# INDIVIDUAL ACTIVITIES OF DAILY LIVING (ADL) DISABILITY CLAIM FORM

Dear claimant,

We are sorry to learn about your disability.

In order for us to process your claim, we require the following:

(1) Claimant's Statement
(2) Doctor's Statement
(3) Heart Attack (Refer to Note A below)
(4) Stroke (Refer to Note B below)
(5) Declaration of Beneficial Ownership (for Trust / Keyman Policies)
(6) Consent Form For Medical Report
(7) Authorisation Form For Crediting to Singapore Bank Account
(8) Available hospital reports, laboratory and test results, diagnostic scan reports
(9) Copy of police report (if disability is due to an accident)
(10) Copy of physical NRIC of claimant
(11) Proof of relationship for 3rd party policies
(12) Reimbursement benefit, if any under the policy (Refer to Note C below)
(13) All documents which are in foreign language must be officially translated to English (translated by official Authority / Notary Public / Embassy) before submitting to us

Once we have received **all** the above required documents, we will process your claim and inform you of the outcome as soon as possible.

Note:

(A) For Heart Attack, please provide the Individual Dread Disease/Critical Illness/Terminal Illness Claim Doctor's Statement, ECG reading, Troponin reading and Cardiac Enzyme Assays.

(B) For Stroke, please provide the Individual Dread Disease/Critical Illness/Terminal Illness Claim Doctor's Statement, CT Scan and MRI Scan results.

(C) Please submit the original bills/receipts for the following benefits:
- Rehabilitation benefit
- Mobility Aids reimbursement benefit
- Transport benefit
- Home Improvement benefit

**Submission of Claim Documents**

Please submit all claim documents:

(I) Through your servicing adviser; OR

(II) By post to the below address:

Life Claims Department
Tokio Marine Life Insurance Singapore Ltd
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

(2024.03)

TOKIO MARINE
INSURANCE GROUP

# INDIVIDUAL ACTIVITIES OF DAILY LIVING DISABILITY CLAIM CLAIMANT'S STATEMENT

**IMPORTANT NOTES :**
(1) The issue of this claim form is not an admission of liability.
(2) This claim form is to be completed by the Assured.
(3) Tokio Marine Life Insurance Singapore Ltd. reserves the right to request for additional medical reports when it deems necessary.

**PART 1: DETAILS OF POLICY(IES)**

1.1 Policy No. : (a) _____ (b) _____

(c) _____ (d) _____

**PART 2: DETAILS OF ASSURED**

2.1 Name : _____
( as stated in NRIC / Passport )

2.2 NRIC / Passport No. : _____

2.3 Residence address : _____

2.4 Occupation : _____

2.5 Contact No. : _____ (H) _____ (O) _____ (HP)

**PART 3: DETAILS LIFE ASSURED [if different from Part (2)]**

3.1 Name : _____
( as stated in NRIC / Passport )

3.2 NRIC / Passport No. : _____

3.3 Residence address : _____

3.4 Contact No. : _____ (H) _____ (O) _____ (HP)

**PART 4: DETAILS OF LIFE ASSURED'S OCCUPATION**

| | | Before disability | After disability |
|---|---|---|---|
| 4.1 | Occupation : | | |
| 4.2 | Name of employer. : | | |
| 4.3 | List exact duties performed at work : | | |

Note :
(a) If the Life Assured is not working, kindly provide a list of daily activities before and after the disability.
(b) The Company reserves the right to request for supporting documentary evidence.

_____ _____

Signature of Assured Date (dd/mm/yyyy)

(2024.03)



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Singapore: 20 McCallum Street, #07-01 Tokio Marine Centre, Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com
Brunei: Unit 2, 1st Floor, Blk D, Abdul Razak Complex, Gadong, Bandar Seri Begawan BE4119, Brunei Darussalam T: (673) 02-423 755 F: (673) 02-423 754

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**PART 5: DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED**

5.1 Was the disability suffered due to? ☐ Illness ☐ Accident

(a) If it was due to an illness, please provide the following information :

(i) Please describe fully the symptoms for which the Life Assured consulted a doctor :

_____

(ii) Since when did the Life Assured have the symptoms before he / she consulted a doctor? _____ (dd/mm/yyyy)

(iii) Date when the Life Assured **first** consulted a doctor? _____ (dd/mm/yyyy)

(iv) Describe fully the extent and nature of the illness or injury :

_____

(b) If it was due to an accident, please provide the following information :

(i) Date of accident : _____ (dd/mm/yyyy) Time of accident : _____

Place of accident : _____

(ii) Describe in detail how the accident happened :

