FWD insurance

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FWD Term Life 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 Term Life Plus policy

This is a non-participating term life insurance plan offered by FWD Singapore Pte. Ltd ("FWD").

> ! '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 Term Life Plus policy is not a savings or investment product. We will not pay any money under this policy other than from the death benefit, terminal illness benefit and/or spouse benefit.

Your FWD Term Life Plus 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.

Words with special meaning

Some words in this policy contract have special meaning. We show those meanings on page 15 (important words and phrases). Please refer to this section when you need to.

Age	Policy issue date
Application form	Premium
Coverage start date	Policy illustration
Coverage end date	Policy schedule
Endorsement	Terminal illness or Terminally ill
Medical practitioner	We, our, FWD, us
Period of insurance	You, your, yourself,
Policy	person insured

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 12 (your premiums).

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

- Auto-debit from a credit card, or
- Other modes of payment as updated on our website from time to time.

About your policy

Choosing who receives the benefits

Death benefit

This benefit will be paid to your nominee in a lump sum equivalent to 100% of the sum insured for the death benefit, as stated in the policy schedule.

If you die, one of the following people can request for us to pay them an advance payment of S$5,000 from the death benefit to cover your funeral expenses:

- The nominee under the base plan with written consent of any other nominees.
- If there is no nominee, the legal spouse or an immediate family member along with satisfactory proof of relationship.

We will only make the advance payment of S$5,000 when we receive the death certificate. The remainder of the sum insured under the death benefit will be paid after we have assessed the death claim application.

Terminal illness benefit

This benefit will be paid to you in a lump sum equivalent to 100% of the sum insured for the death benefit, as stated in the policy schedule.

Spouse benefit

If we pay the death benefit or terminal illness benefit under this policy, your legal spouse can ask us to issue him/her a new complimentary insurance policy without any underwriting:

- with a sum insured of 50% of the death benefit under this policy, or S$250,000 (whichever of the two is lower) payable if he/she dies or suffers from terminal illness; and
- with a policy term of 1 year.

The legal spouse must be aged 55 years old or under at the time of his/her complimentary policy issuance. The complimentary insurance policy issued to your legal spouse cannot be renewed or extended beyond the first 1 year.

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 renewable plan, where the period of insurance stated in the policy schedule is “one year”. If this policy (including any add-on rider plans) is valid at the end of the period of insurance, we will automatically renew this policy by one more year.

You can choose not to renew 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 death benefit. See page 9 (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.

Surrender values

If you surrender (cancel) your policy, you:

- will lose the coverage under this policy; and
- will not receive any amount in return.

In addition, any changes to your health or circumstances in the future may make it more difficult or costly for you to get coverage in the future.

14-day 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.

What you need to do

You must write to us to cancel this policy. We must receive your notice within the 14-day 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-day 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.

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 10 (how to notify us of a claim) for more details on making a claim.

How to resolve a concern or complaint

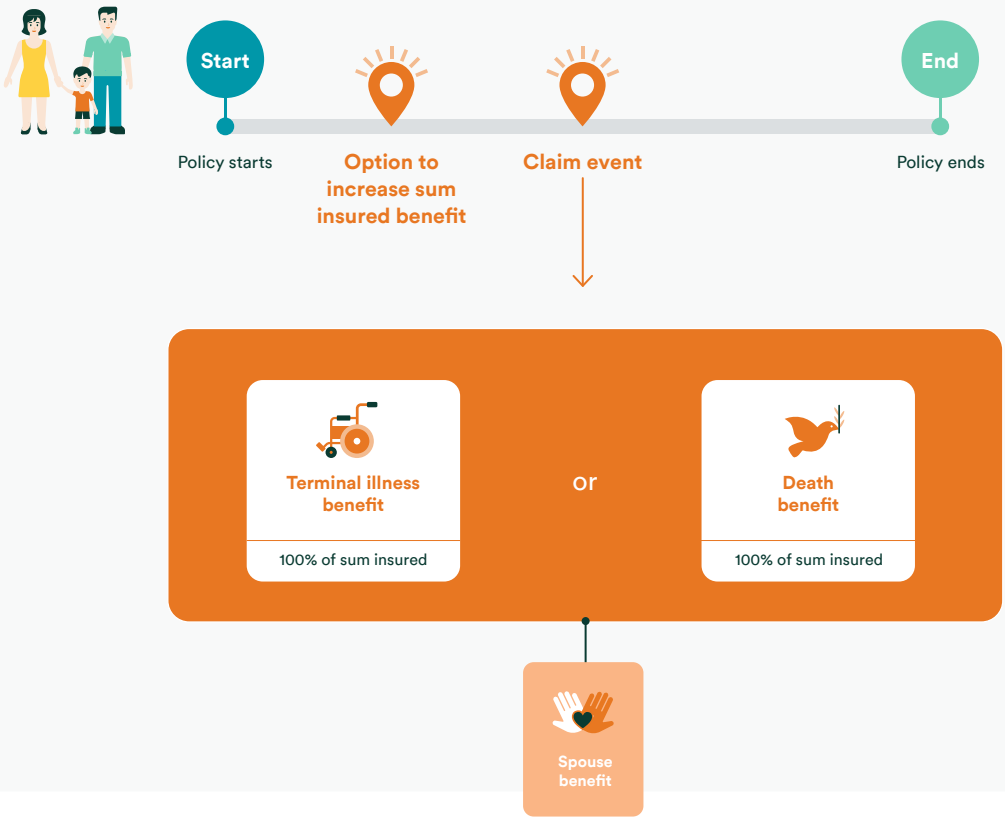
We want to resolve any concerns or complaints you may have as quickly as possible. You should follow the steps below to resolve your concerns.

