CONSULTATION PAPER

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# The Proposed Regulatory Framework For Accident & Health Insurance Business

MAS
Monetary Authority of Singapore

# EXECUTIVE SUMMARY

MAS issued a consultation paper in August 2002 on a proposed regulatory framework for health insurance business. A dedicated work group involving industry practitioners and MAS officials was subsequently formed in November 2002 to consider the feedback collected during the consultation phase and to develop the details of the framework. This consultation paper aims to:

- describe the scope of the proposed regulatory framework for accident and health ("A&H") insurance business;
- explain the re-classification of life and general insurance business;
- explain the activities that insurers and insurance intermediaries are allowed to undertake;
- detail the operational requirements on disclosure, fact-finding, and needs analysis as recommended by the work group;
- describe the reporting and reserving requirements in relation to the proposed risk-based capital framework; and
- present the Draft Notice on Disclosure and Advisory Process Requirements for Accident and Health Insurance Products

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# 1 SCOPE OF THE PROPOSED REGULATORY FRAMEWORK

The proposed framework for A&H insurance governs both the underwriting and distribution of policies that contain "accident and health benefits"[1]. Included under this definition are products commonly known as medical expense insurance, disability income insurance, long-term care insurance, critical illness insurance, managed healthcare schemes and personal accident insurance. As insurers become more innovative in tailoring products to their clients' needs, they often bundle A&H benefits with other insurance products, such as life insurance policies. To minimize the likelihood of regulatory arbitrage, the proposed framework will apply when A&H benefits are offered on a stand-alone basis, as well as when packaged with other insurance products.

[1] As defined in the Insurance (Amendment) Bill 2003, "accident and health benefits" means benefits which are paid out—

(a) in the event of an injury to, or a disability of, the insured as a result of accident or sickness;
(b) in the event of the insured being found to have a condition or disease stated in the policy of the insured;
(c) with respect to health services;
(d) on the death, by accident or some other cause stated in the policy, of the insured; or
(e) on the happening of a combination of any of the above,

but does not include benefits that are payable with respect to any loss arising out of a liability to pay compensation or damages.

This new definition will replace the existing definition of "personal accident policies". From the feedback received during the consultation phase of the draft Bill, one respondent is concerned that the definition may be overly narrow. Such an inclusive definition could also give rise to difficulties if new medical conditions develop which are not covered by this definition occurs in future. The respondent suggested that the Act be amended to enable the Minister to add to or modify this definition should the need arise.

The Authority feels that the "accident and health benefits" definition put forth is adequate in encompassing the A&H products currently available in the market. On the other hand, the Authority agrees that there might be future needs for the definition to be modified. The Bill will therefore introduce a new provision to allow the Minister to amend the Schedules where necessary.

# 2 CLASSIFICATION OF INSURANCE BUSINESS AND ROLES OF INSURERS AND INTERMEDIARIES

2.1 Recognizing the change in demography and the needs of the general population for long-term health insurance services, many insurers have begun introducing products that guarantee long duration of coverage in recent years. Such a trend has created more long-term obligations for insurers. With the current legislation subsuming A&H insurance under general insurance business and permitting life insurers to underwrite only limited standalone A&H policies[2], the capacity for the insurance industry to provide continuous health insurance benefits is greatly reduced. In order to help satisfy the healthcare financing needs of the population, as well as to strengthen the management of monies supporting long-term health insurance obligations, a re-classification of business activities under the Insurance Act ("IA") is necessary.

2.2 Stand-alone A&H policies will be divided into two categories, long-term and short-term. An A&H policy is deemed long-term when it meets the following 2 conditions:

- the duration of coverage exceeds five years; and
- the policy is not subjected to unilateral cancellation by the insurer.

The ElderShield scheme (a nation-wide long-term disability insurance scheme) is one such long-term A&H product. In determining the duration of coverage, one should assume that the insured will exercise the option of extending his or her policy duration whenever the terms and conditions of the contract provide for this to happen, whether on the same terms and conditions or otherwise.

2.3 A&H policies not deemed long-term in nature are treated as short-term A&H policies. This type of policy includes most personal accident products and yearly renewable group medical insurance policies. Short-term A&H policies may

[2] Under the existing MAS Notice 315, direct life insurers are allowed to underwrite standalone A&H policies provided the premium income derived from these policies does not exceed the lower of a) $2 million; or b) 20% of the average total premium income of the life insurance fund in the current and the preceding 2 years. This Notice will be repealed with the introduction of the health insurance regulatory framework.

also contain features that provide guaranteed insurability for up to five years. This is a feature frequently found in personal accident policies that provide "return-of-premium" benefits.

2.4 Some insurers have suggested that the following adjustments to the definition of long-term A&H policies should be made:

- An A&H policy should be classified as long-term only if it also provides guaranteed premium rates over the duration of contract and if it uses premiums collected in earlier years to finance the cost of claims in later years (commonly known as pre-funding).
- The existence of a clause in A&H policies that allows the insurer to unilaterally cancel a policy where there is a fraudulent act or material non-disclosure on the part of the insured in relation to the contract should not immediately disqualifies it from being classified as long-term.

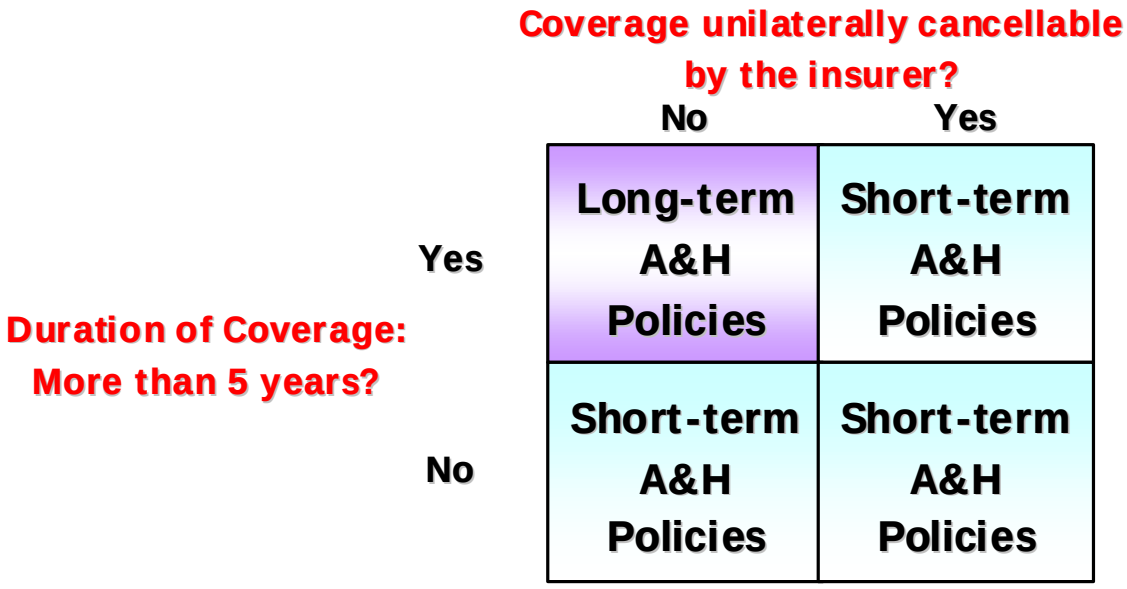
2.5 Whether to include a premium review mechanism into the features of an insurance product is a risk management decision that the Authority would leave to insurers own discretions[3]. The lack of premium guarantee, however, does not automatically make a policy "short-term in nature". Market forces may bind insurers from adjusting premiums, creating a long-term financial obligation on insurers just like a contractual premium guarantee might. Therefore, to add the existence of premium rate guarantee as the third condition which an A&H policy has to satisfy before it can be called a "long-term A&H policy" will make the definition too narrow.

2.6 Likewise, the pre-funding feature may or may not lead a policy to produce a long-term financial commitment for its underwriter. This attribute is therefore not chosen in defining long-term A&H policies.

2.7 The Authority agrees with the suggestion that the definition of long-term A&H policy needs to be adjusted to allow for unilateral cancellation of a policy by the insurer where there is a fraudulent act or material non-disclosure on the part of the insured. The Bill has been amended to adopt this feedback.

[3] Insurers are reminded, however, that where premium rate are not guaranteed, proper disclosure should be made to consumers and the risk relating to buying into such products should be duly explained.

2.8 The following diagram summarises this new classification:




2.9 Provision of A&H coverage for a long period involves the same financial and prudential considerations as does life insurers' core business. Therefore, long-term A&H policies, along with life policies that have A&H benefits bundled in, shall be considered part of life business and be underwritten by life or composite insurers only[4]. On the other hand, all insurers will be allowed to underwrite short-term A&H policies. Short-term A&H benefits will usually be classified as general business. However, life insurers should treat such general business policies as part of their life business. Composite insurers (insurers who are registered in respect of both life and general insurance business) may also treat the whole or any part of such general business as their life business. These treatments shall be applicable to both direct insurers and reinsurers. Going forward, registration for both classes of insurance business will no longer be required for life insurers that underwrite short-term A&H policies as their only type of general business.

2.10 To understand the potential impact of the reclassification of insurance business to the industry, the Authority has conducted a review on how A&H insurance is currently being offered in the marketplace. The Authority finds that almost all A&H products underwritten by general insurers are short-term in

[4] Existing long-term A&H policies underwritten by general insurers will be grandfathered and placed on run-off when the proposed framework comes into force.

nature. For personal accident insurance, which is the key A&H business underwritten by general insurers, guaranteed renewability is rarely offered.

2.11 Furthermore, in the universe of the long-term A&H insurance business, which ElderShield and MediShield-like medical expense insurance products currently dominate (in terms of premiums), almost all such businesses are underwritten by composite insurers. These insurers have been treating the underwriting and reserving of such products like their other life insurance products. The reclassification of A&H insurance business therefore serves to put in place a structure for the better management of fund arising from long-term A&H products, with minimal impact on the way the general insurance sector is currently offering A&H insurance products.

2.12 It should be noted that the Authority's intention in classifying long-term A&H policies under life business is to allow the management of funds arising from insurance business of a long-term nature to rest with insurers engaging in long-term insurance business. The types of A&H product that an insurance intermediary is allowed to distribute to consumers should not be bound by the new classification. Any insurance intermediary who complies with the necessary training, competency, disclosure and needs-based advisory process rules prescribed in the IA may distribute A&H products under one of the predefined modes. One may distribute life policies that contain A&H benefits as a licensed financial adviser or an exempt financial adviser under the Financial Adviser's Act ("FAA"). For the distribution of any stand-alone A&H policy, an intermediary may operate as a registered direct insurance broker[5], as an exempt direct insurance broker, or under an agency agreement with an insurer.

# 3 HEALTH INSURANCE REGULATORY FRAMEWORK WORK GROUP

3.1 On 1 November 2002, MAS formed a work group comprising representatives from the Life Insurance Association of Singapore, General Insurance Association of Singapore, Singapore Reinsurers' Association,

[5] "Direct general insurance broker" are currently allowed to distribute all standalone A&H policies. To maintain status quo for this class of brokers after the reclassification of long-term A&H policies as part of life business, they will be renamed as "direct insurance broker" and be allowed to distribute both general insurance products and long-term A&H policies.

Singapore Actuarial Society and MAS officials (see ***Annex 1*** for the list of members of the work group) to review the feedback received during the 2002 consultation, and to develop the operational details of the regulatory framework. The work group was further split into three sub-groups with the following mandates:

- Sub-group A: To develop disclosure requirements for the distribution of insurance products with A&H benefits.
- Sub-group B: To develop fact-finding and needs analysis requirements for the distribution of insurance products with A&H benefits.
- Sub-group C: To develop "Your Guide to Health Insurance" so as to educate and heighten the awareness of consumers on health insurance-related issues.

3.2 After eight months of intense discussion, the work group arrived at its final recommendations, which subsequently became the inputs to the draft Notice on disclosure and advisory process requirements for A&H insurance products. The following sections will discuss the details of the requirements recommended by the work group.

# 4 REQUIREMENTS ON DISCLOSURE AND ADVISORY PROCESS

4.1 An insurance contract is a contract of "utmost good faith". As it relates to a promise that hinges on the likelihood of an uncertain event occurring in the future, contracting parties rely on each other to produce all information that is relevant and material to the basis of contract. For insurers and their intermediaries to satisfy their side of the deal in an environment where A&H insurance products are becoming more diverse and complex, sufficient disclosure to consumers must be made to facilitate informed decision-making. Disclosure should not be limited to that made at the point of sale. For products where contract terms may change over time (for example, where premium rates are not guaranteed), continual disclosure is necessary to maintain the integrity of the basis of contract.

4.2 In addition, the proposed framework seeks to inculcate in insurers and intermediaries alike the practice of giving advice only when such advice is founded on reasonable grounds. For a piece of advice to be considered

reasonable, it should take into account the client's objectives, financial situation and particular needs, as well as how these factors relate to the products being recommended. This initiative also benefits prospective buyers of A&H insurance products as they are less likely to have to pay for what they do not need.

4.3 The proposed requirements for disclosure and recommendations by intermediaries are based on the following principles:

- The requirements should be applicable to all insurance products that contain A&H benefits, whether they are sold as stand-alone products or as riders to some other insurance policy[6].
- The requirements should take into account different levels of sophistication for individuals versus corporate clients.
- The requirements should focus on the activity undertaken (be it providing information on products or providing advice), and not the means or modes by which the activity is carried out. As there is no reason for the quality of disclosure or recommendation consumers receive to be compromised by consumers' choice of distribution channel, the same minimum standard will be required of all intermediaries, whether they are banks, independent financial advisors, or telemarketers.

