to the person insured, if they would have been apparent to a reasonable person in the same position.

Starting, ending, or reinstating your rider

This section explains when your rider starts and ends, and how to make changes to your rider. We also outline when you can reinstate your rider after it has ended.

When cover starts under your rider

We start the rider cover on the coverage start date shown in your policy schedule, unless noted otherwise in an endorsement. You can only claim the benefit after your rider cover has started.

When your rider cover ends

Your rider ends on the earliest of the following dates:

- the coverage end date shown in your policy schedule;
- when this rider has reached the coverage end date and is not or cannot be renewed if you have chosen the 10-year renewable option under your base plan;
- the date when 100% of the sum insured under your base plan's Critical Illness Benefit is paid out;
- the date when the ICU Benefit under this rider is paid out;
- 60-days after a premium due date, if we do not receive your due premium before then;
- the day before the next premium due date if you request to cancel (terminate) your rider cover;
- the date we are told to cancel your rider cover by law or regulation; or
- the date when the base plan of this rider cover terminates.

You can claim a benefit under your rider after cover has ended if the event happened before the cover ended.

Reinstating your rider

If your rider ends because of non-payment of rider and policy premiums, you can reinstate it within two years of it ending if we agree. You cannot reinstate your rider for any other reason (for example, if you had ended the rider cover).

We only cover events that happen after the reinstatement date.

To reinstate your rider, you will need to provide us with evidence of health of the person insured, and you will need to pay us a lump sum premium made up of the following amounts:

- any amounts you owe us up to your next premium due date; and
- any medical costs that we need to pay in order to assess the health of the person insured.

You must reinstate your base plan as well as this rider.

What you need to do

- Contact us.
- Provide a completed service request form. You need to select the reinstatement service option on the form.
- Confirm that the health of the person to be insured still qualifies for cover (by answering the questions in the service request form).
- Pay us the required premiums.
- Reinstate your base plan as well as this rider.

What we will do

- We will review your request, and if we are satisfied that you have met our requirements, we will reinstate your base plan and this rider. Otherwise, we will not reinstate your rider.
- If we reinstate your base plan and rider, the person insured's cover will be reinstated from the date we tell you.

The person insured will not be covered for any event that took place before your base plan and rider are reinstated.

FWD insurance

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Premium Waiver Benefit add-on rider
Policy contract

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +65 6820 8888

Quick reference

Premium Waiver Benefit

Thank you for choosing FWD Singapore Pte. Ltd. We're pleased to protect you so that you can focus on living life to the fullest.

Part of your policy

This rider becomes part of your FWD Critical Illness Plus insurance policy ("base plan") if we have agreed to provide it to you. The details of your rider cover will be shown in this Premium Waiver Benefit add-on rider policy contract attached to your base plan.

The terms and conditions of the base plan apply to this rider, unless stated otherwise.

Who's covered under your rider

Person insured

The person insured under this rider has to be the same person insured under the base plan. The person insured cannot receive any benefit under this rider, and cannot make changes to this rider, unless the person insured is also the policy owner.

Your rider benefits

Summary of your rider benefits

This section describes the main benefits of your rider. To understand the full details about what we pay and how we pay it, you should read the following section (detailed rider benefits).

You are covered for the following benefit while the base plan and this rider are active.

Detailed rider benefits

This is a regular premium payment, non-participating rider and it provides the following benefits. You need to pay a separate premium to keep this rider active. This rider does not have any cash surrender value.

Premium Waiver Benefit

If you have successfully made a claim under the base plan's Early Cancer, Heart Attack and Stroke Benefit, you will no longer need to pay any premiums under your policy (including any add-on rider plans where applicable) starting from the date your next premium is due after the auto-reload period to the coverage end date, while the base plan and this rider are active.

What happens if you have added the ICU Benefit to your policy

If the ICU Benefit has been added to the policy and a claim has been successfully made under the base plan's Early Cancer, Heart Attack and Stroke Benefit or the ICU Benefit, you will no longer need to pay any premiums under your policy (including any add-on rider plans where applicable) starting from the date your next premium is due after the auto-reload period to the coverage end date, while the base plan and this rider are active.

Please refer to the 'Auto-reload Benefit' in your base plan contract for more details on how the auto-reload benefit works.

What we provide
We will provide the benefit under this rider.

What we won't provide
We won't provide the benefit if any of the following happens:

- your rider has ended. See page 5 (when your rider cover ends); or
- an exclusion applies. See page 4 (what we don't cover).