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 complaints or concerns 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 Disputes 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



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.

Summary of your policy benefits

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

Death benefit

If you die while this policy is in force, we will pay the death benefit equivalent to 100% of the death benefit sum insured, as stated in the policy schedule.

We will deduct any claims already paid under the 'Total and Permanent Disability' and/or 'Critical Illness' add-on rider plans taken along with this base plan (if applicable), and any monies you owe us on your policy before we pay the death benefit.

If you die, one of the following people can request for us to pay them an advance payment of S$5,000 from the death benefit to cover your funeral expenses:

- The nominee under the base plan with written consent of any other nominees.
- If there is no nominee, the legal spouse or an immediate family member along with satisfactory proof of relationship.

We will only make the advance payment of S$5,000 when we receive the death certificate. The remainder of the sum insured under the death benefit will be paid after we have assessed the death claim application.

The policy will end after this benefit is paid. We will deduct any monies you owe us on your policy before we pay any claim.

When we won't pay

We won't pay the death benefit if any of the following happens.

- Your policy has ended. See page 8 (when your policy ends).
- We have already paid the terminal illness benefit.
- An exclusion applies. See page 10 (when we will not pay any benefit).

Terminal illness benefit

If you suffer a terminal illness while this policy is in force, we will pay the terminal illness benefit equivalent to 100% of the death benefit sum insured, as stated in the policy schedule. The policy will end after this benefit is paid.

We will deduct any claims already paid under the 'Total and Permanent Disability' and/or 'Critical Illness' add-on rider plans taken along with this base plan (if applicable), and any monies you owe us on your policy before we pay the terminal illness benefit. The policy will end after this benefit is paid.

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

When we won't pay

We won't pay the terminal illness benefit if any of the following happens.

- Your policy has ended. See page 8 (when your policy ends).
- We have already paid the death benefit.
- An exclusion applies. See page 10 (when we will not pay any benefit).
- Please note that in recognition of medical advances, we do not consider AIDS to be a terminal illness.

See page 16 for the meaning of 'terminal illness'.

What you're covered for

Option to increase sum insured benefit

You can apply to increase your sum insured without providing us evidence of good health if the person insured experienced a life event and if the following conditions are met:

- The life event must happen while your policy is active and we must receive satisfactory evidence of the life event;
- The life event must occur before the person insured attains age 50 at age of last birthday;
- The application for this increase of sum insured must be submitted within 90 calendar days from the occurrence of the life event;
- The policy is fully underwritten and issued on standard terms without any loadings or exclusions;
- On the date of the application for this increase of sum insured, there are no previously admitted or submitted claims under this policy or any of the attaching riders;
- All the premiums under this policy and the attaching riders are paid up to-date;
- **For Term Life Plus policy and Total and Permanent Disability Benefit rider:**
  The total sum insured that can be increased, irrespective of the number of times this option is exercised, shall be the lower of 25% of the sum insured at coverage start date or S$500,000 per person insured. If You have more than one Term Life Plus policy and Total and Permanent Disability Benefit rider with FWD, the aggregate sum insured after increase shall not exceed S$1.5 million.
- **For Critical Illness Benefit rider:**
  The total sum insured that can be increased, irrespective of the number of times this option is exercised, shall be the lower of 25% of the sum insured at coverage start date or S$100,000 per person insured. If You have more than one Critical Illness Benefit rider with FWD, the aggregate sum insured after increase shall not exceed S$1.5 million.