4.4 Disclosure Requirements

4.4.1 As a guiding principle, any information or terminology used in the disclosures should be presented in clear and simple English. Consumers' attention should be drawn to any precautionary statements, warnings or qualifications that might affect their decision-making by having these announcements printed in the same font size as the rest of the text.

4.4.2 Due to the many different ways in which A&H benefits may exist in insurance products, it would be impractical for the Authority to define product types (for example, long-term care versus disability income products) categorically, or to specify the format of disclosure for each product type. Instead, requirements will spell out the information and core product features that must be disclosed, and, where necessary, prescribe standard wordings for such disclosures. This is to maintain a minimum standard of disclosure and consistency. Details of the proposed requirements can be found in ***Annex 2***.

[6] The requirements are, however, not applicable to travel insurance products.

4.4.3 *Individual Clients*

4.4.3.1 In dealing with individual clients, it will be necessary to provide clients with the following two documents:

- "Your Guide to Health Insurance"; and
- "Product Summary"

4.4.3.2 "Your Guide to Health Insurance" (attached as ***Annex 3***) is based on its life insurance equivalent. The Guide aims to provide sufficient information that a layperson intending to purchase a health insurance policy will be able to:

- understand the types of health insurance products available;
- identify the type which is most likely to meet his or her own needs;
- understand the contingencies under which benefits are payable for each type of product and the usual limitations imposed on the payment of benefits by insurers; and
- understand the rights and obligations of the insured person under each product type.

4.4.3.3 The "Product Summary" provides clients with details on key product information and features, contract provisions or terms and conditions, and other relevant information that may affect their decision to purchase the product.

4.4.3.4 Special consideration has been given to distribution through direct marketing and telemarketing channels. As there is no face-to-face contact between the insurer (or its intermediaries) and the insured in these cases, the compulsory disclosure materials will be given to the insured only after the contract has been made. The insured may utilize the "14-day Free Look Period" to review the disclosure materials and decide if the insurance policy purchased is satisfactory.

4.4.3.5 Within the universe of A&H benefits, the purpose of personal accident coverage is arguably the most easily understood and the least likely to be confused with that of other A&H benefits (unlike that between medical expense benefits and hospital cash benefits). Simplifications to the disclosure regime for personal accident benefits have therefore been made. Insurers should highlight in all pre-sales marketing materials that the benefits of the policy are payable only upon an accident occurring. Insurers are required to seek clients' confirmation that they understand this through their proposal forms. There must

not be any misleading statements that would give prospective clients the impression that the policy covers costs arising from causes other than an accident. In addition, to discourage policyholders from switching between personal accident policies without considering whether the switch is detrimental to them, insurers and intermediaries are required to highlight the potential disadvantages of switching.

4.4.3.6 Some insurance contracts provide that insurers may modify the terms and conditions of coverage in a prescribed manner. To help insureds gain awareness of the changes made to their coverage so they can then decide whether to continue such coverage, insurers are required to make continual disclosure to insureds after policy inception whenever modifications are made to the existing policy provisions.

### 4.4.4 *Corporate Clients*[7]

4.4.4.1 A&H products for corporate clients are often tailored to the client's specific needs. As the terms of contract are generally not standardised and represent the result of direct negotiations between reasonably knowledgeable parties, disclosure requirements will remain simple and flexible. A list of information to be disclosed will be provided, but no specific format or wordings will be prescribed. The responsibility of communicating A&H product features to members of the corporation will rest on the shoulders of the company itself.

4.4.4.2 Additional disclosure to individual members of a corporate client is required, however, where participation in the plan is, in full or in part, at the discretion of members themselves (this is commonly known as a voluntary plan). Such disclosure will follow that required of individual businesses, as described in section 4.4.3 earlier.

## 4.5 Requirements on Advisory Process for A&H Products

4.5.1 A sales process that is based on clients' needs begins with "knowing your client", that is, understanding the client's financial condition, existing insurance coverage and the perceived importance of various risks in his or her mind that may require protection through insurance products. An intermediary

[7] For the purpose of this consultation paper, references to "corporate clients" include affinity groups. Business relating to corporate clients is commonly known as group insurance business.

should, based on an analysis of the information collected, recommend to his or her client products that best match the client's needs. Where there is no product in the intermediary's portfolio that suits his or her client's needs, the intermediary should inform the client accordingly.

4.5.2 Requirements relating to the advisory process already exist for the distribution of life insurance policies with the adoption by the FAA of recommendations by the Committee for Effective Distribution of Life Insurance ("CEDLI"). Advisory process requirements for A&H business are therefore built around the CEDLI framework, with appropriate modifications to take into account the uniqueness of A&H insurance products. Details of the proposed requirements can be found in ***Annex 4***.

4.5.3 Personal accident products, due to their simplicity (as previously discussed), will be excluded from the advisory process requirements.

4.5.4 *Individual Clients*

4.5.4.1 In order to know one's client, an insurance intermediary is expected to collect information on, among other things, the client's health insurance protection requirements, his or her financial situation, and the health insurance coverage that the client currently has. A "Fact-find Form" that facilitates information collection should be used.

4.5.4.2 After analysing the information provided by the client, an insurance intermediary can then identify and recommend product(s) that suit the client's needs. The insurance intermediary should explain to his or her client the basis for the recommendation. This basis should be documented.

4.5.4.3 Controls will also be put in place to deter switching between health insurance products in a manner that would be detrimental to policyholders. The following factors are considered in determining whether a switch is detrimental:

- whether the client suffers any penalty for terminating the original product;
- whether the client will incur any transaction cost while gaining no real benefit from such a switch;
- whether the replacement product confers a lower level of benefit at a higher or equal cost to the client, or the same level of benefit at a higher cost; and

- whether the replacement product is less suitable for the client.

4.5.4.4 The advisory process requirements have to be adhered to while switching between products. The client should be told of any fee or charge that he or she will have to bear, and any change in the terms and conditions of the new policy.

4.5.4.5 To maintain consistency in the quality of advice that consumers receive from all distribution channels, the advisory process requirements are to be complied with before any advice can be presented in direct marketing materials or given by telemarketers. For telemarketing, clients' verbal confirmation may be used in lieu of signatures on the "Fact-find Form". Clients should be given the Form, completed by the telemarketers, at the same time policy documents are delivered to them. All tele-conversations should be recorded and retained for a reasonable period to facilitate future audits.

4.5.5 *Corporate Clients*

4.5.5.1 Since October 2001, the insurance industry has adopted a common Group Insurance Fact-find Form ("GIFF") to be used by all distribution channels in the arrangement of group insurance products for corporate clients. Improvements have been made to the GIFF to facilitate, in addition to the original information-collection function, a needs analysis and documentation of recommendations made.

# 5 REQUIREMENTS ON RESERVING AND REPORTING FOR A&H BUSINESS

5.1 Market conduct requirements help provide consumers peace of mind by allowing them to obtain quality information and needs-based advice on A&H insurance products before signing on the dotted line. However, consumers are equally concerned with the financial soundness of the insurers they are dealing with. Prudential rules requiring insurers to set aside sufficient financial resources to meet their liabilities and to continuously monitor their financial position are therefore necessary.

5.2 Reserving and reporting requirements for the insurance industry will be revised with the impending launch of the Risk-based Capital ("RBC") framework.

As a result, rules relating to A&H insurance business will have to be aligned with the broad principles of the RBC framework.

5.3 On reserving requirements, long-term A&H liabilities, being part of life insurance business, will be valued in the same manner as other life policies, using realistic valuation assumptions. On the other hand, valuation of short-term A&H liabilities will generally require separate calculations of "premium liabilities" and "claims liabilities" as per the valuation of other general insurance business. This requirement will also apply to short-term A&H liabilities underwritten by life insurers where the size of such business is of a substantial magnitude.

5.4 In additional to submitting accounts and statements on the financial condition of insurance funds and insurance companies, insurers should also submit a separate statement relating to the volume and profitability of their A&H business, separated by different product types and clientele groups. The proposed format of this statement is attached as ***Annex 5***. Should the need to further monitor the state of affairs in the A&H insurance market arise, the Authority may, from time to time, required additional reporting from insurance companies.

5.5 The full reserving and reporting requirement will be published at a later date when the proposed RBC framework undergoes consultation.

# 6 NOTICE ON DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

The draft Notice on Disclosure and Advisory Process Requirements for Accident and Health Insurance Products (attached as ***Annex 6***) describes the key requirements on disclosure and advisory process discussed earlier. The Notice makes reference to industry standards, which will be subsequently developed, for specific requirements on presentation format and wording. It will take effect on 1 January 2004.

# 7 REQUEST FOR COMMENTS

7.1 MAS invites interested parties to come forward with their views and comments on the proposed regulatory framework for accident and health insurance business and the draft Notice on Disclosure and Advisory Process Requirements for Accident and Health Insurance Products. Written comments should be submitted by 17 November 2003 to:

Insurance Supervision Department
Monetary Authority of Singapore
10 Shenton Way
MAS Building
Singapore 079117

Email: hicon03@mas.gov.sg
Fax: (65) 6229-9694

7.2 Please note that all submissions received may be made public unless confidentiality is specifically requested for the whole or part of the submission.

# ANNEX 1: MEMBERS OF HEALTH INSURANCE REGULATORY FRAMEWORK WORK GROUP

Monetary Authority of Singapore – Insurance Supervision Department

| | |
|---|---|
| Dr. Leow Yung Khee | Director |
| Mrs. Wong Yuen Foon | Deputy Director |
| Ms. Lim Pei Bin | Associate |
| Mr. Albert Chua | Associate |
| Mr. Alex Lee | Associate |

Life Insurance Association of Singapore Representatives

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|---|---|
| Ms. Theresa Nai | Convenor – Underwriting & Claims Subcommittee |
| Ms. Chua Peng Tien | Convenor – Group Insurance Subcommittee |
| Mr. William Fong | |
| Mr. Reeve Ong | |

General Insurance Association of Singapore Representatives

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| Mr. Adam Tang | Convenor – Health Insurance Committee |
| Ms. Rosalind Phuan | |
| Mr. Sebastian Tan | |

Singapore Reinsurers' Association Representative

Mr. Andres Webersinke

Singapore Actuarial Association Representative

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| Mr. Chi Cheng Hock | Honorary Secretary |

# ANNEX 2: SPECIFIC RECOMMENDATIONS ON DISCLOSURE FOR A&H PRODUCTS

This Annex describes the recommended disclosure requirements for the distribution of A&H products. The attached appendices illustrate how the requirements may be complied with. They are not meant to be the only format that insurers can use, and they may not be sufficient in some circumstances. Communications that insurers and intermediaries make to clients should be based on the principle of full disclosure and must not be done on a biased or selective basis.

## INDIVIDUAL BUSINESS

### *Documents to be presented to client at the pre-sales stage*

1 It is compulsory to provide, to all clients or prospective clients, the following two documents:

- "Your Guide to Health Insurance"; and
- "Product Summary".

Further, the titles used for these documents (i.e. "Your Guide to Health Insurance" and "Product Summary") shall be standardised.

2 An existing policyholder need not be provided these documents when he changes his servicing agent at the point of policy renewal. This exemption, however, does not apply where the policyholder is instituting a new policy to replace an existing one.

3 Insurers shall require all proposers to sign the proposal form to confirm that they have been given a copy of the required documents, and that the contents of these have been explained to their satisfaction.

### *Specific guidelines for the "Product Summary"*

1 The "Product Summary" aims to provide prospective buyers with details on key product information and features, contract provisions or terms and conditions, and other relevant information that may affect their decision to purchase the policy.

2 To ensure proper disclosure and acknowledgement of the information presented, the original signature of the prospective dient and the intermediary must be obtained. Both these endorsements should be made on the front page of the "Product Summary".

3 The "Product Summary" shall comprise two sections:

- Product Information
- Key Product Provisions

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

5 Disclosure of distribution costs, charges & expenses in the "Product Summary" is not mandatory. However, it should be made clear in this document that that such information will be made available at the client's request.

6 Specific guidelines for Product Information

This Product Information section shall include all relevant information on the benefits and coverage, limits of compensation, premium rates and commitment of the health insurance policy. Specifically, the following information shall be covered:

- *Summary of Benefits or Covered Events:* Description of the product, including the covered event(s) and the sum assured (where applicable).
- *Benefits Schedule Table (where applicable):*
  (a) Limits on the benefits claimable for each covered event, in the form of a table featuring the limits of compensation and amount of coverage e.g. Limits of Compensation table or Benefits Schedule table.
  (b) The minimum amount of the claim that must be borne by the policyholder, per policy year or per claim made – in percentage terms or as a fixed sum of the amount claimed e.g. deductible or co-insurance.
  (c) The maximum amount which will be reimbursed per policy year or per lifetime of the insured e.g. annual limits or lifetime limits of the policy.
- *Premium Rates or Premium Rates Table:* The premium rate at entry age that is payable for each premium instalment, or a premium rates table where the premium is not level.
- *Premium Payment Duration:* The number of years premiums are payable for.
- *Duration of Policy Cover:* Duration of policy coverage in terms of number of years, expiry date of cover or age of cessation of cover.
- *Definition of Activities of Daily Living (where applicable):* If Activities of Daily Living (ADL) is a listed claims criteria, their definitions should be in the document.

