INDIVIDUAL JUVENILE CONDITION CLAIM FORM

Dear claimant,

We are sorry to learn about your illness.

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

(1) Claimant's Statement
(2) Doctor's Statement (medical fee to be borne by policyholder)
(3) Declaration of Beneficial Ownership (for Trust / Keyman Policy)
(4) Authorization Form For Medical Report
(5) Copy of physical NRIC of claimant and life assured
(6) Proof of relationship for 3rd party policies
(7) Available laboratory and test results
(8) Documents which are in foreign language must be officially translated to English (translated by official Authority / Notary Public / Embassy) before submitting to us
(9) Documents extracted from overseas must be certified true copy by Notary Public
(10) Documents signed overseas must be submitted to us in originals

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

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 Pte. Ltd.
20 McCallum Street
#07-01 Tokio Marine Centre
Singapore 069046

(2025.10)

TOKIO MARINE
INSURANCE GROUP

INDIVIDUAL JUVENILE CONDITION
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 Pte. Ltd. reserves the right to request for additional medical reports when it deems necessary.

CLAIMANT'S STATEMENT : TO BE COMPLETED BY ASSURED

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 : _____

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 Occupation : _____

3.5 Contact no. : _____ (H) _____ (O) _____ (HP)

PART 4 : DETAILS OF ILLNESS(ES) / MEDICAL CONDITION(S) OF LIFE ASSURED

4.1 Describe fully the symptoms experienced for which the Life Assured consulted a doctor :

_____

4.2 When did the symptoms first appear before the Life Assured consulted a doctor?

_____
(dd/mm/yyyy)

4.3 Date when the Life Assured **first** consulted a doctor for the above symptoms :

_____
(dd/mm/yyyy)

_____ _____
Signature of Assured Date (dd/mm/yyyy)

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4.4 If consultation was for illness, describe fully the nature and extent of the Life Assured's Illness :

4.5 If consultation was due to an accident, describe fully the nature of the Life Assured's injuries and how it happened :

4.6 Has the Life Assured previously suffered from or received treatment for a similar / related illness? ☐ Yes ☐ No
If **yes**, please provide details :

PART 5 : DETAILS OF MEDICAL CONSULTATIONS / HOSPITALISATION

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

Name of doctor / hospital	Address	Date of first consultation / hospitalisation

5.2 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

Signature of Assured

Date (dd/mm/yyyy)

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PART 6 : OTHERS

6.1 Has any of the Life Assured's family members suffered from a similar / related illness? ☐ Yes ☐ No

Relationship	Nature of illness	Date of diagnosis (dd/mm/yyyy)

6.2 Does the Life Assured smoke cigarette? ☐ Yes ☐ No

If **yes**, what is the Life Assured's daily consumption? _____ Sticks

How long has the Life Assured been smoking? _____ years _____ months

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

Signature of Assured

Date (dd/mm/yyyy)

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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) 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)

(2023.05)

Tokio Marine Life Insurance Singapore Ltd. (Company Reg. No.: 194800055D)
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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Personal Data Notice

I / We agree and consent that Tokio Marine Life Insurance Singapore Pte. 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 Pte. 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 JUVENILE CONDITION
DOCTOR'S STATEMENT

Name of Patient : _____ **NRIC / Passport No :** _____
(as stated in NRIC / Passport)

INSTRUCTIONS: Please tick [✓] in the appropriate box and complete the relevant sections in respect to the illness claimed. Please submit ONLY the relevant sections to us upon completion.

	Sections to be completed		Sections to be completed
• Glomerulonephritis with Nephritic Syndrome	☐ 1 & 9	• Rheumatic Fever with Valvular Impairment	☐ 1 & 6
• Insulin Dependent Diabetes Mellitus	☐ 1 & 2	• Severe Haemophilia	☐ 1 & 5
• Kawasaki Disease	☐ 1 & 3	• Severe Juvenile Rheumatoid Arthritis	☐ 1 & 7
• Osteogenesis Imperfecta	☐ 1 & 4	• Leukaemia	☐ 1 & 11
• Rabies	☐ 1 & 10	• Severe Asthma	☐ 1 & 12
• Type 1 Juvenile Spinal Amyotrophy	☐ 1 & 8	• Autism of Specified Severity	☐ 1 & 13

Please enclose copies of Histopathology / Biopsy Report, Echocardiograph Report and all laboratory and Test results, etc and any relevant hospital reports that are available.