Your premiums

Your premiums are the amounts you pay for protection. It is important to pay your premiums on time, so your rider stays active and the person insured continues to be covered. Below we outline how you can pay your premiums and what happens if you don't pay.

Amount

Your current policy schedule shows the amount and the period you need to pay your premiums for this add-on rider.

When you need to pay premiums for your rider

You need to pay your premiums for this rider at the same time that you pay your premiums for your base plan (annually or monthly). You can change your chosen method any time – if you do, then your premiums for both base plan and rider will be changed. Please refer to 'changing your premium payment method or frequency' in your base plan policy contract to find out how to do so.

Premium rates are not guaranteed

The premium rates stated in your policy schedule are not guaranteed. This means we can change the premium rates by giving you at least 30 days' notice in writing.

What happens if you don't pay on time?

Your rider premiums are due on the due date. We give you a 60-day grace period after the due date to pay your premium. Your rider coverage will continue if you pay your overdue premium within this 60-day grace period. If we do not receive your premium within this period, we will cancel your rider coverage.

If your rider ends because you missed a premium payment, you can apply to reinstate it. See page 5 (reinstating your rider) for more details.

Refund of premiums after we approve a claim

If we accept a claim for the benefit, we will refund premiums paid to us after the confirmed diagnosis.

Any refunded premium amount will be paid on top of the other amounts due to be paid under your rider, if any.

Premiums must be paid until we approve the claim

All premiums due under the base plan and any riders must be paid until we approve the claim for the benefit.

What we don’t cover

What we don’t cover

This rider has certain exclusions, meaning situations where we won’t provide a benefit under your rider. We list below the exclusions that apply to the benefit under your rider.

We may also apply specific exclusions to your rider when we offer to issue your policy. If any specific exclusion applies, we will record the details in a rider endorsement.

Suicide or self-inflicted act	We will not provide any benefit under this rider if the claim arises from suicide, attempted suicide or an intentional self-inflicted act, within one year of the start of your rider cover, or the date we last reinstate (restart) your rider. This applies regardless of the mental state of the person insured. If this happens, the rider will be cancelled.
Unlawful acts	We will not provide any benefit under this rider if the claim arises because you or the person insured deliberately participated in an unlawful act or failed to act in accordance with the law.

We won’t provide any benefit if the signs or symptoms leading to diagnosis and claim became apparent to the person insured:

- before the rider issue date; or
- before the rider reinstatement date (if the rider cover was reinstated).

The above applies even if the signs or symptoms were not apparent to the person insured, if they would have been apparent to a reasonable person in the same position.

Starting, ending, or reinstating your rider

This section explains when your rider starts and ends, and how to make changes to your rider. We also outline when you can reinstate your rider after it has ended.

When cover starts under your rider

We start the rider cover on the coverage start date shown in your policy schedule, unless noted otherwise in an endorsement. You can only claim the benefit after your rider cover has started.

When your rider cover ends

Your rider ends on the earliest of the following dates:

- the coverage end date shown in your policy schedule;
- on the date of the person insured's death;
- the date when 100% of the sum insured under your base plan's Late-stage Critical Illness Benefit is paid out;
- 60-days after a premium due date, if we do not receive your due premium before then;
- the day before the next premium due date if you request to cancel (terminate) your rider cover;
- the date we are told to cancel your rider cover by law or regulation; or
- the date when the base plan of this rider cover terminates.

You can claim a benefit under your rider after cover has ended if the event happened before the cover ended.

Reinstating your rider

If your rider ends because of non-payment of rider and policy premiums, you can reinstate it within two years of it ending if we agree. You cannot reinstate your rider for any other reason (for example, if you had ended the rider cover).

We only cover events that happen after the reinstatement date.

To reinstate your rider, you will need to provide us with evidence of health of the person insured, and you will need to pay us a lump sum premium made up of the following amounts:

- any amounts you owe us up to your next premium due date; and
- any medical costs that we need to pay in order to assess the health of the person insured.

You must reinstate your base plan as well as this rider.

What you need to do

- Contact us.
- Provide a completed service request form. You need to select the reinstatement service option on the form.
- Confirm that the health of the person to be insured still qualifies for cover (by answering the questions in the service request form).
- Pay us the required premiums.
- Reinstate your base plan as well as this rider.

What we will do

- We will review your request, and if we are satisfied that you have met our requirements, we will reinstate your base plan and this rider. Otherwise, we will not reinstate your rider.
- If we reinstate your base plan and rider, the person insured's cover will be reinstated from the date we tell you.

The person insured will not be covered for any event that took place before your base plan and rider are reinstated.