7 Specific guidelines for Key Product Provisions

The Key Product Provisions section shall include relevant information on the following contract provisions, on other terms and conditions that would affect the premium, coverage or benefits of the policy. Specifically, the following information (where applicable) should be covered:

- *Cancellation/Termination Clause:* Stating explicitly that the policy may be unilaterally cancelled or terminated by the insurer.
- *Renewability of the Policy or Terms of Renewal:* Information on the terms relating to policy renewal (for example, whether policy renewal is guaranteed by the payment of renewal premium or is subject to fulfilment of a limited premium payment period). The last age of policy renewal should also be specified.

- *Premium Guarantee:* Where premium rates are not guaranteed or can be increased at the insurer's discretion, this must be clearly indicated.
- *Waiting Period:* Where policy benefits are payable only a specified length of time after policy inception, this must be clearly stated.
- *Benefit Limitations:* Conditions under which benefits of the policy will not be payable.
  (a) The following standard statement must be highlighted in the document:
  "There are certain conditions whereby the benefits under this plan will not be payable. These are stated as exclusions in the contract. You are advised to read the policy contract for the full list of exclusions."
  (b) In addition to the standard statement above, if any of the following three conditions are excluded from the contract, they shall be highlighted:
    - Pre-existing conditions;
    - Limits of Compensation; and
    - Congenital Anomalies or Defects.
  (c) The list shall be extended to include exclusions that may influence the prospective client's decision in the prevailing environment. For example, the exclusion on communicable disease was once considered a redundant exclusion. However, this exclusion may now be an important factor in light of the heightened concern over SARS.
- *Other Circumstances that Affect Premium Rates or Policy Benefits:* Other provisions stated in the contract that may affect premium rates or the benefits payable, and which require continued disclosure by the insured after policy inception. Examples of such provisions are Change of Occupation or Change of Country of Residence.
- *Deferment Period/Pre-Benefit Period:* Where the policy benefits are payable only a certain period after the occurrence of the covered event, this must be clearly stated.
- *Survival Period:* Where the insured must survive for a certain length of time after the occurrence of the covered event before the policy benefits are payable, this must be clearly stated.

8 The following appendices to this Annex provide further guidance on the presentation of the Product Summary:

- Appendix I – Specimen wordings to be used for Key Product Provisions.
- Appendix II – A sample Product Summary for hospital and surgical plans.
- Appendix III – A sample Product Summary for critical illness plans.
- Appendix IV – A sample Product Summary for long-term care plans.
- Appendix V – A sample Product Summary for disability income plans.

## *Application of the guidelines to direct marketing and telemarketing channels*

1 This section relates to situations where there is no face-to-face contact at all between the client and the insurer/intermediary throughout the sales process (for example, when a sale is concluded through direct marketing or telemarketing channels without clients being referred to a financial advisor or insurance broker). Where a financial advisor or insurance broker is

subsequently involved in the sales process as a result of a referral, the standard guidelines previously discussed shall apply.

2 For the purpose of this section,

- "direct marketing" shall be defined as marketing through the use of direct response advertising communications of any medium, including mail, print, TV, radio, and electronic media; and
- "telemarketing" shall be defined as marketing through the use of a call centre of any description.

3 In the case of direct marketing, the insurer must have control over the entire process, from publication and distribution of promotional materials to delivery of the policy document. For telemarketing, the insurer must have sufficient control over its telemarketing staff or, where the function is outsourced, over the telemarketing firm, such that it is able to ensure that the information conveyed on product features is accurate.

4 Where, in communications made through direct marketing or telemarketing channels, a piece of advice (or a recommendation) is made to an intending insured to purchase a health insurance product, such advice (or recommendation) shall only be made if it has a reasonable basis. To establish such reasonable grounds, the advisory process requirements described in ***Annex 4*** shall be adhered to.

5 For direct marketing that only involves the presentation of product information without making recommendations,

- the following statements need to be highlighted in the marketing materials:
  "This is only product information provided by us. You should seek advice from a qualified advisor if in doubt. Buying health insurance products that are not suitable for you may impact your ability to finance your future healthcare needs."
- the following clause must be highlighted to the proposer and should be included in the proposal form before the proposer's signature column, :
  "I am aware that I can seek advise from a qualified advisor before I sign this application/proposal form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives."

6 The above statements should also be emphasised to the client before the contract is made when the product is sold through telemarketing and no advice has been given to the client. A verbal acknowledgement of these statements from the client should be sought.

7 The insurers must make adequate arrangements to provide appropriate post-sales disclosures to policyholders who have purchased health insurance products through direct marketing or telemarketing channels. Such post-sales disclosures include a "follow-up letter" which:

- advises the proposer to read the two compulsory disclosure documents enclosed;
- highlights to the proposer that he or she is entitled to a "14-day Free Look" period and can decide to cancel his coverage without penalty within this period if he deems the product unsuitable; and
- requests the proposer to return the enclosed pre-paid reply card to the insurer to confirm his receipt of the disclosure documents.

8 With such procedures in place, the following standard disclosure requirements will not apply to direct marketing and telemarketing:

- Having the proposer sign on the proposal form stating that he or she has been given the two compulsory disclosure documents, and that the contents of these have been explained to his or her satisfaction; and
- Having the proposer sign on the first page of the Product Summary.

## *Disclosure requirements for personal accident products*

1 In all pre-sales marketing materials and in the application forms, the insurer is required to highlight to prospective clients that the benefits of the policy will only be payable upon an accident occurring. There must not any misleading statements to give prospective clients the impression that the policy covers events arising from causes other than an accident.

2 In addition, to discourage insureds from switching personal accident policies without considering whether the switch is detrimental to them, the insurer is required to highlight to clients the potential disadvantages of switching.

## *Post-sales disclosure*

1 Insurers are required to make continual disclosures to policyholders after policy inception whenever there are modifications to the Product Information or Key Policy Provisions specified in the Product Summary. The documents required for continual disclosure will not be prescribed as long as they disclose the pertinent information recommended in the guidelines .

2 Circumstances that would require continual disclosure include, but are not limited to, modifications to policy provisions in the following areas:

- Premium rates or premium rates table
- Policy benefits or coverage
- Exclusion clauses
- Change in definition of contract provision

3 Both the existing and the modified benefits/terms need to be shown. In cases where some original benefits are withdrawn or new exclusions are added with no change in premium rates, this must be highlighted to policyholders.

4 Insurers are required to give policyholders advance written notice of at least 30 days before the modifications take effect.

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

- obtain written acceptances of the modified terms from policyholders; **OR**
- where no written acceptances of the modified terms is sought, the insurer must ensure that all of the following conditions are fulfilled:
  i) policyholders are given the option to reject the modified terms;
  ii) in the notification letter to policyholders:
    a) the modified terms must be conspicuously indicated on the front page of the notification letter,
    b) the modified terms must be highlighted in bold print on the notification letter, and
    c) the print size of the modified terms should not be smaller than the rest of the text on the notification letter.
  iii) the following standard statement (wherever applicable) must be highlighted on the notification letter:

> "Please be informed that unless otherwise advised by the Owner of the policy, receipt of the renewal premium by the Company shall be construed as an acceptance of the modified terms and the modified terms shall take effect from the date of policy renewal".
>
> **OR**
>
> "Please be informed that unless otherwise advised by the Owner of the policy by DD/MM/YY (expiry date of the advance notice), the modified terms shall take effect from DD/MM/YY (effective date of the modified terms)".

## CORPORATE BUSINESS

### *Information to be disclosed to clients at the pre-sales stage*

1 A list of the information it is mandatory for insurers to disclose to corporate clients at the pre-sale stage is given below. The format and wording of such disclosure will not, however, be prescribed. The responsibility of communicating A&H product features to members of the corporate client will rest on the shoulders of the company itself.

- Name of insurer underwriting the product
- Duration of coverage
- Premium rates per person/total premiums and bases by which these figures were arrived at

- Benefit schedules, including details on coinsurance, deductibles, waiting period, restriction to panels or hospitals, etc.
- Period of validity of a proposal (or a quote)
- Other key policy terms and conditions
  - Eligibility for coverage
  - Exclusions & limitations (including exclusions for pre-existing conditions)
  - Provisions relating to termination of coverage (e.g. when insured attains age 65, short-period rates, grace period, etc.)
  - Obligations to be met by client and rights of insurers when these are not met (any individual underwriting requirements, declaration on named basis, etc.)
- Whether premium rates are guaranteed and, if so, for how long
- Whether renewals are guaranteed and, if so, for how long
- Whether the product is a qualified plan under the Transferable Medical Insurance Scheme (TMIS)
- Whether or not the free look period is applicable
- Upon request by client, commission amounts must be disclosed (as per CESGI requirements)

2 The final proposed terms are to be signed by the client or a legally appointed representative of the client. (e.g. when letter of authorization clearly states that the broker is allowed to sign binding insurance contracts on the client's behalf).

3 Additional disclosure to individual members of a corporate client is required where participation in the plan is, in full or in part, at the discretion of the members themselves (commonly known as a voluntary plan). Such disclosure will follow the rules prescribed for individual insureds, as described earlier in this Annex.

APPENDIX I

**Specimen Wordings to be Used for Disclosure of Key Product Provisions**

1) Cancellation clause (relating to insurers' rights to unilaterally terminate policies)

*"The Company reserves the right to terminate the coverage at any time by giving <number of days> days' notice in writing to the Owner. Whenever such cancellation occurs, the Company shall return the unearned portion of premiums paid. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination."*

2) Terms of renewal

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

3) Non-guaranteed premium

*"Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company."*

4) List of standard exclusions

*"There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan:*

- Pre-existing condition
- Congenital anomalies or defect
- Pregnancy, miscarriage or child birth

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

5) Waiting period

a) For hospital and surgical plans

*"No benefits will be payable if the illness or disorder, which results in the Insured's hospitalisation or having to undergo surgery, is diagnosed within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later"*

b) For critical illness, long term care or disability income plans

*"No benefits will be payable if the Insured has been <diagnosed as suffering from a critical illness/unable to perform any activities of daily living/deemed disabled> within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later"*

6) Change of occupation

*"In the event of a change in occupation of the Insured, the Insured shall notify the Company in writing of the new occupation. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation. "*

7) Deferment period

*"This is the period following the onset of disability before the benefits under this policy will be payable."*

8) Survival period

*"No benefits under this policy shall be payable if the Insured dies within 30 days of being diagnosed as suffering from a critical illness."*

APPENDIX II

**Sample Product Summary for Hospital & Surgical Plan**

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

---

Plan Name: _____ Expiry Date of Cover: _____

*Premium Rates Table:*

The annual premium rates for this plan are as set out below. Please note that the premium rates are not guaranteed and the Company may, at its sole discretion, increase the premium rates from time to time depending on its claims experience. The annual premium is based on the Insured's age last birthday and the renewal premium rates as determined by the Company at the time of renewal, based on the attained age of the Insured. This plan will terminate immediately following the 80th birthday of the insured.



| | **Plan A Plus** | **Plan B Plus** |
|---|---|---|
| Age Group (Attained age last birthday) | 1st Year Premium* (S$) | 1st Year Premium* (S$) |
| 30 & below | 95 | 57 |
| 31 to 40 | 143 | 86 |
| 41 to 50 | 285 | 171 |
| 51 to 55 | 476 | 285 |
| 56 to 60 | 491 | 295 |
| 61 to 65 | 812 | 488 |
| 66 to 70 | 1167 | 700 |
| 71 to 73 | 1673 | 1004 |
| 74 to 75 | 1964 | 1178 |
| 76 to 80 (renewal Premium) | 2730 | 1649 |

*Product Information:*

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

| Schedule of Benefits<br>(Limits of Compensation) | **PLAN A PLUS (S$)** | **PLAN B PLUS (S$)** |
|---|---|---|
| Hospitalisation Benefits | | |
| Daily Room & Board* | 650 | 400 |
| Daily Intensive Care Unit* | 1,000 | 625 |
| Surgical Benefits | | |
| Surgery Limits** | 480 to 7,200 | 390 to 6,500 |
| Surgical Implants/ Approved Medical Consumables (per year) | 3,500 | 2,500 |
| Gamma Knife (per procedure) | 12,600 | 9,600 |

| | | |
|---|---|---|
| Out-Patient Hospital Benefits | | |
| Radiotherapy for cancer (per day) | 280 | 240 |
| Stereotactic Radiotherapy for cancer per treatment | 2,500 | 2,000 |
| Chemotherapy for cancer (per month) | 1,000 | 800 |
| Immunotherapy for cancer(per month) | 800 | 600 |
| Renal Dialysis (per month) | 2,500 | 2,000 |
| Erythropoietin (per month) | 500 | 400 |
| Cyclosporin (per month) | 500 | 400 |
| Extra Cancer Coverage # | | |
| • Per Policy Year | 30,000 | 30,000 |
| • Per Lifetime | 100,000 | 100,000 |
| Final Expenses Benefit ## | 5,000 | 3,000 |
| **Limit per policy year** | 110,000 | 85,000 |
| **Limit per lifetime** | 330,000 | 250,000 |
| **Deductible per policy year** | 2,500 | 1,500 |
| **Co-insurance** | 15% | 15% |

* Inclusive of meals, prescriptions, professional charges, investigations & other miscellaneous charges

** Limits vary according to the level of complexity of the surgical operation

\# The extra cancer coverage is provided over and above the Policy Year and Lifetime Limits and can be claimed for hospitalisation following diagnosis of Cancer. Cancer is defined as a histologically confirmed malignant tumour exhibiting invasion of adjacent tissues. Tumours classified as carcinoma in situ and localised skin cancers are specifically excluded.