If we agree to increase the sum insured, the increased sum insured will be effective from the next policy monthiversary of your policy. The premium payable for the increased sum insured for the remaining term of your policy will be calculated based on the person insured's attained age at time of increase.

Policy monthiversary means the same date each month as the effective date. If the monthiversary does not exist in a particular month, it will be the last day of the month.

Life event shall be defined as follows:

Life event for the person insured	Evidence to be submitted	90 calendar days starts from
Getting married	Certified copy of marriage certificate	The date of marriage as indicated on the marriage certificate
Purchasing a home as a permanent residence and taking out a mortgage on that residence	Certified copy of the cover and first page of the home financing documents	The settlement date
The person insured completing their first tertiary education qualification	Certified copy of graduation documents	The graduation date as indicated on the graduation certificate
The person insured starting their first paid job	Confirmation letter from person insured's employer	The job start date

Spouse benefit

If we pay the death benefit or terminal illness benefit under this policy, your legal spouse can ask us to issue him/her a new complimentary insurance policy without any underwriting:

- with a sum insured of 50% of the death benefit under this policy, or S$250,000 (whichever of the two is lower) payable if he/she dies or suffers from terminal illness; and
- with a policy term of 1 year.

The legal spouse must be aged 55 years old or under at the time of his/her complimentary policy issuance. The complimentary insurance policy issued to your legal spouse cannot be renewed or extended beyond the first 1 year.

What you need to do

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

When we won't offer the new policy

- We won't offer your legal spouse the new policy unless the death or terminal illness benefit has been paid.

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

Your 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 up the required form and pass it to us.

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 up the required form and pass it to us.

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 death benefit under your policy. See page 9 (the main people under your policy) for more details on your different choices.

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 policy will continue to provide coverage up to the next date in which your premium is due. 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.

What you need to do

- Contact us.
- Fill up 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.

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

If you tell us to cancel your policy within the 14 calendar day free-look period, we'll give you a full refund (less any fees and expenses) – see page 2 (14-day free-look period) for more details.

No reinstatement after cancelling

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

When your policy ends

Your policy (including any add-on rider plans) will end on the earliest of the following dates:

- When the total benefit amount we have paid under this policy (including any add-on rider plans) equals to the death benefit sum insured;
- This policy has reached the coverage end date;
- We do not receive the premium within the 62-day grace period;
- When we receive your notice in writing to terminate your policy; or
- Any other event that leads to a termination, as stated in this policy, such as providing inaccurate information, submitting a fraudulent claim, or if we are required to do so under the laws or regulations of Singapore.

If you choose to terminate your policy early and you have paid your premiums, your policy will continue to provide coverage up to the day before the next due date for the premium payment.

Coverage renewal option

The coverage renewal option is available on the renewable plan, where the period of insurance stated in the policy schedule is "one year". If this policy (including any add-on rider plans) is valid at the end of the period of insurance, we will automatically renew this policy by one more year.

The premium we charge you for the next year will be the same as the premium that we charge people who have the same age, gender, occupation, sum insured, and smoking status as yourself on the day this policy is renewed. We will not take into account any changes in your health, but any conditions we made when we first issued this policy (such as charging higher premiums because of a health condition you had) will continue to apply to your policy.

This coverage renewal option is available every year until you are 100 years old and as long as this policy remains valid. Please note that the 'Total and Permanent Disability' add-on rider plan (if applicable) will end on your 65th birthday, even if you renew this policy beyond the age 65.

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 (including any add-on rider plans) ends because of non-payment of policy premiums, you can reinstate it within three 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).

We only cover events that happen after the reinstatement date.

We may refuse your reinstatement application or adjust the terms of this policy. If we approve your application, this policy will be reinstated on the date we confirm in writing (the "Reinstatement Date"). If this policy is reinstated, we will only insure events that take place after the Reinstatement Date.

What you need to do

- Contact us within three years from the date of termination.
- Complete a service request form and pass it to us. You need to select the reinstatement service option.
- Pay us all unpaid premiums and interest due (at a rate to be determined by us) and the administrative fees, if any.
- Confirm that the health of the person to be insured still qualifies for cover (by answering the questions in the service request form).

What we will do

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

Important note
You will not be covered for any event that takes place before your policy is reinstated.

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 FWD Term Life Plus policy contract, you are the policy owner and person insured, unless there were changes made to your policy through an assignment of benefits. See page 9 (assignment of benefits).

You may choose a person to receive the benefits payable upon death 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 when you can apply	Must be at least 18 years old.
Maximum age when you can apply	Must be younger than 60 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 death benefit under this policy, and you can decide how much of the death benefit 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. 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 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.