_____

_____

(iii) Please describe the nature and extent of injuries sustained :

_____

_____

(iv) Was there any eye-witness to the accident? ☐ Yes ☐ No

If **yes**, please give name(s) and address(es) of witness(es) :

| Name of Witness | Address |
|---|---|
| | |
| | |

(v) Was the accident reported to the police? ☐ Yes ☐ No

If **yes**, please give the name of the police station reported to (please enclose a copy of the police report) :

_____

_____ _____

Signature of Assured Date (dd/mm/yyyy)

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5.2 Date the Life Assured last worked prior to disability (dd/mm/yyyy): _____

5.3 Is the Life Assured currently confined to? ☐ Bed ☐ House ☐ Wheelchair ☐ Neither

5.4 Is the Life Assured able to perform without assistance on the following activities of daily living :

| | | | |
|---|---|---|---|
| (a) | Eating? | ☐ Yes | ☐ No |
| (b) | Walking? | ☐ Yes | ☐ No |
| (c) | Dressing? | ☐ Yes | ☐ No |
| (d) | Bathing? | ☐ Yes | ☐ No |
| (e) | Using the Toilet? | ☐ Yes | ☐ No |
| (f) | Getting in and out of Bed? | ☐ Yes | ☐ No |

**PART 6: DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION**

6.1 Please provide details of doctor(s) whom the Life Assured has consulted in connection to his / her illness / injury :

| Name of doctor / hospital | Address | Date of first consultation / hospitalization |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

6.2 Please provide details of the Life Assured's regular doctor(s), date and reason(s) of consultation :

| Name of doctor | Address | Date of consultation | Reason(s) of consultation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**PART 7 : OTHER INSURANCES**

7.1 Was the Life Assured insured with other insurance company(ies)? ☐ Yes ☐ No

If **yes**, please provide the following details :

| Name of insurance company | Date of issue | Sum assured | Type of plan | Claim amount | Claim notified |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

_____ _____

Signature of Assured Date (dd/mm/yyyy)

(2024.03)



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## PART 8: DECLARATION FOR COMMON REPORTING STANDARD (CRS)

8.1 Please provide information on your Tax Residency. (This will usually be where you are liable to pay income taxes.)

| | Country of Tax Residence | Taxpayer Identification Number (TIN)<br>In Singapore, TIN for Individuals would be your NRIC/FIN | If no TIN available, enter Reason A, B or C | Please state reason(s) if Reason B is selected |
|---|---|---|---|---|
| Proposer | | | | |
| | | | | |
| Joint Life Assured | | | | |
| | | | | |

If you are a tax resident in more than two countries, please use a separate Individual Tax Residency Self-certification Form.
If a Taxpayer Identification Number (TIN) is unavailable, please provide the appropriate reason A, B or C:

**Reason A** The country where you are liable to pay tax does not issue TINs to its residents.
**Reason B** You are otherwise unable to obtain a TIN or equivalent number (Please explain why you are unable to obtain a TIN in the below table if you have selected this reason).
**Reason C** No TIN is required. (Note: Only select this reason if the authorities of the country of tax residence entered below do not require a TIN to be disclosed).

For more information on Common Reporting Standard, you can refer to our company website.
(http://www.tokiomarine.com/sg/en/about-us/crs.html)

For Entity and/or Controlling Persons, please complete the Entity Tax Residency Self-Certification Form and/or Controlling Person Tax Residency Self-Certification Form (forms can be obtained from the same website). If you have any questions on how to define your tax residency status, please visit the IRAS website or speak to a professional tax adviser as we are not allowed to give tax advice.

Signature of Assured

Date (dd/mm/yyyy)

(2024.03)



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**Personal Data Notice**

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. and Tokio Marine Insurance Singapore Ltd. ("Tokio Marine Insurance Group") may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group's Data Protection Policy available at www.tokiomarine.com which I / we have read, understood and agreed to the same.

**Declaration**

I / We agree that:-

(i) all answers given by me / us in this form are, to the best of my / our knowledge and belief, true and complete;

(ii) Tokio Marine Life Insurance Singapore Ltd ("TMLS") shall not be deemed to provide cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America;

(iii) where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph (iv) below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in paragraph (ii), TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final; and

(iv) a person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries' beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/constitution/establishment, particulars and identification documents of these persons.

I / We hereby also authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by TMLS, any relevant information concerning the below-named assured, and;

(b) TMLS to release to any medical source, insurance office, or organization, any relevant information concerning the below-named assured, at any time.

A photocopy of this authorization shall have the same effect as the original.