## This benefit is a waiver of the deductible and co-insurance amounts, up to the limits stated, upon death occurring during hospitalisation or within 30 days of discharge of the hospitalisation and provided death occurs as a result of the cause of the hospitalisation.



*Key Product Provisions*

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

a) Cancellation Clause
The Company reserves the right to terminate coverage at any time by giving 30 days' notice in writing to the Owner. Whenever such cancellation occurs, the Company shall return the unearned portion of premiums paid. The termination of coverage shall be without prejudice to payment of claims arising prior to the date of termination.

b) Terms of Renewal
Coverage may be renewed on the Policy Anniversary Date by payment of the annual premium.

c) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

d) Exclusions
There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. **The exclusions for this plan include, but are not limited to, the following 3 conditions. You are advised to read the policy contract for the full list of exclusions.**

- **Pre-existing condition** – This is defined as any known medical condition from which the Insured is suffering on or before the issuance of the policy, including those for which treatment, medication or advice have been received before the issuance of the policy. **This plan does not cover any hospitalisation or surgical charges incurred if the condition resulting in the hospitalisation or surgery existed on or before the issuance of the policy contract.**

- **Congenital Anomalies or Defect** – This plan does not cover any hospitalisation or surgical charges incurred directly or indirectly for the treatment for congenital abnormalities and physical defects that have been in existence since birth.

- **Reasonable & Customary Charges** – This is defined as the general level of charges applicable in Singapore when furnishing similar or comparable treatment, services or supplies to individuals of the same sex and comparable age, for similar disease or injury. **The benefits payable under this plan shall be the lower of the Reasonable and Customary Charges in Singapore and those in the foreign country in which the Insured seeks similar medical treatment.**

e) Waiting Period
This plan shall not apply or no benefits will be payable if the illness or disorder, which results in the Insured's hospitalisation or having to undergo surgery, is diagnosed within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later.

f) Change of Occupation
In the event of a change in occupation of the Insured, the Insured shall notify the Company in writing of the new occupation. The Company shall increase or reduce the premium rates according to the risk classification for the new occupation.

APPENDIX III

**Sample Product Summary for Critical Illness Plan**

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

---

Plan Name: _____ Sum Assured ($): _____

Premium Rate: _____ Expiry Date of Cover: _____

Please note that the premium rates are not guaranteed and the Company may at its sole discretion increase the premium rates from time to time depending on its claims experience.

*Product Information:*

This policy will pay the lump sum benefit (sum assured) when the Insured is diagnosed as suffering from any one of the 30 covered Critical Illnesses listed below, as defined in the policy contract. With effect from DD/MM/YY, the Insurance Industry has adopted common definitions for all critical illnesses. This means that each illness covered will bedefined the same way by all insurance companies. You are advised to refer to the policy contract for definitions of the covered Critical Illnesses.



1. First Heart Attack (Excludes coverage within 90 days)
2. Stroke
3. Coronary Artery Surgery (Excludes coverage within 90 days and excludes angioplasty, laser or other intra-arterial procedures)
4. Occupationally Acquired HIV and HIV due to blood transfusion (Excludes HIV infection from other means including sexual activity and use of intravenous drugs)
5. Angioplasty and Other Invasive Treatments for Coronary Artery Disease
6. Cancer (Excludes coverage within 90 days, includes leukaemia other than chronic lymphocytic leukaemia but excludes non-invasive cancers in situ, tumours in the presence of HIV and any skin cancer other than Malignant Melanoma)
7. Fulminant Viral Hepatitis
8. Pulmonary Arterial Hypertension
9. Kidney Failure
10. Major Organ Transplant
11. Multiple Sclerosis
12. Blindness
13. Paralysis (Excludes self-inflicted injuries)
14. Muscular Dystrophy
15. Alzheimer's Disease / Irreversible Organic Degenerative Brain Disorders (Excludes neurosis, psychiatric illness and any drug or alcohol related organic disorder)
16. Coma (Excludes illness resulting from drug or alcohol abuse)
17. Loss of Hearing
18. Heart Valve Replacement
19. Loss of Speech (Excludes all psychiatric causes)
20. Major Burns
21. Surgery to Aorta
22. Terminal Illness

23. End-stage Lung Disease
24. Chronic Liver Disease (Excludes illness resulting from drug or alcohol abuse)
25. Motor Neurone Disease
26. Parkinson's Disease (Excludes drug-induced or toxic causes)
27. Aplastic Anaemia
28. Bacterial Meningitis (Excludes illness resulting from HIV infection)
29. Benign Brain Tumour (Excludes cysts, granulomas, malformations in, or of, the arteries or veins of the brain, haematomas and tumours in the pituitary or spine)
30. Encephalitis (Excludes illness resulting from HIV infection)

*Key Product Provisions*

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

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

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) Exclusions
There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. **The exclusions for this plan include, but are not limited to, the following 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

**Pre-existing condition – This plan shall not apply or no benefits will be payable if the Insured has been diagnosed with the Critical Illness before the issuance of the policy. This includes those for which treatment, medication, or advice had been received before the issuance of the policy.**

**Congenital Anomalies or Defect** – This plan shall not apply or no benefits will be payable if the Critical Illness is due to any congenital abnormalities and physical defects that have been in existence since birth.



d) Waiting Period
This plan shall not apply or no benefits will be payable if the Insured is diagnosed as suffering from a Critical illness within 30 days of the date of issue or endorsement of the policy or date of reinstatement, whichever is later.

e) Survival Period
This plan shall not apply or no benefits will be payable if the Insured dies within 30 days from the day on which the Insured is diagnosed as suffering from a Critical Illness.

APPENDIX IV

**Sample Product Summary for Long Term Care Plan**

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

---

Plan Name: _____ Premium Rate ($): _____

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

Death Benefits ($): _____



Please note that the premium is not guaranteed and the Company may at its sole discretion increase the premium from time to time depending on its claims experience.

*Product Information:*

This plan will provide the following benefits when the Insured is diagnosed to have suffered a Qualifying Loss of Functional Capacity.

1) Monthly Cash Benefit
The monthly benefit will be paid to the Applicant for as long as the Insured suffers from a Qualifying Loss of Functional Capacity. Should the Insured recover from the Qualifying Loss of Functional Capacity, the Company will stop further monthly benefit payments and the Policy will terminate.

2) Waiver of Premium
Premium for this plan will be waived during the period the Insured suffers a Qualifying Loss of Functional Capacity.

Upon the death of the Insured, the death benefit will be payable.

*Qualifying Loss of Functional Capacity:*

The Insured is considered to have suffered from a Qualifying Loss of Functional Capacity if the Insured is unable to perform (with or without assistance) at least 3 out of 6 Activities of Daily Living, or if the Insured suffers from Advanced Dementia (including Alzheimer's Disease), as defined in the Contract.

*Activities of Daily Living:*

The 6 Activities of Daily Living covered under this plan are defined as follows:

- **Washing** - the ability to wash in the bath or shower (including getting into and out of the bath or shower), or to wash satisfactorily by other means;
- **Dressing** - the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
- **Transferring** - the ability to move from a bed to an upright chair or wheelchair and vice versa;
- **Mobility** - the ability to move indoors from room to room on level surfaces;
- **Toileting** - the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
- **Feeding** - the ability to feed oneself once food has been prepared and made available.

*Advanced Dementia:*

Advanced Dementia, including Alzheimer's disease, is defined as a medically confirmed diagnosis of dementia which is solely responsible for the inability of the Insured to perform unassisted any two of the Activities of Daily Living.

*Key Product Provisions*

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

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

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) Exclusions
There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. **The exclusions for this plan include, but are not limited, to the following 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

**Pre-existing condition** – **This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to a medical condition that occurred or was diagnosed before the issuance of the policy. This includes conditions for which treatment, medication, or advice was received before issuance of the policy.**

**Self-inflicted Injury –** This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to any injury or illness, caused directly or indirectly, by self-destruction or intentional self-inflicted injury, drugs or alcohol abuse, or because of injuries sustained as a direct result of a criminal act or attempted suicide, whether the Insured is sane or insane.



d) Waiting Period
The Insured must suffer from a Qualifying Loss of Functional Capacity for a continuous period of at least 90 days before the benefits under this plan are payable by the Company. No benefits will be paid during the waiting period.

APPENDIX V

**Sample Product Summary for Disability Income Plan**

Presented to: _____ Signature of Applicant:_____
(Name of Applicant)

Covered Member:_____ Name & Signature of
(Name of Insured) Financial Services
Consultant:: _____

Age & Gender: _____ Date: _____
(Age last birthday & Gender of Insured)

---

Plan Name: _____ Premium Rate ($): _____

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

Deferment Period: _____ Death Benefits ($): _____

Please note that the premium is not guaranteed and the Company may at its sole discretion increase the premium from time to time depending on its claims experience.



*Product Information:*

This plan will provide the following benefits in the event of disability due to illness or injury resulting in inability of the Insured to perform all the duties of his/her occupation or any other occupation after the onset of disability.

1) Monthly Cash Benefit
In the event of total disability, the Monthly Benefit will be paid to the Insured for as long as the Insured is unable to perform his/her occupation or any other occupation after the onset of disability. In the case of partial disability, if the monthly earned income of the Insured falls by at least 25%, a pro-rated amount of the monthly benefit will be paid to the Insured. Payment of the Monthly Benefit will commence after the Deferment Period.

2) Waiver of Premium
Premium for this plan will be waived for the period the monthly benefit is paid to the Insured.

Upon the death of the Insured, the death benefit will be payable.

*Total Disability:*
The Insured is considered to be totally disabled if he/she is unable to perform his/her usual occupation, or any occupation or profession to earn or obtain any wages for compensation or profit.

*Key Product Provisions*

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions in the contract. Please consult your Financial Services Consultant should you require further explanation.

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

b) Non-Guaranteed Premium
Premiums payable for this coverage are not guaranteed and may be increased at policy renewal at the full discretion of the Company.

c) Exclusions
There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this plan. **The exclusions for this plan include, but are not limited to, the following 2 conditions. You are advised to read the policy contract for the full list of exclusions.**

**Pre-existing condition** – **This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to a medical condition that occurred or was diagnosed before the issuance of the policy. This includes conditions for which treatment, medication, or advice was received before the issuance of the policy.**

**Self-inflicted Injury –** This plan shall not apply or no benefits will be payable if the Qualifying Loss of Functional Capacity is due to any injury or illness caused directly or indirectly by self-destruction or intentional self-inflicted injury, drugs or alcohol abuse, or because of injuries sustained as a direct result of a criminal act or attempted suicide, whether the Insured is sane or insane.

d) Deferment Period
The deferment period is the period of time after becoming disabled during which no benefits will be paid despite being under insurance coverage.

# ANNEX 3: DRAFT OF "YOUR GUIDE TO HEALTH INSURANCE"

**DISCLAIMER: This version of the Guide is in draft form and is subjected to change taking into account feedback received during this consultation phase.**

## Introduction

This Guide explains to you (prospective buyer) the basic concept of health insurance and the various products that are available in the market may meet your healthcare financing needs. It gives you basic information that you should be aware of so you can discuss your needs with your advisor.

## What Is Health Insurance?

Health insurance gives you and your family financial protection against financial loss arising from accident, illness or disability. It can provide you income during your hospitalisation or disability, or cover the cost of your medical treatment or nursing care.

## What Type Of Health Insurance Product Do You Need?

The type of health insurance product that you need depends on what you are seeking protection against.

| If you are looking to… | You should consider … |
|---|---|
| • reimburse your medical expense | Medical Expense Insurance |
| • protect your income during disability | Disability Income Insurance |
| • receive some fixed amount of cash during hospitalisation | Hospital Cash Insurance |
| • reduce the financial impact when you are diagnosed with a major illness (e.g. cancer) | Critical Illness Insurance |
| • defray the cost of care should you be too weak to look after yourself | Long-term Care Insurance |

You can find more information on each type of product at the last part of this Guide.

## How Much Of Health Insurance Should You Purchase?

You should consider the quality of healthcare service or the level of income protection that you prefer should you fall ill or become disabled, and purchase sufficient coverage to meet your expectation. However, you should also consider your ability to continue paying the premiums. You may have to prioritise your protection needs and structure your health insurance coverage accordingly if you do not have sufficient resources.

### Are You Already Covered By Other Health Insurance Policies?

You should check what health insurance policies are you already covered under before you purchase any new ones. You should particularly note the following:

- **Multiple Medical Expense Policies**
  Regardless of the number of medical expense insurance plans that you own, the total reimbursement that you will get from all plans is limited by the amount you have actually incurred. Therefore, paying for many medical expense insurance plans does not necessarily give you additional benefits.

- **Switching between Health Insurance Products**
  Health insurance products usually do not cover any illness or disability that you already have at the time you sign up. Therefore, before you make a switch to a similar health insurance product that is supposed to give you better benefits, you should look at your current health status. After the switch, you may no longer be able to make claims relating to medical conditions that have developed since you sign up for your original health insurance policy.

## What Are The Key Features You Should Look Out For In Health Insurance Products?

### Age Limit

Most health insurance products do not allow you to sign up if you are beyond some stipulated maximum age. Therefore it is generally better for you to sign up early while you are still healthy and eligible.

While some health insurance products provide you with lifetime coverage, others cover you up to a certain age. You should choose a product with duration of coverage that suits your needs.

**Premium**

You may be charged premiums in one of the following ways:

- Periodic payment of a fixed amount throughout the life of the policy;
- Periodic payment of a fixed amount, but the insurer may adjust this fixed amount in future by giving you a notification before the adjustment;
- Periodic payment of an amount that increases with age according to a predetermined schedule; or
- A lump sum payment upfront.