We're here for you

We understand that dealing with the diagnosis of a terminal illness or death of a loved one is difficult – you can always call us at our hotline at +65 6820 8888 (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)) for help with the claim process.

Filling-in your claim form

We will provide the relevant claim and any applicable consent forms we require in order for us to process and review your claim. Claims must be made on forms provided by us together with the supporting documents and any other information and documents that we ask for, including any consent forms we require you to sign. We will not be able to process a claim until we receive all documents, information, the completed claim form and any applicable consent forms.

Every effort should be made for claim forms and supporting documents to be sent to us within 6 months from the terminal illness diagnosis date or death being claimed for.

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 two years from the start of your policy cover, the last reinstatement date (if your policy has been reinstated) or the date that we approve an increase in the sum insured (in respect of that increase), whichever is later. This applies regardless of the mental state of the person insured. If this happens, we will refund the premiums we received without interest and 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 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

You or your legal personal representative are legally responsible for all costs incurred including travel, accommodation and other costs in providing us the necessary documents we request in order to assess your claim, except for the cost of any additional medical examinations we require you to have as requested by our appointed medical practitioner. The opinion and diagnosis of this medical practitioner is binding on you and us. You must co-operate fully with us and our appointed medical practitioner.

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 terminal 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 on time.

Amount

Your policy schedule shows the amount you need to pay for your policy. To enjoy the benefits provided by this policy, please pay each premium before it is due.

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.
- Semi-annually in two instalments.
- Quarterly in four instalments.
- By monthly instalments.

You can change your chosen method any time. See page 7 (changing your premium payment method or frequency) for how.

Payment method options

You can pay using any of the following options.

- Auto-debit from a credit card, or
- Other modes of payment as updated on our website from time to time.

Premium rates are guaranteed

The premium rates stated in your policy schedule are guaranteed for your base plan for the stated period of insurance. This means we will not change the premium rates during the policy term.

Premium rates upon renewal of the policy are not guaranteed

If you have chosen the coverage renewal option under this policy, then the premium rates stated in your policy illustration for future renewals are not guaranteed. This means that we may change the premium rates 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 62-day grace period after the due date to pay your premium. Your policy will continue if you pay your overdue premium within this 62-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, semi-annual, quarterly 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 62-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).

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 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:

- Letting us have the correct and complete information.
- Being careful when answering our questions, or when you or the person insured confirm or amend any information you have given to us.
- Co-operating with us when making a claim and providing us and/or our third party service providers or representatives with any information and help that we need to process the claim, including signing any documents or forms to allow us to obtain relevant information and records, at your own cost, from any medical service provider, hospital, clinic or other sources.

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 14 (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 (if applicable) or any applicable policy exclusion, we will not declare your policy void 2 years after the policy issue date or the last reinstatement date (if your policy had 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.

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.
Coverage start date	Refers to the date the first premium is due, and the date cover starts under your policy. This date is shown in your policy schedule.
Coverage end date	Refers to the date your policy ends. This date is shown in your policy schedule.
Endorsement	Refers to any additional document attached to this policy outlining adjustments to the standard terms and conditions that we have made as a condition to providing this policy.
Medical practitioner	Refers to a medical examiner or doctor who: ▪ has a recognised medical degree in western medicine; ▪ is authorised to practise in his country; and ▪ has the skill to provide medical services for the illness, disease or condition concerned; or ▪ is in Singapore and is approved by us. This person must not be you, your spouse, relative or business partner.
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.
Policy	All of the documents listed below. ▪ the application form and any documents you provided with it; ▪ this policy contract; ▪ the policy schedule; and ▪ any endorsement to your policy, if applicable. This person must not be you, your spouse, relative or business partner.
Policy issue date	Refers to the date as shown in the 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.

Important word and phrases

Policy schedule	Refers to the documents attached to this policy that shows important information about you and this policy: the policy number, your personal details, period of insurance, sum insured, frequency of premium payment, and premium payable.
Terminal illness or Terminally ill	Refers to any medical condition that, in the opinion of a medical practitioner, is expected to lead to death within the next 12 months.
We, our, FWD, us	Refers to FWD Singapore Pte. Ltd., the issuer of this insurance policy.
You, your, yourself, person insured	Refers to the person who is the owner of and insured by this policy as shown in the policy schedule and endorsement.

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FWD Total and Permanent Disability 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

FWD Total and Permanent Disability add-on rider

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. This rider provides additional protection if the person insured suffers total and permanent disability ("TPD").

Part of your policy

This rider becomes part of your FWD Term Life Plus policy ("base plan") if we have agreed to provide it to you. The details of your total and permanent disability cover will be shown in this FWD TPD rider contract attached to your base plan.