_____ Signature of Attending Doctor

Name & Qualification : _____

_____ Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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SECTION 1 : GENERAL INFORMATION

a Are you the patient's regular doctor? ☐ Yes ☐ No
If **Yes**, since : _____ (dd/mm/yyyy)

If **No**, kindly provide the Name and Address of the patient's regular doctor (if known to you):

b When did patient first consult you for this illness? _____ (dd/mm/yyyy)

c Please state symptoms presented and the date symptoms first appeared as follows :

Symptoms Presented	Date symptoms first started (dd/mm/yyyy)	Duration of symptoms

d Please provide full and exact details of the diagnosis and its clinical basis.

e What is the date of diagnosis? _____ (dd/mm/yyyy)

f What is the date when diagnosis was first made known to the patient? _____ (dd/mm/yyyy)

g Has the patient previously suffered from the condition described above or any related illness? ☐ Yes ☐ No
If **Yes**, kindly provide the details below:

Illness	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

h Is there anything in the patient's personal medical history or family history which would have increased the risk of the above illness? If yes, please give full details including the date of diagnosis and name & address of attending doctor. ☐ Yes ☐ No

i Is the patient suffering from other significant illness(es) / condition(s)? ☐ Yes ☐ No
If **Yes**, kindly provide the details below:

Illness	Date of First Diagnosis (dd/mm/yyyy)	Name and Address of Attending Doctor

j Please give details of the patient's past and present smoking habits, including the duration and number of cigarettes smoked per day.

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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SECTION 2 : INSULIN DEPENDENT DIABETES MELLITUS

a Please provide a description of the extent of the illness.

b Does the illness involve the followings:

(i) Insulin therapy and dietary regulation ☐ Yes ☐ No

(ii) dependency on insulin therapy has persisted for more than 6 months ☐ Yes ☐ No

c Please provide the results of investigations done (if any)

SECTION 3 : KAWASAKI DISEASE

a Please provide a description of the extent of the illness.

b Is there any evidence of cardiac involvement manifested by dilation or aneurysm formation of at least 5mm in the coronary arteries which persists for 12 months after the initial acute episode? ☐ Yes ☐ No

c Please provide the results of investigations done including echocardiograph report (if any)

SECTION 4 : OSTEOGENESIS IMPERFECTA

a Please provide the exact diagnosis and a description of the extent of the illness.

b Does the illness involve the followings:

(i) growth retardation and hearing impairment ☐ Yes ☐ No

(ii) multiple fracture of bones and progressive kyphoscoliosis ☐ Yes ☐ No

(iii) positive result of skin biopsy ☐ Yes ☐ No

c Please provide the results of investigations done including the result of physical examination, result of x-ray and biopsy report (if any)

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

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SECTION 5 : SEVERE HAEMOPHILIA

a Please provide the exact diagnosis and a description of the extent of the illness.

b Does the illness involve the followings:

(i) spontaneous haemorrhage ☐ Yes ☐ No

(ii) clotting factor VIII or factor IX of less than one (1) percent ☐ Yes ☐ No

c Please provide the results of investigations done (if any)

SECTION 6 : RHEUMATIC FEVER WITH VALVULAR IMPAIRMENT

a Please provide a description of the extent of the illness

b Does the illness involve the followings:

(i) one or more heart valves with at least mild valve incompetence attributable to rheumatic fever ☐ Yes ☐ No

(ii) the valve incompetence has persisted for at least six (6) months ☐ Yes ☐ No

c Please provide the results of investigations done (if any)

SECTION 7 : SEVERE JUVENILE RHEUMATOID ARTHRITIS

a Please provide a description of the extent of the illness including details of any cardinal manifestations

b Is there documentation of the condition for at least 6 months? ☐ Yes ☐ No

c Please provide the results of investigations done including the 6 months' period of documentation (if any)

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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SECTION 8 : TYPE 1 JUVENILE SPINAL AMYOTROPHY

a Please provide a description of the extent of the illness

b Is there progressive dysfunction of the anterior horn cells in the spinal cord and brainstem cranial nerves with profound weakness and bulbar dysfunction? ☐ Yes ☐ No

c Please provide the results of investigations done including electromyography and muscle biopsy report (if any)

SECTION 9 : GLOMERULONEPHRITIS WITH NEPHRITIC SYNDROME

a Please provide a description of the extent of the illness

b Does the illness involve the followings:

(i) a treatment regimen appropriate to the clinical presentation has been followed throughout the period to which syndrome relates? ☐ Yes ☐ No

(ii) the syndrome has continued for a period of at least six (6) months with or without intervening periods of remission? ☐ Yes ☐ No

c Please provide the results of investigations done (if any)