Under the periodic payment mode, you are required to pay your premiums promptly when they fall due so as to maintain continuous coverage. You should therefore consider if your finances could cope with this on-going commitment before making any purchase.

**Renewal of Policy**

Under the periodic premium payment mode, premiums that you pay represent your intention to renew your coverage. While some health insurance products guarantee the renewal of your coverage as long as you pay premiums promptly, others give insurers the right to cancel your coverage by giving you advance notice in writing before your policy is due for renewal. Products that guarantee renewal mean that you need not worry that your coverage being cancelled, but they are generally more costly. You should choose a product that suits your needs and budget.

You should note that even if renewal of coverage is guarantee, some health insurance products allow insurers to change the benefits, premium rates or other terms and conditions when the products are due for renewal.

**Termination of Policy**

Your health insurance policy may be terminated for any of the following reasons:

- you have attained the maximum age that the product sets out to cover

- you have received the maximum benefits payable under the product;
- your coverage has been cancelled by the insurer; or
- you have failed to pay your premiums

The first thee reasons for termination are permanent, while the last one may be reversed. To get your insurance coverage reinstated, however, insurers will usually consider your age and health status at the time of reinstatement. Higher the age or poorer the health status at reinstatement often result in higher premium rates.

**Policy Exclusions**

All health insurance products contain some exclusion clauses specifying the circumstances under which benefits will not be paid. As exclusions vary from product to product, you should therefore read the policy document carefully to understand exactly what you are or are not covered for, and check with your advisor if you have any doubt.

"Pre-existing conditions" exclusion is one of the common exclusions that you may find in health insurance products. This exclusion means that any illness or disability that you already have at the time you sign up for the product will not be covered. Therefore, it is important that you purchase health insurance while you are young and healthy to enjoy the full benefits of the product.

## What Should You Note When You Sign Up For Health Insurance?

**Your Duty to Reveal Information**

A health insurance contract is based on good faith. You must truthfully reveal all the information asked for in the proposal form and/or health questionnaire and provide any other details they ask for (for example, age, occupation, history of illnesses, medical condition, disability or abnormality).

If you do not provide important information on your proposal form and/or health questionnaire, any policy issued may not be valid. If you are not sure whether a fact is important, you should reveal it anyway. This includes any information that you may have given to the advisor but was not included in the proposal and/or health questionnaire. Please check to make sure that you are fully satisfied with the information shown in your proposal and/or health questionnaire.

**Acceptance of Your Application**

Insurers will assess your application using the information that you have provided them. Depending on your health status, insurers may exclude certain benefits from the product, increase premium rates charged, or decline your application if you are not in good health. Therefore, it is important that you buy health insurance while you are young and healthy.

## How Should You File A Claim?

When you file a claim, you would generally be required to submit a copy of the insurer's claim form, together with the following supporting documents:

| Product Type | Supporting Document Required |
|---|---|
| Medical Expense Insurance | Original hospital bill; and<br>Accompanied doctor's report |
| Disability Income Insurance | Original copy of the doctor's report; and<br>Official declaration of your monthly earnings (inclusive of all sources of income) |
| Critical Illness Insurance | Original copy of the doctor's report; and<br>Laboratory test results |

You may be asked to provide more supporting documents if the insurer feels that it is necessary in making a fair judgement on your claim.

## Other Things That You Should Know

**"14-days Free Look"**

You have 14 days to review your new policy. If you decide that the policy is not suitable for your needs, the insurer will refund all your premiums less medical and other expenses they have incurred. You will need to send the insurer written notice within 14 days from the date you received your policy.

**When You Are Hospitalised …**

In Singapore, quality healthcare is easily available in both the public and the private sectors. However, healthcare cost differs significantly between private and public hospitals, and between different classes of wards, due to government subsidies. Therefore, when you are hospitalised, you are advised to:

- check the ward charges and costs of medical treatment recommended by your doctor;

- understand how the benefit limits of your health insurance policies will apply to cover such costs;
- evaluate the options available to you; and
- choose the type of ward or treatment according to what you can afford.

**Geographical Coverage**

Health insurance products generally provide you with worldwide coverage. This means that you are covered for medical treatments performed anywhere in the world should you fall sick or become injured. Occasionally, you would find products that impose geographic limitations. This means that treatments performed in specific countries or region (say, Europe of America) will not be covered.

You should also note that some insurance products will only reimburse your cost of overseas treatment up to the level that is reasonable and customary according to Singapore's standard, if such treatments are also locally available.

**Information On Specific Types Of Health Insurance Products**

The following briefly explains what each type of health insurance product covers and to answer some general questions about them. As the terms and conditions may not be exactly the same for every health insurance product, you should check the details of your policy and speak to your adviser should you have any doubt.

Medical Expense (or Hospital & Surgical) Insurance

Medical expense insurance provides for reimbursement of medical expenses incurred as a result of an accident or sickness. The policy will reimburse expenses relating to in-patient medical treatment or surgery, some outpatient charges for day surgery, pre-/post hospital specialist consultation, and diagnostic X-ray and laboratory tests.

Major medical expense insurance will reimburse expenses incurred for longer period of hospitalization due to a major illness or for major surgery such as a heart bypass or organ transplant.

Medical expense insurance will not reimburse you more than the actual amount

of medical expenses incurred for hospitalisation or surgery, regardless of the number of policies you have. There are limits to the amount of expenses you can claim under each medical expense policy. The policy may be subject to itemised benefit limits, as well as an overall limit per illness, per disability, per year or per lifetime. You can combine the limits of two or more policies to enjoy higher benefits. Policies may also have exclusions for treatment relating to some illnesses, such as those which are optional and relate to pre-existing conditions.

Some medical expense policies may also have deductible and co-insurance features. A deductible is a fixed sum you have to pay out-of- pocket before policy benefits are payable. Co-insurance is calculated as a percentage of the amount remaining after applying the deductible that you have to bear. Hence, you will not receive full reimbursement of medical expenses incurred from this type of medical expense policy.

Hospital Cash (or Hospital Income) Insurance

Hospital cash insurance pays a fixed amount of benefit per day of hospitalisation for medical treatment or surgery, regardless of the actual expenses incurred. This means that the total amount of benefits payable under the hospital cash insurance may be more or less than the actual hospitalisation expenses incurred.

A hospital cash policy may be subject to a waiting or deferral period, which means benefits are paid only after you have fulfilled a minimum number of days' stay in the hospital. The policy benefits payable may also be subject to a maximum number of days limit per year and per lifetime. The policy will terminate once the lifetime benefit payment limit is reached. The deferment period and benefit payment limits may vary across policies.

Critical Illness (or Dread Disease) Insurance

A critical illness policy pays a lump sum benefit upon either definite diagnosis of one of a list of several diseases covered by the policy, or after performance of one of a list of surgeries specified in the policy. The lump sum benefit payable does not depend on admission to the hospital or on the actual expenses incurred for medical treatment.

Although the types of diseases covered by critical illness policies may vary from one insurer to another, some major illnesses and surgeries are covered by

almost all policies. These diseases include coronary artery bypass, stroke and kidney failure. Benefits are payable only if the disease or surgery completely fulfils the definition specified in the policy. The definition of diseases is standardised across all insurance companies in Singapore.

The critical illness policy will not pay benefits for pre-existing conditions. The policy usually has a waiting period. Within this specified length of time, no benefits are payable on diagnosis of diseases even if they fulfil the definitions specified in the policy.

Disability Income Insurance

Disability income insurance pays a fixed monthly benefit to replace income lost through inability to work as a result of an accident or illness. Disability income is based on the concept of income protection, which aims to defray income loss but is not intended to replace completely the income earned prior to the accident or sickness. Therefore, disability income insurance usually pays not more than 80% of the insured's average monthly salary.

Disability income insurance may have a waiting or deferral period in which benefits will not be payable; benefits will only commence if the insured is disabled continuously for longer than the minimum deferral period. The duration of monthly income benefits payable are subject to maximum periods of 5 or 10 years, or up to ages 60 or 65. The benefit payment will cease once the insured is able to resume work, or it may be reduced in proportion to partial recovery from the disability. Recovery is determined through medical check-ups conducted by the insurance company.

The most important aspect of disability income insurance is the definition of disability used in the policy. Some policies define disability as the inability to perform the insured's own (original) occupation, whereas others define it as the inability to perform any occupation whatsoever. The second definition is more restrictive and therefore, the probability of claiming under it is lower. Hence, the premium payable for a policy using the second definition will be lower compared to a policy using the first, more liberal definition of disability.

Long-Term Care Insurance

Long-term care insurance pays a fixed monthly benefit to provide for expenses

relating to long-term medical treatment. There is usually no limit to the age of the insured.

Long-term care benefits are payable upon the insured's inability to perform some Activities of Daily Living (ADLs); these include bathing, dressing, feeding, toileting, mobility and transferring. The definitions of ADLs and the minimum number of ADLs the insured must not be able to perform to qualify for long-term care benefits may vary from one policy to another. The benefits will cease once the insured recovers and is able to perform more than the minimum number of ADLs.

Long-term care benefits are payable up to a maximum number of years. Once the benefits are paid up to the maximum duration, the policy will terminate. There is also a deferral period, meaning long-term care payments will begin only after the insured is unable to perform the minimum number of ADLs continuously for that period of time.

# ANNEX 4: SPECIFIC RECOMMENDATIONS ON ADVISORY PROCESS FOR HEALTH INSURANCE PRODUCTS

## INDIVIDUAL BUSINESS

### *Pre-sales advisory process*

1 To know one's client, an insurance intermediary is expected to collect the following information:

- the health insurance protection requirements of the client;
- the employment status of the client;
- the financial situation of the client;
- the current health condition of the client;
- the health insurance coverage that the client currently has; and
- the bio-data of spouse or dependants of the client (where the client intends to cover them).

2 The insurance intermediary is also expected to highlight to his or her client that the information provided will form the basis on which a recommendation for which insurance plan to purchase will be made. Thus, any inaccurate or incomplete information may affect the suitability of the recommendation.

3 The format of the proposed "Fact-find Form" for individual clients is found in Appendix I of this Annex.

4 The insurance intermediary shall analyse the information provided by the client and identify the product that is suitable for the client based on the information obtained. Where the insurance intermediary is unable to identify a suitable product, he or she shall inform the client accordingly.

5 An insurance intermediary shall explain to his or her client the basis for his or her recommendation. This basis should then be documented.

6 Where a client does not want:

(a) to provide any information requested by the insurance intermediary; or
(b) to accept the recommendation of the insurance intermediary and chooses to purchase another health insurance product which is not recommended,

the insurance intermediary may proceed with the client's request, but he or she must document the decision of the client and highlight that it is the client's responsibility to ensure the suitability of the product selected.

7 Where a client chooses not to receive any recommendation from an insurance intermediary, the insurance intermediary shall ensure that there is proper documentation to demonstrate this.

8 An insurance intermediary shall furnish the following documents to a client when making a recommendation:

(a) a summary of the information gathered from the client
(b) any recommendation made by the insurance intermediary, as well as the basis for the recommendation,

and, where applicable, a statement that the client has chosen not to:

(i) provide the information requested;
(ii) accept the recommendation of the insurance intermediary and has instead purchased another health insurance product which is not recommended; or
(iii) receive any recommendation from the insurance intermediary,

before the client signs the application form for the purchase of a health insurance product.

9 For practical purposes, the insurance intermediary may, with the client's consent, give the client an abridged version of the document or statement listed above. The insurance intermediary shall also maintain a copy of the document or statement and its abridged version, where applicable, for record-keeping purposes.

10 An insurance intermediary shall not recommend that a client switch from one health insurance product (the "original product") to another health insurance product (the "replacement product") in a manner that would be detrimental to the client. In considering whether a switch would be detrimental, the following factors are taken into account:

(a) whether the client will suffer any penalty for terminating the original product;
(b) whether the client will incur any transaction cost without gaining any real benefit from such a switch;
(c) whether the replacement product confers a lower level of benefit at a higher or equal cost to the client, or the same level of benefit at a higher cost; and
(d) whether the replacement product is less suitable for the client.

11 Any insurance intermediary which makes a recommendation to a client to switch from one health insurance product to another health insurance product shall comply with all the advisory process requirements described above. The insurance intermediary shall also disclose to the client any fee or charge the client would have to bear for making the switch, in order to ensure that the client is able to make an informed decision on whether to switch.

### *Application of the requirements for direct marketing and telemarketing channels*

To ensure consistency in the quality of advice that consumers receive from all distribution channels, the advisory process requirements are to be complied with before any advice can be presented in direct marketing materials or given by telemarketers.

## CORPORATE BUSINESS

1 Since October 2001, the insurance industry has adopted a common Group Insurance Fact-find Form (GIFF) to be used by all distribution channels in the arrangement of group insurance products for corporate clients. Improvements have been made to the GIFF to facilitate, in addition to its original information-collection function, needs analysis and documentation of any recommendations made. The modified GIFF can be found in Appendix II of this Annex.

2 The insurance intermediary is also expected to highlight to his or her client that the information provided by the client will form the basis for the recommendation to be made, so any inaccurate or incomplete information provided by the client may affect the suitability of the recommendation.