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

Who's covered under your rider

Person insured

We will pay the TPD benefit in a lump sum equivalent to 100% of the sum insured for the TPD benefit, as stated in the policy schedule, if you become totally and permanently disabled due to an accident or sickness while this rider is in place.

The person insured under this rider has to be the same as the person insured under your policy. The person insured cannot receive any benefit under this rider, and cannot make changes to your 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.

Totally and permanently disabled or Total and permanent disability	Means that, before your 65th birthday and due to accident or sickness, you: ▪ Are disabled to the extent of being completely unable to engage in any occupation, business or activity for income, remuneration or profit. The disability must continue uninterrupted for at least six consecutive months from the time when the disability started and must, in the view of a medical practitioner, be deemed permanent with no possibility of improvement in the foreseeable future; and/or ▪ Suffer total and irrecoverable loss of: » Entire sight in both eyes; » Use of any two limbs at or above the wrist or ankle; or » The entire sight in one eye and use of any one limb at or above the wrist or ankle.

Your rider benefits

Summary of your 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 can claim the following benefit while the rider is in place.

The TPD benefit ends on the coverage end date, as stated in your policy schedule, or on the policy anniversary of when you reach age 65, whichever comes first.

We will pay you 100% of the TPD benefit sum insured if the person insured suffers total and permanent disability.

Detailed rider benefits

This is an accelerating rider and it provides the following protection benefits. You need to pay a separate premium to keep this protection in place.

How an accelerating rider works

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

Your coverage under accelerating rider

If the TPD benefit sum insured equals to the death benefit sum insured under the base plan, both the rider and the base plan will terminate automatically after we pay the TPD benefit.

When a valid claim is paid for the person insured under a rider, the coverage for the base plan is reduced by the amount we pay. If this revised coverage under the base plan is less than coverage offered under other active riders, then the sum insured under these riders will be adjusted to such revised sum insured. In such instance, the base plan will continue, and your subsequent premiums will be reduced proportionately to your new sum insured.

At any point in time, the TPD benefit payable will not be more than the death benefit sum insured or the reduced death benefit sum insured (if applicable).

If you have made a claim for other benefits which reduces the death benefit sum insured to be less than the TPD benefit sum insured, we will cap the amount payable for the TPD benefit at the reduced death benefit sum insured.

Once we pay the reduced TPD benefit, death benefit or terminal illness benefit, the rider and the base plan will terminate automatically.

What we pay

Total and permanent disability benefit

If during the time this rider is valid:

- You first experience symptoms that may lead to you becoming totally and permanently disabled; and
- a medical practitioner subsequently confirms that you become totally and permanently disabled,

we will pay you the TPD benefit in a lump sum equivalent to 100% of the sum insured for the TPD benefit, as stated in the policy schedule. The cover for TPD will end when it is paid.

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

Important Notes
Please note that part of how we define total and permanent disability is that you must be completely unable to carry out any occupation. This benefit is not payable if you are unable to perform the same job duties you had before your disability, or are unable to perform a job that fits your training, education, or experience, but you are able to engage in other occupations, businesses or activities for income, remuneration or profit.

Your premiums

Your premiums are the amount 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 you need to pay 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 as you pay your premiums for your base plan (annually, semi-annually, quarterly, 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 contract for how to do so.

Premium rates are guaranteed during the period of insurance

The premium rates for the TPD benefit, as stated in your policy schedule, are guaranteed during the period of insurance. This means we will not change the premium rates during the period of insurance.

Premium rates upon renewal of the base plan are not guaranteed

If you have chosen the coverage renewal option under the base plan, then the premium rates stated in your policy schedule for future renewals are not guaranteed. This means we may 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 62-day grace period after the due date to pay. Your rider coverage will continue if you pay your overdue premium within this 62-day period. If we do not receive your premium within this period, we will cancel your rider coverage.

If your rider coverage ends because you missed a premium payment, you can apply to reinstate (restart) 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 TPD benefit, we will refund prorated 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 TPD 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. We list below the exclusions that apply to the benefits under your rider.

We may also apply specific exclusions to your rider when we offer to issue your rider.

If any specific exclusions apply, 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 suicide, attempted suicide or an intentional self-inflicted act. This applies regardless of the mental state of the person insured. If this happens, the 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 illness that lead to total and permanent disability and claim, became apparent:

- before the rider issue date;
- before the rider reinstatement date (if the rider cover was restarted): or
- before the date that we approve an increase in the sum insured (in respect of that increase);

whichever is later.

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

Starting, ending, or reinstating your total and permanent disability cover

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 cover starts under your rider

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

When your rider cover ends

The rider cover ends on the earliest of the following.