SECTION 10 : RABIES

a Is the disease transmitted to the patient though a bite of an infected animal? ☐ Yes ☐ No

If yes, please provide details:

b Is there any evidence of the followings:

(i) typical symptoms of difficulty in swallowing, excessive salivation, fear of water (hydrophobia) and hallucinations ☐ Yes ☐ No

(ii) presence of rabies virus antigen or rabies-neutralizing antibody titer in the CSF ☐ Yes ☐ No

c Please provide the results of investigations done (if any)

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

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SECTION 11 : LEUKAEMIA

a Please provide the histological diagnosis and a description of the extent of the illness.

b

(i)	Is this condition pre-malignant or borderline cancer?	☐	Yes	☐	No
(ii)	Is this condition Chronic Lymphocytic Leukaemia less than RAI stage 3?	☐	Yes	☐	No
(iii)	Is this condition in the presence of HIV infection?	☐	Yes	☐	No
(iv)	Is this condition another type of cancer of blood cells?	☐	Yes	☐	No
(v)	Is this condition a myeloproliferative or myelodysplastic disorder?	☐	Yes	☐	No

c Please provide details of treatment administered (e.g. surgery, chemotherapy, radiotherapy etc)

d Will the patient be undergoing a bone marrow transplant? ☐ Yes ☐ No

If yes, please provide the following:

(i) Who is the donor?

(ii) When will the transplantation be performed?

_____ (dd/mm/yyyy)

e Has the patient or parent(s) or sibling(s) ever suffered from cancer, malignant, pre-malignant or other related conditions or risk factors? ☐ Yes ☐ No

If yes, please provide full details with dates of consultation and the resulting diagnosis

SECTION 12 : SEVERE ASTHMA

a Please provide a description of the extent of the illness

b Was hospitalization required? ☐ Yes ☐ No

If yes, when was patient admitted and discharged from hospital?

Date of Admission: _____ Date of Discharge: _____

c Was there evidence of an acute attack of severe asthma with persistent status asthmaticus requiring endotracheal intubation and mechanical ventilation for a continuous period of at least 4 hours? ☐ Yes ☐ No

If yes, please specify the date(s)

d Has the patient or parent(s) or sibling(s) ever suffered from asthma or other related conditions or risk factors? ☐ Yes ☐ No

If yes, please provide full details with dates of consultation and the resulting diagnosis

Signature of Attending Doctor

Address and Official Stamp of Hospital / Clinic

Name & Qualification : _____

Date (dd/mm/yyyy) : _____

(2025.10)

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SECTION 13 : AUTISM OF SPECIFIED SEVERITY

a Please provide a description of the extent of the illness

b What was the exact date of diagnosis?

(dd/mm/yyyy)

c Was there persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following:

(i)	Severe deficits in verbal and nonverbal social communication skills causing severe impairments in functioning, very limited initiation of social interactions and minimal response to social overtures from others?	☐ Yes	☐ No
(ii)	Restricted, repetitive patterns of behavior, interests, or activities such as inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfering with functioning in all spheres?	☐ Yes	☐ No
(iii)	Great distress/difficulty changing focus or action?	☐ Yes	☐ No
(iv)	Symptoms causing clinically significant impairment in social, occupational or other important areas of current functioning?	☐ Yes	☐ No

d When was the initial symptom(s) first presented?

(dd/mm/yyyy)

e Please provide details of the symptom(s) presented

f Was there unequivocal evidence of autism of specified severity level 3 based on Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lasting without interruption for a period of at least 6 months? ☐ Yes ☐ No

g Was there at least 2 different assessment performed 6 months apart? ☐ Yes ☐ No

If yes, please provide the dates of assessment:

h Is the child undergoing:

(i)	Behavioral therapy?	☐ Yes	☐ No
(ii)	Psychological interventions?	☐ Yes	☐ No
(iii)	Special education at a recognized institute?	☐ Yes	☐ No

Signature of Attending Doctor

Name & Qualification : _____

Address and Official Stamp of Hospital / Clinic

Date (dd/mm/yyyy) : _____

(2025.10)

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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 ☐ Singapore 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 : _____

(2025.10)

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AUTHORIZATION 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 Pte. Ltd. ("Company"), any relevant information concerning the above-named patient, and;

(b) the Company 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

(2025.10)

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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 Pte. 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 Pte. 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.

(2025.10)

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20 McCallum Street #07-01 Tokio Marine Centre Singapore 069046 T: (65) 6592 6100 F: (65) 6223 9120 W: tokiomarine.com

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 Pte. 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: _____

(2025.10)

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