APPENDIX I

**Sample Fact-Find Form for Individual Business**

**LOGO of INSURER / BROKER / BANK / IFA COMPANY**

"Know Your Client" Form

**Confidential Fact Find for**

e.g. Ms Tan Siew lee

BY

e.g. Alex Lim Boon Howe

| **Important Notice to Clients** |
|---|
| For Life/General agents, banks and financial institutions<br>Your life/general insurance advisor is a representative of (name of company) and can advise you on the products of (name of company/companies)<br><br>For Life/General insurance brokers<br>Your life/general insurance advisor is a broker with (name of company). As a life/general insurance broker, your advisor is able to source for and objectively recommend the products of various life/general insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the life/general insurance companies from which he sources the products<br>.<br>Standard statement applicable to all advisors<br>**Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given.**<br><br>**A policy purchased without the completion of a "Know Your Client" form may not be appropriate to your needs.** |

| **Client's Choice** |
|---|
| ☐ I/We wish to disclose information in this form.<br><br>☐ I/We wish to receive product advice only. I take sole responsibility for ensuring that this product is appropriate to my financial and insurance objectives. I understand that buying health insurance products that are not suitable may impact my future healthcare needs.<br><br>I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.<br><br>Signature of Client : Signature of Advisor :<br>Date : Date : |

## 1 PERSONAL INFORMATION

### 1a. Personal Details of Client

**Name:** Mr/Mrs/Miss/Ms/Dr _____

**NRIC/ Passport No.**: _____ **Date of Birth**: ____/____/____

**Marital Status:** Single / Married / Divorced / Separated / Widowed **Gender:** M/ F

### 1b. Employment Details

**Current Occupation** _____ **Monthly Income** _____

### 1c Details of Spouse & Dependants (If family coverage is required)

| Name / Relationship | Age | DOB | Gender | Occupation | Monthly Income |
|---|---|---|---|---|---|
| _____ | ___ | ___/___/___ | M/F | _____ | _____ |
| _____ | ___ | ___/___/___ | M/F | _____ | _____ |
| _____ | ___ | ___/___/___ | M/F | _____ | _____ |
| _____ | ___ | ___/___/___ | M/F | _____ | _____ |

## 2 EXISTING HEALTH INSURANCE POLICIES

This covers all Health Insurance Polices you currently have (i.e. CPF-approved Medical Scheme, Personal Medical, Hospital Income, Long Term Care, etc). This includes any policies that are provided by your current employer.

| Policy Type* | Insured** | Sum Insured | Annual Premium | Expiry Date |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

* Please specify if the policy is provided by your current employer

** Y = You; S = Spouse; J = Joint

## 3 PERSONAL PRIORITIES

| **Your Health Insurance Needs** | **Level of Priority in Your Personal Needs** | | |
|---|---|---|---|
| | *Low* | *Medium* | *High* |
| *Cover for hospitalisation expenses* | € | € | € |
| *Cover for outpatient medical expenses* | € | € | € |
| *Cover for major illnesses (e.g. cancer, kidney dialysis, etc.)* | € | € | € |
| *Cover for dental expenses* | € | € | € |
| *Cover for old age disabilities* | € | € | € |
| *Cover for loss of income due to illness or sickness* | € | € | € |

**4 HEALTH CONDITION**

Do you have any medical condition which requires you to receive regular attention from a doctor in a clinic or hospital? € Yes € No

If 'Yes', what is/are these medical condition(s)?

_____

**5 REPLACEMENT OF POLICY**

Is this product intended to replace any existing health insurance policy? **Yes / No**
**(IF YES, ADVISOR SHOULD STATE THE REASONS FOR REPLACEMENT IN THE "STATEMENT BY ADVISOR" SECTION)**

_____

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

Signature of Advisor: _____ Date: _____

**LOGO of INSURER / BROKER / BANK / IFA COMPANY**

"Know Your Client" Form

**Confidential Fact Find for**

e.g. Ms Tan Siew lee

BY

e.g. Alex Lim Boon Howe

**ADVISOR'S RECOMMENDATION**

| **STATEMENT BY ADVISOR** |
|---|
| The recommendations in this document are based on the information collected in the "Know Your Client" Form. If there have been any changes in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. |

| Product Recommended | Reasons for Recommendations | Remarks |
|---|---|---|
| | | |

| **ACKNOWLEDGEMENT** |
|---|
| I understand that the above recommendation(s) is/are based on the facts furnished in the Confidential Fact Find Form and I agree / do not agree* with the recommendations.<br><br>Signature of Client : Signature of Advisor :<br>Date : Date :<br><br>**NOTE: IT IS USUALLY DISADVANTAGEOUS TO REPLACE AN EXISTING POLICY WITH A NEW ONE. SOME OF THE DISADVANTAGES ARE:**<br>**A) YOU MAY NOT BE INSURABLE AT STANDARD TERMS**<br>**B) YOU MAY HAVE TO PAY A HIGHER PREMIUM IN VIEW OF HIGHER AGE**<br>**C) THE WAITING PERIOD WILL COMMENCE FROM THE ISSUE DATE OF THE NEW POLICY, EVEN THOUGH IT MAY HAVE EXPIRED OR IS NO LONGER APPLICABLE IN YOUR EXISTING POLICY.**<br>Note: Client's Signature is required for face-to face fact find and telemarketing sale involving advice other than disclosure of product information only. |

APPENDIX II

**Group Insurance Fact-Finding Form**

**KINDLY COMPLETE FULLY IN BLOCK LETTER AND INK**
Kindly tick boxes (X) where appropriate
**PERIOD OF INSURANCE** from _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

**REQUEST FOR QUOTATION** was submitted on _____
(dd/mm/yyyy)

**REQUEST FROM :** _____
(Name of Insurance Company)

## 1. GENERAL INFORMATION

**a)** Name of Company : _____

**b)** Nature of Business : _____

**c)** Presently Insured? Yes / No

If yes, name of current insurer : _____

**d)** Type of Policy : _____

Period Of Insurance: from _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

**e)** Total number of employees: _____ No of employees to be insured :_____

**f)** Participation :

*We assume that participation in the group insurance program is on a compulsory basis, unless otherwise **indicated with a tick** here,under "Participation – Voluntary".*

| **Insurance Coverage** | **Participation** | |
|---|---|---|
| | **Compulsory** | **Voluntary** |
| Group Term Life | | |
| Group Personal Accident | | |
| Group Hospital & Surgical | | |
| - for employees only | | |
| - for dependants only | | |
| Group Critical Illness | | |
| Group Disability Income | | |

Please note:

**Voluntary**: Participation is voluntary if employees or dependants are given the choice to opt for cover(s).

## 2. GROUP TERM LIFE INSURANCE

### a. Basis of Coverage

| Category of Employees / Occupation | | Basis of Coverage Sum Insured (S$) |
|---|---|---|
| (i) | | |
| (ii) | | |
| (iii) | | |
| (iv) | | |

Example 1 :

| | Category of Employees / Occupation | Basis of coverage |
|---|---|---|
| (i) | Senior Management (Director, General Manager, Senior Manager) | 100,000 |
| (ii) | Manager & Executive | 50,000 |
| (iii) | All Others | 25,000 |

Example 2 :

| | Category of Employees / Occupation | Basis of coverage |
|---|---|---|
| (i) | All Employees | 24 x Basic Monthly Salary |

### b. Details of Employees:

| Age Band (Age Next Birthday) | No. of Employees | | Sum Insured | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| 16-30 | | | | |
| 31-35 | | | | |
| 36-40 | | | | |
| 41-45 | | | | |
| 46-50 | | | | |
| 51-55 | | | | |
| 56-60 | | | | |
| 61-65 | | | | |
| Total : | | | | |

### c. Claims Experience for the past 3 years:

| Period of Coverage from/to (dd/mm/yyyy) | Number of Insured as at _____ (dd/mm/yyyy) | Paid Claims | | Outstanding Claims | |
|---|---|---|---|---|---|
| | | Number | Amount | Number | Amount |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*The Insurer reserves the right to request for more information.*

**d.** Is any member of the corporation terminally ill or in hospital? Yes / No

If **Yes,** Kindly provide the following details

Number of members : _____

Reason for hospitalisation: _____

Nature of illness: _____

**e**. Is any member of the corporation based outside Singapore? Yes / No
If **Yes**, kindly provide the following details
Number of members: _____
Sum Insured: _____
Country based in: _____

## 3. GROUP PERSONAL ACCIDENT INSURANCE

### a. Basis of Coverage

| Category of Employees / Occupation | | Basis of Coverage Sum Insured (S$) |
|---|---|---|
| (i) | | |
| (ii) | | |
| (iii) | | |
| (iv) | | |

*Kindly refer to the example on Basis of Coverage for Group Term Life (Page2)*

### b. Details of Employees :

| Category of Employees / Occupation | No. of Employees | | Sum Insured | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| (i) | | | | |
| (ii) | | | | |
| (iii) | | | | |
| (iv) | | | | |
| Total : | | | | |

### c. Claims Experience for the past 3 years :

| Period of Coverage from/to (dd/mm/yyyy) | Number of Insured as at _____ (dd/mm/yyyy) | Paid Claims | | Outstanding Claims | |
|---|---|---|---|---|---|
| | | Number | Amount | Number | Amount |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*The Insurer reserves the right to request for more information.*

**d.** Is any member of the corporation engaged in hazardous occupation/sports? Yes / No
If **Yes,** what is the nature of his/her work? _____
What kind of sports? _____

FOR YOUR INFORMATION – Occupational Classifications :

| | |
|---|---|
| Class 1 | Clerical, administrative or other similar non-hazardous occupation |
| Class 2 | Occupations where some degree of risk is involved e.g. supervision of manual workers, totally administrative job in an industrial environment |
| Class 3 | Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident |
| Class 4 | High risk occupations involving heavy manual work including hot works |

## 4. GROUP HOSPITAL & SURGICAL INSURANCE

### a. Basis of Coverage:

| Category of Employees / Occupation | | Room and Board Benefit Plan |
|---|---|---|
| (i)<br>(ii) | | |
| (iii) | | |
| (iv) | | |

***Important Note**: Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.*

Example 1:

| | Category of Employees / Occupation | R & B Benefit Plan |
|---|---|---|
| (i) | Senior Management (Director, General Manager, Senior Manager) | 360 |
| (ii) | Manager & Executive | 200 |
| (iii) | All Others | 100 |

### b. Details of Insured Members:

| No. of Employees | | | | | |
|---|---|---|---|---|---|
| | **Plan 1** | **Plan 2** | **Plan 3** | **Plan 4** | **Plan 5** |
| Employee Only | | | | | |
| Employee & Spouse | | | | | |
| Employee & Child(ren) | | | | | |
| Employee & Family | | | | | |

### c. Claims Experience for the past 3 years :

| **Period of Coverage from/to (dd/mm/yyyy)** | **Number of Insured as at _____ (dd/mm/yyyy)** | **Paid Claims** | | **Outstanding Claims** | |
|---|---|---|---|---|---|
| | | **Number** | **Amount** | **Number** | **Amount** |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*The Insurer reserves the right to request more information.*

**d.** Kindly attach a copy of the Schedule of Benefits (if currently insured).

**e.** Is any of the corporation member terminally ill or in hospital? Yes / No

If **Yes,** Kindly provide the following details

Number of members : _____

Reason for hospitalisation: _____

Nature of illness: _____

*Kindly note that we will not reimburse the claims of any members in hospital at the time of application.*

**f**. Is any member of the corporation based outside Singapore? Yes / No

If **Yes**, kindly provide the following details:

Number of members: _____
Country based in: _____

**g.** Is any member of the corporation engaged in hazardous occupation/sports? Yes / No
If **Yes,** what is the nature of his/her work? _____
What kind of sports? _____

## 5. GROUP CRITICAL ILLNESS INSURANCE

### a. Basis of Coverage

| Category of Employees / Occupation | | Basis of Coverage Sum Insured (S$) |
|---|---|---|
| (i) | | |
| (ii) | | |
| (iii) | | |
| (iv) | | |

*Kindly refer to the example of Basis of Coverage for Group Term Life (Page2)*

**b.** Does this benefit advance on the term life death benefit or is it an additional amount to the term life?
If it is accelerating, what is the percentage? _____

### c. Details of Employees :

| Age Band (Age Next Birthday) | No. of Employees | | Sum Insured | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| 16-30 | | | | |
| 31-35 | | | | |
| 36-40 | | | | |
| 41-45 | | | | |
| 46-50 | | | | |
| 51-55 | | | | |
| 56-60 | | | | |
| 61-65 | | | | |
| Total : | | | | |

### d. Claims Experience for the past 3 years :

| Period of Coverage from/to (dd/mm/yyyy) | Number of Insured as at _____ (dd/mm/yyyy) | Paid Claims | | Outstanding Claims | |
|---|---|---|---|---|---|
| | | Number | Amount | Number | Amount |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*The Insurer reserves the right to request more information.*

.