_____ _____

Signature of Assured Date

Name(s) : _____

NRIC No(s) : _____

Address(es) : _____

(Note: Our correspondence will be sent to your policy's mailing address. If you have moved, please update your mailing address via TMLS Policyholders Portal https://mypolicy.tokiomarine-life.sg before submitting this claim.)

Email Address : _____

Contact No(s) : (HP) _____

Relationship to Life Assured : _____



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# INDIVIDUAL ACTIVITIES OF DAILY LIVING DISABILITY CLAIM DOCTOR'S STATEMENT

| **Name of Patient (as stated in NRIC / Passport)** | **NRIC/FIN or Passport No.** |
|---|---|
| | |

| **Date of your assessment on patient to complete this Form** | (DD/MM/YYYY) |
|---|---|
| | |

| **Patient's Height** (cm) | **Patient's Weight** (kg) |
|---|---|
| | |

| **Occupation and Duties before Disability** |
|---|
| |

| **A. ACTIVITIES OF DAILY LIVING** |
|---|
| 1. Based on your assessment, please tick the applicable patient's ability to perform the Activities of Daily Living (ADLs), even with the aid of special equipment. |

| **Definition of ADL** | **Extent of Dependency (pls tick the one which is applicable)** | | | | **Due to what condition(s)?** | **Since when has the patient been unable to do so? (DD/MM/YYYY)** |
|---|---|---|---|---|---|---|
| | Able to perform independently and without any assistance | Require the physical assistance of another person for up to 74% of the time | Require the physical assistance of another person for ≥ 75% of the time | Require 100% hands-on assistance of another person | | |
| **Transferring:** the ability to move from a bed to an upright chair or wheel chair and vice versa | | | | | | |
| **Mobility:** the ability to move from room to room on level surfaces | | | | | | |

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

(2024.03)



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| Definition of ADL | Extent of Dependency (pls tick the one which is applicable) | | | | Due to what condition(s)? | Since when has the patient been unable to do so? (DD/MM/YYYY) |
|---|---|---|---|---|---|---|
| | Able to perform independently and without any physical assistance from another person | Require the physical assistance of another person for up to 74% of the time | Require the physical assistance of another person for ≥ 75% of the time | Require 100% hands-on assistance of another person | | |
| **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a reasonable level of personal hygiene | | | | | | |
| **Dressing:** the ability to put on, take off, secure and unfasten all garments and as appropriate, any braces, artificial limbs or other surgical appliances | | | | | | |
| **Washing:** the ability to wash in the bath or shower (including getting into and out of the bath or shower) | | | | | | |
| **Feeding:** the ability to feed oneself once food has been prepared and made available. | | | | | | |

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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2. Is the patient confined to home, hospital or other institution requiring constant care?

☐ Confined to home

☐ Confined to hospital, name of hospital: _____

☐ Confined to other institution that provides constant care and medical attention.

Name of institution: _____

☐ Not confined to any of the above

3. Is the patient mentally incapacitated in accordance to the Mental Capacity Act?

☐ No

☐ Yes. Please provide date when mental incapacity started: _____ (DD/MM/YYYY)

**B. MEDICAL HISTORY**

1. Please provide the medical conditions which the patient has been diagnosed with.

| Medical Condition | Date of Diagnosis (DD/MM/YYYY) | Name and address of treating doctor(s) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

2. What is the source of the above information?

☐ Patient ☐ Caregiver ☐ Medical Report (please provide copy)

☐ Others (please specify) _____

3. Are you the patient's regular doctor?

☐ Yes, please state since when: _____ (DD/MM/YYYY)

☐ No, please state the name and address of the patient's regular doctor:

_____

_____ _____

Signature of Attending Doctor | Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____ Date (dd/mm/yyyy) : _____

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4. Is the disability arising caused directly or indirectly, partly or wholly by any of the following:

| | Please tick box if applicable |
|---|---|
| Self-inflicted injury, suicide or attempted suicide whether sane or insane | ☐ |
| Under the influence of alcohol or drugs, except for drugs prescribed by a Medical Practitioner for the purpose of treatment | ☐ |
| Any deliberate or intentional act of the Life Assured, or putting oneself in danger if such act could have been reasonably avoided, except in an attempt to save human life | ☐ |
| Communicable or infectious disease, congenital anomalies or physical defects (please specify) | ☐ |
| Acquired Immunodeficiency Syndrome (AIDS), AIDS related complex or infection by any Human Immunodeficiency Virus (HIV) | ☐ |
| Engaging in or taking part in air, military, naval training, exercises, manoeuvres, warlike operations or handling of explosives and demolition materials and while under orders for restoration of public order, whether in time of peace, declared or undeclared war except where operationally ready national services duties are carried out in Singapore or overseas (where applicable) pursuant to the Enlistment Act (Cap 93) | ☐ |
| Engaging in aerial activities (except as a fare-paying passenger or as a crew member in a properly licensed private and/or commercial aircraft operated by a private and/or commercial passenger airline on a regular scheduled passenger trip or established route) | ☐ |
| Engaging in a sport in a professional capacity (please specify) regardless whether the patient earn any form of income or remuneration from engaging in such sport | ☐ |
| Engaging in hazardous sport(s) (including but not limited to winter sports, ice hockey, horse riding, polo playing, canoeing, sailing or windsurfing, mountaineering, rock climbing, caving, potholing, hunting, hang gliding, sky diving, parachuting, scuba diving boxing, wrestling, martial arts activities), unless such activities are engaged on a recreational basis with a licensed organisation | ☐ |
| Any racing (other than on foot) or any accident while driving or riding on a motor race track | ☐ |
| Radiation or contamination by radioactivity. | ☐ |
| Childbirth or pregnancy, unless the disability lasts for more than 90 days after the termination of pregnancy or childbirth | ☐ |
| Any Injury which arises in the course of the patient's occupation if the patient's occupation falls within the following categories or involves the following activities: vessel workers, ship or navy crew, marine salvage crew, offshore oil rig workers, professional divers, professional sports people, cheer leaders, jockeys, stevedores, people directly involved in making or handling explosives, people who are working outdoor at heights above 15 metres | ☐ |

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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**D. HOME MODIFICATIONS**

1. Based on your assessment, does the patient require home modifications to facilitate his/her movement in and around the Home due to certain disabilities?

☐ No

☐ Yes, please complete Question 2 below.

| 2. Pls tick all the Home Modification which are Medically Necessary to facilitate his/her movement in and around the Home due to certain disabilities. | |
|---|---|
| Bath safety grip handles or grip bars | ☐ |
| Raised toilet seats | ☐ |
| Walk-in bath tubs | ☐ |
| Widening bathroom doors | ☐ |
| Repositioning existing sink in bathroom or toilet | ☐ |
| Modifying width of entrance, exits and doorways to accommodate a wheelchair | ☐ |
| Lowering locks on doors | ☐ |
| Fixing ramps for entrances, exits or doorways | ☐ |
| Fixing wall mounted rails or grab bars in the bedrooms | ☐ |
| Others. Pls specify: | ☐ |

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

(2024.03)



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# DECLARATION OF BENEFICIAL OWNERSHIP

Is there a beneficial owner in receiving this payment? ☐ Yes ☐ No

If Yes, please provide the particulars of the beneficial owner(s) to this policy and submit a copy of their NRIC / Passport (certified by your servicing adviser) to us.

Name(s) : _____

NRIC / Passport No(s) : _____

Address(es) : _____

_____

Contact No(s) : _____ (H) _____ (O) _____ (HP)

Relationship to Deceased :

Nationality: ☐ Singaporean ☐ Singaporean PR ☐ Others, please specify _____

*Note:*
Beneficial owner, in relation to a customer of a financial adviser, means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over body corporate or unincorporated.

_____
Signature of Claimant

Date : _____
**(dd/mm/yyyy)**

Name(s) : _____

NRIC No(s) : _____

Address(es) : _____

_____

Contact No(s) : (HP) _____

Relationship : _____

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# CONSENT FORM FOR MEDICAL REPORT

NAME OF PATIENT : _____

NRIC NO. : _____ POLICY NO. : _____

This consent form is required for an insurance claim.

**Authorization**

I / We hereby authorize:

(a) any medical source, insurance office, or organization to release to or when requested to do so by Tokio Marine Life Insurance Singapore Ltd. ("Company"), any relevant information concerning the above-named patient, and;

(b) the Company to release to any medical source, insurance office, or organization, any relevant information concerning the above-named patient, at any time.

A photocopy of this authorization shall have the same effect as the original.

Yours faithfully

_____

Signature of *Patient / Patient's Parent / Guardian

Name : _____

Address : _____

_____

NRIC No. : _____ Relationship to patient : _____

* If the patient is below 21 years old, this form should be signed by the patient's parent / guardian

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# AUTHORISATION FORM FOR CREDITING TO SINGAPORE BANK ACCOUNT

| | |
|---|---|
| **Policy No** | |
| **Type of Payment** | Claims |

**Please select ONE option:**

☐ **PayNow registered with Singapore NRIC/FIN**

- Please note that PayNow account registered with mobile number is not accepted.
- You may register for PayNow account using your Singapore NRIC/FIN via "Manage Paynow" in your internet banking or mobile banking application.
- If the PayNow transaction is unsuccessful, we will send you a cheque to your mailing address.

