

WARNING: PURSANT TO SECTION 25(5) OF THE INSURANCE ACT CAP. 142, YOU ARE TO DISCLOSE IN RESPECT OF THIS APPLICATION, FULLY AND FAITHFULLY, ALL FACTS YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY ISSUED MAY BE VOID

Important Notes:

1. This form must be completed in ink. Any amendments must be countersigned. The signature(s) must be consistent with our records.
2. For company-owned policy, please provide a list of signatories authorized to sign this form. This form must bear the company stamp. Please also submit a photocopy of the NRIC/PP of the authorized signatory and a copy of the ACRA business profile (extracted not more than 3 months from the date of submission of this form).
3. If a material fact is not disclosed in this form, reinstatement may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the Representative but was not included in the form. Please check to ensure you are fully satisfied with the information declared in this form.

1) ENHANCED CUSTOMER DUE DILIGENCE (ECDD) – POLITICALLY EXPOSED PERSON (PEP)
(To be completed by Owner)

Have you or any close relative ever held a senior position in a government, political party, military tribunal or government-owned corporation? θ Yes θ No

If yes, please answer questions below.

a) What is the name of the person who holds or held the office? _____

b) In which country is/was the position held? _____

c) Period the position was held? Starting Year: _____ Ending Year: _____

d) What position was held by the person who is or was politically exposed?

- | | |
|---|--|
| <input type="checkbox"/> Head of state or head of government | <input type="checkbox"/> Senior executive of a state-owned corporation |
| <input type="checkbox"/> Member of the executive council of government or member of a legislature | <input type="checkbox"/> Head of a government agency |
| <input type="checkbox"/> Government Minister (or equivalent) | <input type="checkbox"/> Judge |
| <input type="checkbox"/> Ambassador or ambassador’s attaché or counsellor | <input type="checkbox"/> Leader or president of a political party in a legislature |
| <input type="checkbox"/> Others (please identify) | <input type="checkbox"/> Senior Judicial or military official |

e) Title of position held? _____

f) What is the relationship of the person listed above to the Life Insured?

- Self Spouse Child Others: _____

2) ENHANCED CUSTOMER DUE DILIGENCE (ECDD) – POLITICALY EXPOSED PERSON (PEP)
(To be completed by Life Insured)

Have you or any close relative ever held a senior position in a government, political party, military tribunal or government-owned corporation? θ Yes θ No
 If yes, please answer questions below.

a) What is the name of the person who holds or held the office? _____

b) In which country is/was the position held? _____

c) Period the position was held? Starting Year: _____ Ending Year: _____

d) What position was held by the person who is or was politically exposed?

- | | |
|---|--|
| <input type="checkbox"/> Head of state or head of government | <input type="checkbox"/> Senior executive of a state-owned corporation |
| <input type="checkbox"/> Member of the executive council of government or member of a legislature | <input type="checkbox"/> Head of a government agency |
| <input type="checkbox"/> Government Minister (or equivalent) | <input type="checkbox"/> Judge |
| <input type="checkbox"/> Ambassador or ambassador’s attaché or counsellor | <input type="checkbox"/> Leader or president of a political party in a legislature |
| <input type="checkbox"/> Others (please identify):
_____ | <input type="checkbox"/> Senior Judicial or military official |

e) Title of position held? _____

f) What is the relationship of the person listed above to the Owner?

- Self Spouse Child Others: _____

(Life Insured) – Answer “Yes” or “No” to the following questions 3) to 21) and provide details if necessary.

Note: We need to review the answers to the medical questions before quoting our underwriting requirements.

- 3) Do you participate in aviation activities other than as a passenger on a regularly scheduled commercial airline? Yes No
 If yes, please complete aviation questionnaire.
- 4) Have you ever participated in hazardous avocations such as skin or scuba diving, hang-gliding, sky diving/parachuting, mountain and/or rock climbing, motor vehicle or power boat racing or any other hazardous activity? Yes No
 If yes, please complete the relevant questionnaire.
- 5) a) Do you drive after using alcoholic beverages? Yes No
- b) Within the last 3 years have you had any violation for speeding, improper turn, failure to stop at a light or any other *moving violation? Yes No
- c) Have you ever been charged with driving while intoxicated or while otherwise impaired? Yes No
- d) Have you ever been charged due to a motor vehicle accident or had your driver’s licence suspended? Yes No

Note: *A moving violation constitutes any citation received by the Life Insured for violating a driving law or regulation. Examples of a moving violation include: speeding, illegal turn, failure to obey a stoplight/stop sign, etc.