**e.** Is any member of the corporation terminally ill or in hospital? Yes / No
If **Yes,** Kindly provide the following details
Number of members : _____
Reason for hospitalisation: _____
Nature of illness: _____

**f**. Is any member of the corporation based outside Singapore? Yes / No
If **Yes**, kindly provide the following details
Number of members: _____
Sum Insured: _____
Country based in: _____

**g**. If you are presently insured, please provide a list of critical illnesses covered.

## 6. GROUP DISABILITY INCOME INSURANCE

**a.** If currently insured, please attach a copy of the definition of Disability.

**b.** What is the waiting period? _____

**c.** What is the benefit duration? _____(e.g. 2 years, 5 years, till age 60 or 65?)

**d.** Any requirement for partial disability benefits? Yes / No

**e. Basis of Coverage**

| Category of Employees / Occupation | | Monthly Salary(S$) | Basis of Coverage Sum Insured (S$) (% of Monthly Salary S$) |
|---|---|---|---|
| (i) | | | |
| (ii) | | | |
| (iii)<br>(iv) | | | |

**f. Details of Employees:**

| Age Band (Age Next Birthday) | No. of Employees | | Sum Insured | |
|---|---|---|---|---|
| | Male | Female | Male | Female |
| 16-30 | | | | |
| 31-35 | | | | |
| 36-40 | | | | |
| 41-45 | | | | |
| 46-50<br>51-55 | | | | |
| 56-60 | | | | |
| 61-65 | | | | |
| Total : | | | | |

**g. Claims Experience for the past 3 years:**

| Date of Disability (dd/mm/yyyy) | Cause of Disability / Nature of illness | Claims Amount (S$) | |
|---|---|---|---|
| | | Paid | Outstanding |
| | | | |
| | | | |
| | | | |

*The Insurer reserves the right to request more information.*

**h.** Is any member of the corporation terminally ill or in hospital? Yes / No
If **Yes,** Kindly provide the following details
Number of members : _____
Reason for hospitalisation: _____
Nature of illness: _____

**i**. Is any member of the corporation based outside Singapore? Yes / No
If **Yes**, kindly provide the following details
Number of members: _____
Sum Insured: _____
Country based in: _____

**j**. If you are presently insured, please provide a list of critical illnesses covered.

## 7. NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box to indicate the priority ordering of your company's needs:

| Company's Priorities | Low | Med | High | **Advisor's Recommendation** |
|---|---|---|---|---|
| **Cover for outpatient medical expenses** | ☐ | ☐ | ☐ | |
| **Cover for hospitals & surgical expenses** | ☐ | ☐ | ☐ | |
| **Cover for dental expenses** | ☐ | ☐ | ☐ | |
| **Cover for major illnesses** (e.g. cancer, kidney failure, etc.) | ☐ | ☐ | ☐ | |
| **Cover for loss of income due to sickness or accident** | ☐ | ☐ | ☐ | |
| **Cover for long term medical treatment** | ☐ | ☐ | ☐ | |

Others : _____

## 8. DECLARATION

*[This section must be printed at the end of each form for all the types of applicable business.]*

I / We hereby declare that, to the best of my / our knowledge and belief, the information given here is true and complete, and agree that if a contract of insurance is effected, all information submitted in connection with this application shall form the basis of said contract between the client and the insurer.

| | |
|---|---|
| _____ | _____ |
| Signature of Authorised Officer | Signature of Broker / Agent (if any as appropriate) as a witness |
| Name | Name |
| Designation | Designation |
| Company Stamp (if applicable) | Company Stamp (if applicable) |
| Date | Date |

# ANNEX 5: STATEMENT ON ACCIDENT AND HEALTH INSURANCE BUSINESS

**NAME OF INSURER**

**STATEMENT ON ACCIDENT AND HEALTH INSURANCE BUSINESS**

**FROM 1 JAN ____ TO 31 DEC ____**

Co Code | | | | Yr | | | | Mth | | |

**Accident and Health Insurance (Long -term)**

$

| | Row No. | Medical Expense | | Critical Illness | | Long-term Disability | | Personal Accident | |
|---|---|---|---|---|---|---|---|---|---|
| | | Individual | Group | Individual | Group | Individual | Group | Individual | Group |
| **A. PREMIUMS** | | | | | | | | | |
| Gross premiums | 1 | | | | | | | | |
| Reinsurance ceded | 2 | | | | | | | | |
| Net premiums written (1 -2) | 3 | | | | | | | | |
| Reserve for unexpired risk at the beginning of year | 4 | | | | | | | | |
| Reserve for unexpired risk at the end of year | 5 | | | | | | | | |
| Premiums earned during the year (3+4 -5) | 6 | | | | | | | | |
| **B. CLAIMS** | | | | | | | | | |
| Gross claims | 7 | | | | | | | | |
| Reinsurance recoveries | 8 | | | | | | | | |
| Net claims paid (7 -8) | 9 | | | | | | | | |
| Loss reserve at the beginning of year | 10 | | | | | | | | |
| Loss reserve at the end of year | 11 | | | | | | | | |
| Net claims incurred (9 -10+11) | 12 | | | | | | | | |
| **C. COMMISSION AND EXPENSES** | | | | | | | | | |
| Commissions | 13 | | | | | | | | |
| Net commission incurred | 14 | | | | | | | | |
| Management expenses | 15 | | | | | | | | |
| **D. UNDERWRITING RESULTS (6 -12-14-15)** | 16 | | | | | | | | |
| **E. POLICIES AND CLAIMS SETTLED** | | | | | | | | | |
| Number of policies | 17 | | | | | | | | |
| Number of lives covered | 18 | | | | | | | | |
| Number of claims registered | 19 | | | | | | | | |

**Accident and Health Insurance (Shor t-term)**

$

| | Row No. | Medical Expense | | Critical Illness | | Long-term Disability | | Personal Accident | |
|---|---|---|---|---|---|---|---|---|---|
| | | Individual | Group | Individual | Group | Individual | Group | Individual | Group |
| **A. PREMIUMS** | | | | | | | | | |
| Gross premiums | 1 | | | | | | | | |
| Reinsurance ceded | 2 | | | | | | | | |
| Net premiums wri tten (1 -2) | 3 | | | | | | | | |
| Premium liabilities at the beginning of year | 4 | | | | | | | | |
| Premium liabilities at the end of year | 5 | | | | | | | | |
| Premiums earned during the year (3+4 -5) | 6 | | | | | | | | |
| **B. CLAIMS** | | | | | | | | | |
| Gross claims | 7 | | | | | | | | |
| Reinsurance recoveries | 8 | | | | | | | | |
| Net claims paid (7 - 8) | 9 | | | | | | | | |
| Claims liabilities at the beginning of year | 10 | | | | | | | | |
| Claims liabilities at the end of year | 11 | | | | | | | | |
| Net claims incurred (9 -10+11) | 12 | | | | | | | | |
| **C. COMMISSION AND EXPENSES** | | | | | | | | | |
| Commissions | 13 | | | | | | | | |
| Net commission incurred | 14 | | | | | | | | |
| Management expenses | 15 | | | | | | | | |
| **D. UNDERWRITING RESULTS (6 -12-14-15)** | 16 | | | | | | | | |
| **E. POLICIES AND CLAIMS SETTLED** | | | | | | | | | |
| Number of policies | 17 | | | | | | | | |
| Number of lives covered | 18 | | | | | | | | |
| Number of claims registered | 19 | | | | | | | | |

Name and signature of Principal Officer: _____

Date: _____

# ANNEX 6: DRAFT NOTICE ON DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

**DISCLAIMER: This version of the Notice is in draft form and is subjected to change taking into account feedback received during this consultation phase.**

MAS 1XX

31 Dec 2003

NOTICE TO ALL DIRECT INSURERS, FINANCIAL ADVISERS, EXEMPT FINANCIAL ADVISERS, DIRECT INSURANCE BROKERS AND EXEMPT DIRECT INSURANCE BROKERS

INSURANCE ACT (CAP. 142)

NOTICE ON DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

**Introduction**

1 This Notice is issued pursuant to sections 35P, 35TA and 64(2) of the Insurance Act (Cap. 142) ["the Act"] and comprises both mandatory requirements and best practice standards the disclosure of information and provision of advice to insureds for accident and health insurance products.

2 This Notice applies to any:

(a) direct insurer registered under the Insurance Act;
(b) licensed financial adviser or exempt financial adviser which provides any financial advisory service in respect of life policies;
(c) representative of a licensed financial adviser or an exempt financial adviser who provides any financial advisory service in respect of life policies;
(d) direct insurance broker or exempt direct insurance broker;
(e) person acting for a direct insurance broker or an exempt direct insurance broker;
(f) insurance agent operating under written agreement pursuant to section 35M; or
(g) insurance agent who is not required to comply with section 35M

when it provides advice or arranges contracts of insurance or both in respect of accident and health insurance products.

3 This Notice sets out the following in two parts:

(a) Part I — Mandatory Requirements
    (i) Division 1: Disclosure requirements for accident and health policies;
    (ii) Division 2: Disclosure requirements for life policies that contain accident and health benefits;
    (iii) Division 3: Additional disclosure requirements for direct insurers

(iv) Division 4: Requirements on provision of advice relating to accident and health policies

(v) Division 5: Requirements on provision of advice relating to life policies that contain accident and health benefits.

(vi) Division 6: Offences relating to this Part

(b) Part II — Non-mandatory Best Practice Standards on Information Disclosure and Provision of Advice

4 This Notice shall come into effect on 1 January 2004.

**Definitions**

5 For the purpose of this Notice:

"accident and health insurance product" means any policy with accident and health benefits but does not include travel insurance policies;

"accident and health insurance intermediary (hereinafter referred to as A & H insurance intermediary)" means—

(a) a direct insurer;

(b) a licensed financial adviser;

(c) an exempt financial adviser;

(d) a direct insurance broker; or

(e) an exempt direct insurance broker,

who provides advice on or arranges contracts of insurance or both, in respect of accident and health insurance products as an insurance intermediary;

"accident and health insurance representative (hereinafter referred to as A&H insurance representative) " means a person who is –

(a) employed by or who acts as an insurance agent for a direct insurer;

(b) employed by or who acts for a direct insurance broker or an exempt direct insurance broker; or

(c) employed by or who acts as a representative of a licensed financial adviser or exempt financial adviser,

and provides advice on or arranges contracts of insurance or both, in respect of accident and health insurance products as an insurance intermediary, but does not include a person who is an A&H insurance intermediary;

"Central Provident Fund Board" means the Central Provident Fund Board constituted under section 3 of the Central Provident Fund Act (Cap.36);

"exempt direct insurance broker" means a person exempt from registering as a direct insurance broker under section 3ZN(1)(a) to (ea) of the Act who has notified the Authority, in such manner as may be prescribed under section 64(1), of his commencement of insurance broking business;

"health insurance policy" means an accident and health insurance policy that is not a personal accident policy;

"insured" includes an intending insured;

"personal accident policy" means an accident and health policy where accident and health benefits are paid out only—

(a) in the event of an injury to, or disability of , the insured as a result of accident;

(b) on the death by accident of the insured; or

(c) on the occurrence of a combination of (a) and (b);

"representative" has the same meaning as set out in section 2 of the Financial Advisers Act (Cap 110) ["the FA Act"];

"switching" includes terminating an accident and health insurance product and replacing it with another accident and health insurance product, and "switch" shall be construed accordingly.

6 The expressions used in this Notice shall, except where expressly defined in this Notice or where the context otherwise requires, have the same respective meanings as in the Act.

**Sections 35P and 35TA**

7 For the purposes of section 35P(1)(d) and (2)(e) of the Act, an A&H intermediary shall also disclose the material information set out in paragraphs 13 to 19, 21 to 23, and 28(a) to (d).

8 For the purposes of section 35TA of the Act, the standards to be maintained by an insurance intermediary in the conduct of business relating to disclosure and advisory process include those set out in paragraphs 12, 20, 24 to 26, 28(e), 31, 35 to 47, and 49.

**Representative of A&H Insurance Intermediary**

9 Unless otherwise specified, an A&H insurance intermediary shall ensure that all its A&H insurance representatives comply with any mandatory requirement imposed on an A&H insurance intermediary in this Notice when the A&H insurance representatives are acting on behalf of the A&H insurance intermediary.

**Application to Direct Insurers**

10 Unless otherwise specified, this Notice applies to a direct insurer, when it provides advice or arranges contracts of insurance in respect of accident and health policies underwritten by it, as if it were an A&H intermediary.

**Part I – Mandatory Requirements**

Division 1: Disclosure Requirements for Accident and Health Policies

11 This Division sets out minimum standards on disclosure to insureds by A&H insurance intermediaries in relation to accident and health policies that are mandatory.

*Guiding principle*

12 No A&H insurance intermediary shall make a false or misleading statement to its insureds nor shall an A&H insurance intermediary omit to disclose any matter material to the statement.

*General information about the A&H insurance intermediary and Status of an A&H insurance representative*

13 An A&H insurance intermediary shall disclose to the insured in writing its business name under which it conducts its insurance business, business address, and telephone number.

14 An A&H insurance representative shall disclose the following to the insured in writing:

(a) its name; and

(b) the A&H insurance intermediary (or intermediaries) for which it acts.

15 Where there is a change to such information mentioned in paragraphs 13 and 14, an A&H insurance intermediary or an A&H insurance representative shall inform an insured, in writing, of any such change in any subsequent dealings with the insured.

*Remuneration of the A&H insurance intermediary*

16 An A&H insurance intermediary shall, upon request of the insured disclose in writing to the insured all remuneration, including any commission, fee and other benefit, that it has received or will receive for providing advice on, or arranging insurance contracts or both, in respect of any accident and health insurance policy.

*Conflict of Interest*

17 An A&H insurance intermediary shall disclose, in writing, to its insureds any actual or potential conflict of interest arising from any connection to or association with any insurer, including any material information or facts that may compromise its objectivity in advice provided by the A&H insurance intermediary.

*Disclosure when Providing Advice*

18 When dealing with an insured who is an individual in respect of any accident and health insurance policy, an A&H insurance intermediary shall disclose the following information to the insured:

(a) Nature and objective of the policy
The A&H insurance intermediary shall disclose and explain to the insured the nature and objective of the policy, including:
(i) whether the policy is a health insurance policy or a personal accident policy; and
(ii) whether the policy seeks to reimburse health services costs incurred by the insured, provide continuous income during disability or sickness, provide lump sum benefits on the occurrence of specified events, or a combination of these purposes.