- The coverage end date shown in your policy schedule.
- The end of the 62-day grace period, 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.
- The date when 100% of the sum insured under your base plan is paid out.
- 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 three 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, and you will need to pay us a lump sum premium made up of the following amounts:

- Any amounts you owe us.
- A rider premium amount that covers the period from your reinstatement date to your next premium due date.
- 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.
- 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 premium amount.
- Reinstate your base plan as well as this rider.

What we will do

- We will review your application, 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, your cover will be reinstated from the date we tell you.

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FWD Critical Illness 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

FWD Critical Illness add-on rider

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. This rider provides additional protection if the person insured suffers one of the covered critical illnesses.

Part of your policy

This rider becomes part of your FWD Term Life Plus policy ("base plan") if we have agreed to provide it to you. The details of your critical illness cover will be shown in this FWD Critical Illness rider 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

We will pay the critical illness benefit in a lump sum equivalent to 100% of the sum insured for the critical illness benefit, as stated in the policy schedule, if you suffer a covered critical illness condition while this rider is in place.

The person insured under this rider has to be the same as the person insured under your policy. The person insured cannot receive any benefit under this rider, and cannot make changes to your 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.

Critical illness or Critical illnesses	Refers to any of the illnesses defined on page 7 (definitions of covered critical illnesses).
Permanent	Means expected to last throughout the lifetime of the person insured.
Permanent neurological deficit	Refer to symptoms of dysfunction in the nervous system that 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.
Activities of daily living (ADLs)	Refer to the following six activities of daily living: i. 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; ii. Dressing — the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances; iii. Transferring — the ability to move from a bed to an upright chair or wheelchair and vice versa; iv. Mobility — the ability to move indoors from room to room on level surfaces; v. Toileting — the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene; vi. Feeding — the ability to feed oneself once the food has been prepared and made available.

Your rider benefits

Summary of your 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 can claim the following benefit while the rider is in place.

The critical illness benefit ends on the coverage end date, as stated in your policy schedule.

We will pay the critical illness benefit in a lump sum equivalent to 100% of the sum insured for the critical illness benefit, as stated in the policy schedule, if the person insured suffers a covered critical illness condition (other than 'Angioplasty and other invasive treatment for coronary artery') while this rider is in place.

Detailed rider benefits

This is an accelerating rider and it provides the following protection benefits. You need to pay a separate premium to keep this protection in place.

How an accelerating rider works

Your base plan provides the amount of cover ("sum insured") for death and terminal illness, 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 sum insured is reached.

Your coverage under accelerating rider

If the critical illness benefit sum insured equals to the death benefit sum insured under the base plan, both the rider and the base plan will terminate automatically after we pay the critical illness benefit.

When a valid claim is paid for the person insured under a rider, the coverage for the base plan is reduced by the amount we pay. If this revised coverage under the base plan is less than coverage offered under other active riders, then the sum insured under these riders will be adjusted to such revised sum insured. In such instance, the base plan will continue, and your subsequent premiums will be reduced proportionately to your new sum insured.

At any point in time, the critical illness benefit payable will not be more than the death benefit sum insured or the reduced death benefit sum insured (if applicable).

If you have made a claim for other benefits which reduces the death benefit sum insured to be less than the critical illness benefit sum insured, we will cap the amount payable for the critical illness benefit at the reduced death benefit sum insured.

Once we pay the reduced critical illness benefit, death benefit or terminal illness benefit, the rider and base plan will terminate automatically.

What we pay

Diagnosis of 'Angioplasty and other invasive treatment for coronary artery'

If during the time this rider is valid:

- You first experience symptoms that result in you needing 'Angioplasty and other invasive treatment for coronary artery'; and
- a medical practitioner subsequently confirms that you need this treatment,

we will pay 10% of the sum insured for the critical illness benefit, subject to a maximum amount of S$25,000.

Both the base plan and this rider will remain valid after this benefit payment. However, the base plan sum insured (death benefit sum insured and terminal illness benefit sum insured) will be reduced accordingly:

Revised base plan sum insured = original base plan sum insured - benefit we have paid you for a claim for 'Angioplasty and other invasive treatment for coronary artery'

For example, if the original base plan sum insured is S$100,000 and the benefit paid is S$25,000, your revised base plan sum insured will be S$75,000 (S$100,000 – S$25,000).

We will also reduce all future premiums in proportion to this revised sum insured.

We will only pay the benefit for 'Angioplasty and other invasive treatment for coronary artery' once under this rider.