☐ **Electronic Fund Transfer to your Singapore Bank Account**

- Please attach a copy of your bank statement/passbook showing your name and bank account no. We accept bank statements with balance/transactions masked. Truncated e-statements downloaded from banks' mobile application are also acceptable as long as the document shows the account holder's name and account number on the same page.

| | |
|---|---|
| Name of Singapore Bank | |
| Account No | |
| Bank Account Holder's Name | |

**Declaration & Authorisation**

I/We Hereby Authorise Tokio Marine Life Insurance Singapore Ltd to Credit The Amounts Due To Me/Us To The Above Requested Paynow/Bank Account, Where Applicable. Amounts so credited would constitute valid discharge of above payment due to me/us.

**I/We understand and agree that:**

a) Where I/we are eligible to receive payments from Tokio Marine Life Singapore Ltd ("TMLS") for policy proceeds ("Payment") as determined by TMLS, the Payment will either be credited to my/our bank account linked to my/our Singapore NRIC/FIN, which I/we have registered with a bank for PayNow or bank transfer (depending on option chosen above). For avoidance of doubt, Payment is not applicable to PayNow linked to your mobile or company UEN.

b) By completing this form, I/we declare it is my/our responsibility to ensure that all information submitted herein is correct and complete to the best of my/our knowledge. TMLS is not obliged to ensure that all information provided by me/us herein is accurate or that it remains true and accurate at the time of processing the Payment.

c) PayNow or the bank transfer service is not operated by TMLS and my/our access to and use of PayNow or for a bank transfer is subject to the availability of PayNow and their services and that of my/our bank for the bank transfer. TMLS does not warrant my/our use of PayNow or for a bank transfer and the use is subject to the relevant terms and conditions of PayNow and/or my/our bank.

d) I/we shall indemnify TMLS against all costs, damages and/or losses arising from or in connection with any breach by me/us of these terms or the terms and conditions imposed by my/our bank in relation to a bank transfer, or PayNow, or their service provider, my/our bank.



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e) TMLS shall bear no liability to me/us or any other party in the event the Payment is not made into my/our bank account otherwise, or the Payment being late, unsuccessful, or incomplete, or the suspension, termination, or discontinuance of PayNow or their services.

f) TMLS has the sole discretion to make Payment using any other method as it deems fit and TMLS shall be entitled to terminate or suspend the Payment of your policy proceeds to me/us, and/or to add to, delete, or change the terms herein at any time without notice, without liability to me/us.

g) TMLS shall not be deemed to provide cover and neither should TMLS be liable to pay any claim, provide any benefit under the Policy/relevant Policy or be required to process any request made to the extent that the provision of such cover, payment of such claim, provision of such benefit or processing of such request would expose TMLS (or its parent company or holding company (in both instances, whether direct or indirect) or the subsidiaries of its parent or holding company) to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the applicable jurisdiction, Singapore, the European Union, United Kingdom or United States of America.

h) Where TMLS becomes aware that I/We, the Life Assured or any person or entity connected with the Policy/relevant Policy (see paragraph below) is/are subject to any sanction, prohibition or restriction under such resolutions, trade or economic sanctions, laws or regulations mentioned in the paragraph above, TMLS shall be entitled to block, suspend and/or terminate the Policy/relevant Policy at any time including but not limited to, not making or receiving any payments under the Policy/relevant Policy. The decision of TMLS on the aforementioned is final.

i) A person or entity connected with the Policy/relevant Policy includes an assignee, a beneficiary, a trustee, an executor, an administrator, a director or direct/indirect shareholder or person having executive authority or natural persons appointed to act on my/our behalf, for my/our beneficial owners or beneficiaries' beneficial owners. As an ongoing obligation, I/We will immediately inform TMLS if there are any changes to the identities, status/ constitution/ establishment, particulars, and identification documents of these persons.

j) A person who is not a party to this agreement shall have no right under the Contracts (Rights of Third Parties) Act 2001 to enforce any of these terms.

k) These terms shall be governed by the laws of Singapore and the exclusive jurisdiction of the Courts of Singapore.

**Personal Data Notice**

I / We agree and consent that Tokio Marine Life Insurance Singapore Ltd. may collect, use, process and disclose the personal data in accordance with the terms and conditions as stated in the insurance application form and/or the Tokio Marine Insurance Group's Data Protection Policy available www.tokiomarine.com which I / we have read, understood and agreed to the same.

_____ _____

Signature of Assured Date

Name: _____ NRIC No: _____

Email: _____ Mobile No: _____



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