(b) Details of the insurer
In addition to disclosing to the insured the insurer underwriting the policy and its relationship with that insurer required under section 35P(1)(a) and (b) of the Act, an A&H insurance intermediary shall disclose to the insured the business address of the insurer.

(c) Contractual rights and obligations
The A&H insurance intermediary shall disclose and explain to the insured—
(i) the party against which the insured may take action to enforce his rights with respect to the policy he has purchased;
(ii) that he is responsible for the accuracy and completeness of the information given to the insurer when applying for the policy and when making a claim under the policy;
(iii) that any mis-statement or non-disclosure of material facts may affect the validity of the policy; and

(iv) the amount of, frequency with which, and period over which, payment is to be made in respect of the policy, including whether the premium rate is guaranteed or non-guaranteed.

(d) Benefits of the policy

The A&H insurance intermediary shall disclose and explain to the insured the benefits of the policy, including—

(i) the conditions under which payment of policy moneys to the insured is made;

(ii) the conditions under which payment of policy moneys to the insured will not be made;

(iii) the amount and timing of the payment of policy moneys ;

(iv) whether the payment of policy moneys are guaranteed or non-guaranteed; and

(v) any lien on the policy.

(e) Risks of the policy

The A&H insurance intermediary shall disclose and explain to the insured the risks to be borne by the insured in the purchase of the policy, including:

(i) whether the insurer may alter the terms of contract, and if so, what are the terms that may be altered and under what conditions would alterations be allowed; and

(ii) whether the insurer may decline to renew the policy or unilaterally terminate the policy.

19 Where a benefit illustration or a product summary in respect of the accident and health insurance policy prepared by the insurer or the A&H insurance intermediary is available, the A&H insurance intermediary shall furnish the insured with, and explain to the insured the content of any such benefit illustration or product summary.

20 Where the A&H insurance intermediary prepares a benefit illustration or a product summary, it shall be prepared according to industry standards, if any, set for insurers.

21 In the case of a personal accident policy, the A&H insurance intermediary shall ensure that the insured is aware that policy moneys will be paid as a result of accident only.

22 When dealing with a person who is, or would be the policy owner of a group policy, in respect of any accident and health insurance policy, an A&H insurance intermediary shall disclose the following information to the insured:

(a) information described in paragraph 18;

(b) duration of coverage; and

(c) whether premium paid under the policy qualifies for any special tax treatment, and if so, the nature of such incentive.

23 For a group policy, where any person insured under the policy is liable to pay any premium (whether in monetary form or otherwise), the A&H insurance intermediary shall disclose to every person in the group the information as if it is dealing with them individually.

*Marketing Material*

24 An A&H insurance representative shall only use marketing materials approved by the A&H insurance intermediary for which he acts.

*Telemarketing and Direct Marketing*

25 Where an A&H insurance intermediary carries on the business of arranging contracts in relation to accident and health insurance policies over the telephone (commonly known as telemarketing) in a manner that is designed to solicit and close a sale without providing any advice, it shall—

(a) communicate to the insured a warning that:
  (i) the insured may wish to seek advice from an A&H insurance intermediary before making a commitment to purchase the policy; and
  (ii) in the event that the insured chooses not to seek advice from an A&H insurance intermediary, he should consider whether the policy in question is suitable for him; and
(b) maintain a record all conversions made over the phone sufficient for the purpose of conducting audit checks where necessary.

26 Where an A&H insurance intermediary engages in the marketing of accident and health insurance products using direct response advertising communications through any medium, including mail, print, TV, radio and electronic media, that is designed to solicit and close a sale, it shall include, in all its marketing materials, a prominent warning that:

(a) the insured may wish to seek advice from an A&H insurance intermediary before making a commitment to purchase the product; and
(b) in the event that the insured chooses not to seek advice from an A&H insurance intermediary , he should consider whether the product in question is suitable for him.

Division 2: Disclosure Requirements for Life Policies that Contain Accident and Health Benefits

27 Any A&H insurance intermediary or A&H insurance representative who is a licensed financial adviser, an exempt financial adviser or a representative providing any financial advisory service in respect of life policies is to comply with the disclosure requirements set out in the FA Act.

28 In addition to those requirements, an A&H insurance intermediaries or an A&H insurance representative shall comply (with the necessary modifications) with the following paragraphs in this Notice when it provides advice to or arrange contracts of insurance or both, in respect of life policies that contain accident and health benefits:

(a) paragraph 18(a), (c)(iv), (d)(i), (d)(ii), and (e);
(b) paragraph 21;
(c) paragraph 22(b) and (c);
(d) paragraph 23; and
(e) paragraph 25.

Division 3: Additional Disclosure Requirements for Direct Insurers

29 When a direct insurer prepares a benefit illustration or a product summary for policies it underwrites, it shall be prepared pursuant to industry standards, if any. This shall not apply to policies underwritten by insurers other than a registered insurer.

30 Where the accident and health insurance policy for an insured who is an individual provides that the insurer may vary, amend, or add to the terms of the contract of insurance in the duration of the contract, the direct insurer shall:

(a) disclose the existing terms of the contract;
(b) disclose and explain the new terms of the contract;
(c) disclose and explain the manner in which the insured may accept the new terms or the circumstances under which the insured will be deemed to have accepted the new terms; and
(d) furnish the information under (a), (b), and (c) to the insured in writing at least 30 days before the variation, amendment or addition takes effect.

Division 4: Requirements on Provision of Advice Relating to Accident and Health Policies

31 No A&H insurance intermediary shall provide any advice with respect to any health insurance policy to a person who may reasonably be expected to rely on the advice if the A&H insurance intermediary does not have a reasonable basis for providing the advice to the person.

32 For the purposes of paragraph 31, an A&H insurance intermediary does not have a reasonable basis for providing an advice to a person unless —

(a) he has, for the purposes of ascertaining that the advice is appropriate, having regard to the information possessed by him concerning the objectives, financial situation and particular needs of the person, given such consideration to, and conducted such investigation of, the subject-matter of the advice as is reasonable in all the circumstances; and
(b) the advice is based on the consideration and investigation referred to in sub-paragraph (a).

33 In this Division, a reference to the provision of advice is a reference to the provision of advice either expressly or by implication and the expression "providing advice" shall be construed accordingly..

34 This Division shall not apply in circumstances where no recommendation is made or where only factual information is provided with respect to any health insurance policy, including the marketing of health insurance policy through—

(a) the use of direct response advertising communications through any medium, including mail, print, television, radio, and electronic media; or
(b) telephone,

and no advice or recommendation is given.

35 An A&H insurance intermediary that is involved in providing advice on health insurance policy to insureds shall comply with the requirements set out in this Division in relation to the following aspects:

(a) "Know-Your-Client";
(b) needs analysis; and

(c) documentation and record keeping.

*"Know-Your-Client"*

36 In order for an A&H insurance intermediary to provide an advice to an individual that takes into account an insured's investment objectives, financial situation and particular needs, the A&H insurance intermediary shall collect and document the following information from the insured:

(a) the objectives of the insured, including—
  (i) the event, or events, which financial impact the insured is seeking protection from; and
  (ii) the nature of benefits payment that the insured is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the insured;
(b) the employment status of the insured;
(c) the income of the insured;
(d) any existing health insurance policy of the insured, including any policy monies arising from any insurance scheme established and maintained by the Central Provident Fund Board;
(e) any medical conditions that the insured may have; and
(f) for any recommendation made in respect of a health policy that intends to include the insured's dependants as the insureds, the information listed in (a) to (e) for such dependants.

37 In order for an A&H insurance intermediary to provide advice in relation to a group insurance policy that takes into account an insured's investment objectives, financial situation and particular needs, the A&H insurance intermediary shall collect and document the following information from the insured:

(a) the objectives of the insured, including—
  (i) the event, or events, which financial impact the insured is seeking protection for the members of the group; and
  (ii) the mode of policy monies payment that the insured is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the insured;
(b) the size and composition of the group, including a breakdown by gender, age, income, occupation;
(c) the claims history of the group; and
(d) any medical conditions that members of the group may have.

38 An A&H insurance intermediary shall highlight the following in writing to its insured:

(a) the information provided by the insured will be the basis on which the advice will be made; and
(b) any inaccurate or incomplete information provided by the insured may affect the suitability of the advice.

*Needs Analysis*

39 An A&H insurance intermediary shall analyse the information provided by the insured and identify the product that is suitable for the insured based on the information obtained from the insured.

40 Where the A&H insurance intermediary is unable to identify a suitable product, it shall inform the insured accordingly.

41 An A&H insurance intermediary shall explain to its insured the basis for its advice. The basis on which the A&H insurance intermediary is providing the advice to the insured shall be documented.

42 Where an insured does not want to:

(a) provide any information requested by the A&H insurance intermediary in accordance with paragraph 36 or 37; or

(b) accept the advice of the A&H insurance intermediary and chooses to purchase another health insurance product which is not advised by the A&H insurance intermediary ,

the A&H insurance intermediary may proceed with the insured's request, but it shall document the decision of the insured and inform the insured that it is the insured's responsibility to ensure the suitability of the product selected.

43 Where an insured chooses not to receive any advice from an A&H insurance intermediary, the A&H insurance intermediary shall properly document the insured's decision.

*Documentation and Record Keeping*

44 An A&H insurance intermediary shall furnish to its insured a document containing the following when providing an advice in respect of a health insurance policy to the insured:

(a) a summary of the information gathered by the A&H insurance intermediary pursuant to paragraph 36 or 37; and

(b) any advice provided to the insured by the A&H insurance intermediary and the basis for the advice,

and, where applicable, a statement that the insured does not want to:

(i) provide any information requested by the A&H insurance intermediary in accordance with paragraph 36 or 37;

(ii) accept the advice of the A&H insurance intermediary and has chosen to purchase another health insurance policy which is not that advised by the A&H insurance intermediary ; or

(iii) receive any advice from the A&H insurance intermediary ,

before the insured signs on the application form for the purchase of a health insurance policy or gives his consent for the withdrawal or surrender of a health insurance policy.

*Switching of Accident and Health Insurance Policies*

45 An A&H insurance intermediary shall not provide an advice to an insured who is an individual to switch from one accident and health insurance policy (referred to as "original policy") to another accident and health insurance policy (referred to as "replacement policy") in a manner

that would be detrimental to the insured. In considering whether a switch is detrimental, the Authority shall have regard to a number of factors, including:

(a) whether the insured suffers any penalty for terminating the original policy;
(b) whether the insured will incur any transaction cost without gaining any real benefit from such a switch;
(c) whether the replacement policy confers a lower level of benefit at a higher cost or same cost to the insured, or the same level of benefit at a higher cost; and
(d) whether the replacement policy is less suitable for the insured.

46 An A&H insurance intermediary that provides an advice to an insured to switch from one accident and health insurance policy to another shall comply with the requirements in relation to provision of advice set out in this Division.

47 An A&H insurance intermediary shall disclose to an insured any fee or charge the insured would have to bear if he were to switch from one accident and health insurance policy to another, in order to ensure that the insured is able to make an informed decision on whether to switch.

Division 5: Requirements on Provision of Advice Relating to Life Policies that Contain Accident and Health Benefits

48 An A&H insurance intermediary or A&H insurance representative who is a licensed financial adviser, an exempt financial adviser or a representative, which provides any financial advisory service in respect of life policies is to comply with requirements relating to recommendations and provision of advice set out in the FA Act and Notices issued thereunder.

49 In addition to these requirements, an A&H insurance intermediaries or A&H insurance representative shall comply (with necessary modifications) with the paragraphs 36(a), (d), (e), (f), 37 and 44 in this Notice when it provides advice in respect of life policies that contain accident and health benefits.

Division 6: Offences relating to this Part

50 Any A&H intermediary who fails to comply with any requirement in paragraphs 13 to 19, 21 to 23, and 28(a) to (d) shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $25,000 or to imprisonment for a term not exceeding 12 months or both.

51 Any A&H intermediary who fails to comply with any requirement in paragraphs 12, 20, 24 to 26, 28(e), 31, 35 to 47, and 49 shall be guilty of an offence and shall be liable on conviction to a fine not exceeding $12,500.

52 Any person who fails to comply with any requirement under any paragraph of this Notice (other than those set out in paragraphs 50 and 51) shall be guilty of an offence punishable under section 55(2) of the Act.

**Part II – Non-mandatory Best Practice Standards on Information Disclosure and Provision of Advice**

53 The best practice standards which an A&H insurance intermediary is expected to meet in all product information disclosures and information (including marketing materials) given to insureds are as follows:

(a) Information disclosed to insureds in any advertisement or publicity material in any media should be presented in plain language, and in a manner that is easy for the insured to understand.

(b) Jargon or technical terms used should be clearly explained to insureds.

(c) Information disclosed to insureds should not be limited to seeking compliance with requirements the Act and this Notice, but should accord with industry best practices. In addition, the information provided should be sufficient to help insureds make an informed decision.

(d) Warning and important information such as the nature and objective of the product, risks of the product, fees and charges, and contractual rights and obligations of insureds and the insurer, should be prominently presented and clearly explained.

(e) Information disclosed to insureds should not be ambiguous in language or presentation.

(f) Information relating to accident and health insurance products should be disclosed in an objective and unbiased manner.

(g) Where an opinion is expressed, there should be a reasonable basis for expressing the opinion and it should be unambiguously stated that it is a statement of opinion.

(h) Documents to be given to insureds should be kept up-to-date.

54 Where an A&H insurance intermediary provides an advice on or arranges contracts of insurance in respect of accident and health insurance products, it is expected to comply with any industry standard and/or guideline on needs-based sales process.


Monetary Authority of Singapore