Diagnosis of other covered critical illnesses

If during the time this rider is valid:

- you first experience symptoms that may be related to a critical illness (other than 'Angioplasty and other invasive treatment for coronary artery'); and
- a medical practitioner subsequently confirms that you suffer from that critical illness,

we will pay you the critical illness benefit in a lump sum equivalent to 100% of the sum insured for the critical illness benefit, as stated in the policy schedule. The cover for critical illness will end when it is paid.

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

Waiting period

For the following critical illnesses, the benefits described under this rider are only available 90 calendar days after the coverage start date, the last reinstatement date (if your policy has been reinstated), or the date of any increase in your sum Insured (in respect of that increase), whichever is later:

- Heart attack of specified severity;
- Major cancer;
- Coronary artery by-pass surgery;
- Angioplasty and other invasive treatment for coronary artery; and
- Other serious coronary artery disease.

This means that no benefit will be available if you first experience symptoms of any one or more of the above critical illnesses before the end of this 90-day period.

Critical illnesses covered

1. Alzheimer's disease / severe dementia
2. Angioplasty & other invasive treatment for coronary artery
3. Benign brain tumour
4. Coma
5. Coronary artery by- pass surgery
6. Deafness (irreversible loss of hearing)
7. End stage kidney failure
8. End stage liver failure
9. End stage lung disease
10. Fulminant hepatitis
11. Heart attack of specified severity
12. HIV due to blood transfusion and occupationally acquired HIV
13. Idiopathic parkinson's disease
14. Irreversible aplastic anaemia
15. Irreversible loss of speech
16. Loss of independent existence
17. Major burns
18. Major cancer
19. Major head trauma
20. Major organ / bone marrow transplantation
21. Motor neurone disease
22. Multiple sclerosis
23. Muscular dystrophy
24. Open chest heart valve surgery
25. Open chest surgery to aorta
26. Other serious coronary artery disease
27. Paralysis (irreversible loss of use of limbs)
28. Persistent vegetative state (apallic syndrome)
29. Poliomyelitis
30. Primary pulmonary hypertension
31. Progressive scleroderma
32. Severe bacterial meningitis
33. Severe encephalitis
34. Stroke with permanent neurological deficit
35. Systemic lupus erythematosus with lupus nephritis

Your premiums

Your premiums are the amount 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 you need to pay 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 as you pay your premiums for your base plan (annually, semi-annually, quarterly, 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 contract for how to do so.

Premium rates are not guaranteed

The premiums that you pay for the critical illness benefit are not guaranteed during the period of insurance and is subject to change during the period of insurance. We will let you know 30 days in advance if your critical illness benefit premiums are being revised.

What happens if you don't pay on time?

Your rider premiums are due on the due date. We give you a 62-day grace period after the due date to pay. Your rider coverage will continue if you pay your overdue premium within this 62-day period. If we do not receive your premium within this period, we will cancel your rider coverage.

If your rider coverage ends because you missed a premium payment, you can apply to reinstate (restart) 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 critical illness benefit, we will refund prorated 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 critical illness 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. We list below the exclusions that apply to the benefits under your rider.

We may also apply specific exclusions to your rider when we offer to issue your rider. If any specific exclusions apply, 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 suicide, attempted suicide or an intentional self-inflicted act. This applies regardless of the mental state of the person insured. If this happens, the 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:

- before the rider issue date; or
- before the rider reinstatement date (if the rider cover was restarted); or
- before the date that we approve an increase in the sum insured (in respect of that increase);

whichever is later.

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

Starting, ending, or reinstating your critical illness cover

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 cover starts under your rider

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

When your rider cover ends

The rider cover ends on the earliest of the following.

- The coverage end date shown in your policy schedule.
- The end of the 62-day grace period, 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.
- The date when 100% of the sum insured under your base plan is paid out.
- 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 three 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, and you will need to pay us a lump sum premium made up of the following amounts:

- Any amounts you owe us.
- A rider premium amount that covers the period from your reinstatement date to your next premium due date.
- 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.
- 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 premium amount.
- Reinstate your base plan as well as this rider.

What we will do

We will review your application, 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, your cover will be reinstated from the date we tell you.

Definitions of covered critical illnesses

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 our 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. Payment under this condition is limited to 10% of the sum insured for the critical illness benefit, subject to a S$25,000 maximum sum payable. This benefit is payable once only and shall be deducted from the base plan sum insured, thereby reducing the amount of the sum insured which may be payable therein. 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.

Definitions of covered critical illnesses

4. 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.
5. 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.
6. 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."
7. End stage kidney failure	Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.
8. 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.
9. 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.

10. 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.
11. 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 us. 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
12. 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 rider contract, 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 rider contract, 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 our satisfaction:

Definitions of covered critical illnesses

	▪ 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.
13. 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.
14. 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.
15. 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.
16. 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 our approved doctor.