If the answers to any of the questions in 5a) to 5d) are “YES”, please provide details below:

Question No.	Date	Country	Details

- 6) Within the past 5 years, have you been convicted of a criminal offence, been imprisoned or are you currently charged with a criminal offence? Yes No
 If yes, please advise nature of offence, dates and sentence (if relevant).

- 7) Do you exercise on a regular basis? Yes No
 If yes, please provide details including type of exercise, frequency and duration of activity.

- 8) Have you been treated for alcohol or drug abuse during the last 5 years or has any such treatment been recommended? Yes No
 If yes, please provide details: _____
- 9) Have you used or experimented with drugs or narcotics (other than drugs prescribed to you)? Yes No
 If yes, please state:
 Type of drugs used: _____ Quantity: _____
 Frequency: _____ Year last consumed: _____

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10) Do you drink beer, wine or spirits? If yes, please state: θ Yes θ No

Type: _____

Quantity consumed per week: _____

11) Have you travelled or do you plan to travel outside your current country of residence? θ Yes θ No
 If yes, please provide the following travel details.

Last 12 months					
Country	Cities Visit	Duration of Stay Per Visit	Frequency of Visits Per Year	Date of Last Visit	Purpose of Travel

Next 12 months					
Country	Cities to Visit	Duration of Stay Per Visit	Frequency of Visits Per Year	Date of Last Visit	Purpose of Travel

12) Do you plan to change your current country of residence? θ Yes θ No
 If yes, please provide details below.

a) Name the city and country in which you plan to reside. _____

b) Reason(s) for your change in residence. _____

c) How long will you be staying at this location? _____

d) Do you plan to return to your current country of residence? θ Yes θ No
 If yes, when: _____

13) Have you ever used tobacco or nicotine products in any form (including cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches or gum)? θ Yes θ No
 If yes, please provide details below.

Product	Amount / Frequency	Current	Past	Date Last Used
Cigarettes				
Cigars				
Others (please specify)				

- 14) Have any of your immediate family members (parents or siblings), being diagnosed with or died of coronary artery disease or cancer prior to age 60? Yes No
 If yes, please provide details below.

Family History	LIVING		DECEASED	
	Medical Condition	Age at onset	Age / Cause of death	Age at onset
Father				
Mother				
Brother(s)				
Sister(s)				

- 15) a) Please provide the following details of your personal or attending doctor/physician.

Personal or attending Doctor's Name:			
Address:	City:	State / Prov:	Country:
Business Phone No.:		Business Fax No.:	
Reason for Consultation:		Date of Last Consultation:	
Diagnosis / Result of Visit:		Treatment / Medication Prescribed:	

- b) Please provide details of any specialist seen.

Name:		Specialty:	
Address:	City:	State / Prov:	Country:
Business Phone No.:		Business Fax No.:	
Reason for Consultation:		Date of Last Consultation:	
Diagnosis / Result of Visit:		Treatment / Medication Prescribed:	

- 16) Have you ever had or been treated for, or been told by a doctor you had:
- a) epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorder? Yes No
- b) diabetes mellitus, thyroid disorder or any other endocrine disorder? Yes No
- c) ear discharge, nose bleeds, double vision, impaired sight, hearing, speech or any other disorder of ear, eye, nose or throat? Yes No

d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorder, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) blood, protein or sugar in urine, kidney stones, infection or any other disorder of the kidney, bladder or genital organs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) slipped disc, gout, arthritis, pain or deformity or disorder of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j) cancer, tumours, cysts or growths of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k) anaemia, any other disorder of the blood, advised to abstain from donating blood or receive blood transfusion or blood products on account of haemophilia or any other reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l) any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17) In the past 5 years, have you had any test done such as X-ray, ultrasound, CT scan, biopsy, electrocardiogram (ECG), blood or urine test? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18) Have you or your spouse been told to have, received any medical advice, counseling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19) Have you ever had HIV testing done (please state reason and results); in the last 3 months ever had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20) Height <input type="text"/> m Weight <input type="text"/> kg		
21) For female insured only		
a) Have you suffered from or are you aware of any breast lumps or any other disorder of your breasts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorder of the female organs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) For females who have conceived, were there any complications during pregnancy such as gestational diabetes, hypertension, etc?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Are you now pregnant? If yes, how many months? _____ months	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If any of the answers to Question 16 – 21 is “Yes”, please number the answers to correspond to the questions & provide details below:

No.	Condition/Diagnosis	Year at onset	Tests done & results (Please state whether result is normal or abnormal)	Hospital / Clinic / Doctor consulted

AUTHORISATION AND DECLARATION BY POLICYOWNER/ASSIGNEE/TRUSTEE/BENEFICIARIES

I/We declare that:

- This Policy is not assigned to any other party.
- I/We am/are not an undischarged bankrupt(s), in winding up, receivership or judicial management. There are currently no pending bankruptcy proceedings, winding up proceedings, receivership or judicial management proceedings against me/us.
- To the best of my/our knowledge, the beneficiary(ies) is/are not an undischarged bankrupt(s), in winding up, receivership or judicial management. There are currently no bankruptcy proceedings, winding up proceedings, receivership or judicial management proceedings against him/her/them.
- I/We understand and agree that policy proceeds made payable to Trustee(s) are for the benefit of beneficiary(ies).
- I/We agree to indemnify and hold harmless the Company from and against all demands, claims, actions, damages, suits, proceedings, assessments, judgements, costs and legal and other expenses arising as a result of the Company acting in accordance with these instructions.
- I/We declare that no material facts, that is, facts likely to influence the assessment of this application for reinstatement have been withheld and to the best of my/our knowledge and belief the information given here is true and complete.
- I/We agree to inform the Company in writing of any change in health, occupation or activity of the Life Insured where such change(s) occurs between the date of this application or the medical examination and the approval of the reinstatement. On receiving the information of any change, the Company is entitled to accept or reject my application for reinstatement.
- I/We agree that the Company may enquire about and/or verify with any medical source, insurance office or organization any relevant information about me and/or the Life Insured. The Company may release any information about me to any of the aforementioned organizations in connection with this application.
- I/We have read Section 25(5) Insurance Act Cap. 142 warning stated on the front of the Application for Reinstatement form.

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1. This section is applicable for policies (including company owned policies) which are not under section 49L Insurance Act:		
Signature of Policy Owner/Assignee:	Signature of Life Insured (if different from Policy Owner/Assignee)	*Representative to sign if submission through Representative
Name:	Name:	Name:
NRIC/PP No.:	NRIC/PP No.:	Branch Code:
Contact No.:	Contact No.:	Contact No.:
Date:	Date:	Date:

2. This section is applicable for policies which are under section 49L Insurance Act:			
Signature Policy Owner:	#Signature of Trustee:	*Signature of Beneficiary/ Parent/Guardian:	*Signature of Beneficiary/ Parent/Guardian:
Name:	Name:	Name:	Name:
NRIC/PP No.:	NRIC/PP No.:	NRIC/PP No.:	NRIC/PP No.:
Contact No.:	Contact No.:	Contact No.:	Contact No.:
Date:	Date:	Date:	Date:
*Signature of Beneficiary/ Parent/Guardian:	*Signature of Beneficiary/ Parent/Guardian:	*Signature of Beneficiary/ Parent/Guardian:	*Representative to sign if submission through representative
Name:	Name:	Name:	Name:
NRIC/PP No.:	NRIC/PP No.:	NRIC/PP No.:	Branch Code:
Contact No.:	Contact No.:	Contact No.:	Contact No.:
Date:	Date:	Date:	Date:

The policy owner must get the consent of:

- (i) #any of the trustees but he/she cannot be the policy owner. If there is only 1 trustee and he/she is the policy owner, the policy owner can re-appoint another trustee using a prescribed form which can be obtained from www.manulife.com.sg, the representative or our Customer Service.; OR
- (ii) *all of the beneficiaries. Each beneficiary must be at least 18 years old. For beneficiary who is below 18 years old, the parent/guardian (who is not also the policy owner) will sign on behalf of the beneficiary. If parent/guardian signing, please submit proof of relationship.

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