	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.
17. Major burns	Third degree (full thickness of the skin) burns covering at least 20% of the surface of the person insured's body.

18. 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.

Definitions of covered critical illnesses

19. 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.
20. 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.
21. 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.
22. 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.
23. 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.
24. 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.
25. 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.
26. 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.
27. 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.
28. 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.
29. 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.
30. 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.

Definitions of covered critical illnesses

31. 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
32. 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.
33. 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.
34. 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.
35. 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.

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

FWD insurance

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FWD Premium Waiver 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

FWD Premium Waiver add-on rider

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. This rider waives future premiums if the person insured suffers a total and permanent disability ("TPD") or a covered critical illness.

Part of your policy

This rider becomes part of your FWD Term Life Plus policy ("base plan") if we have agreed to provide it to you. The details of your premium waiver cover will be shown in this FWD premium waiver rider 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

We will waive future premiums of the base plan and all the riders, if you become totally and permanently disabled or suffer one of the covered critical illness while this rider is in place.

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

Your rider benefits

Summary of your 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 can claim the following benefit while the rider is in place.

Detailed rider benefits

Premium waiver benefit

You do not need to continue paying the premiums of your policy, starting from the date your next premium is due, if you:

- are diagnosed by a medical practitioner as having suffered from a covered critical illness other than 'Angioplasty and other invasive treatment for coronary artery' while this rider is valid; or
- in the opinion of a medical practitioner, become totally and permanently disabled before your 65th birthday and while this rider is valid.

Waiting period

For the following critical illnesses, the benefits described above are only available after 90 calendar days following the coverage start date, the last reinstatement date (if your policy has been reinstated), or the date of any increase in your sum insured (in respect to that increase), whichever is later:

- Heart attack of specified severity;
- Major cancer;
- Coronary artery by-pass surgery; and
- Other serious coronary artery disease.

This means that no benefit will be available if you first experience symptoms of any one or more of the above critical illnesses before the end of this 90-day period.

Your premiums

Your premiums are the amount 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 you need to pay 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 as you pay your premiums for your base plan (annually, semi-annually, quarterly, 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 contract for how to do so.

Premium rates are not guaranteed

The premiums that you pay for the premium waiver benefit are not guaranteed during the period of insurance and is subject to change during the period of insurance. We will let you know 30 days in advance if your critical illness benefit premiums are being revised.

What happens if you don't pay on time?

Your rider premiums are due on the due date. We give you a 62-day grace period after the due date to pay. Your rider coverage will continue if you pay your overdue premium within this 62-day period. If we do not receive your premium within this period, we will cancel your rider coverage.

If your rider coverage ends because you missed a premium payment, you can apply to reinstate (restart) 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 total and permanent disability benefit or the critical illness benefit, we will refund prorated premiums paid to us after the confirmed diagnosis.

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 premium waiver 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. We list below the exclusions that apply to the benefits under your rider.

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

Suicide or self-inflicted act	Premium waiver benefit will not be available for total and permanent disability or critical illness that directly or indirectly results from attempted suicide or an intentional self-inflicted act by yourself. This applies regardless of the mental state of the person insured. If this happens, the rider will be cancelled.
Unlawful acts	Premium waiver benefit will not be available 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.
Angioplasty and other invasive treatment for coronary artery	Premium waiver benefit will not be available for a critical illness that directly or indirectly results from ‘Angioplasty and other invasive treatment for coronary artery’.

We won’t pay any benefit if the signs or symptoms leading to the diagnosis of a critical illness or total and permanent disability, and claim, became apparent:

- before the rider issue date;
- before the rider reinstatement date (if the rider cover was restarted); or
- before the date that we approve an increase in the sum insured (in respect of that increase);

whichever is later.

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

Starting, ending, or reinstating your premium waiver cover

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 cover starts under your rider

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

When your rider cover ends

The rider cover ends on the earliest of the following.

- The coverage end date shown in your policy schedule.
- The end of the 62-day grace period, 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.
- The date when 100% of the sum insured under your base plan is paid out.
- The date when the base plan of this rider cover terminates.

Reinstating your rider

If your rider ends because of non-payment of rider and policy premiums, you can reinstate it within three 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, and you will need to pay us a lump sum premium made up of the following amounts:

- Any amounts you owe us.
- A rider premium amount that covers the period from your reinstatement date to your next premium due date.
- 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.
- 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 premium amount.
- Reinstate your base plan as well as this rider.

What we will do

- We will review your application, 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, your cover will be reinstated from the date we tell you.