FWD insurance

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FWD Big 3 Critical Illness insurance
Policy contract

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +65 6820 8888

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About your policy

Thank you for choosing FWD Singapore Pte. Ltd. We're pleased to protect you so that you can focus on living life to the fullest.

Your FWD Big 3 Critical Illness insurance policy

This is a non-participating critical illness plan offered by FWD Singapore Pte. Ltd. ("FWD").

> 'Non-participating' means the person insured does not participate in the insurance company's business. This means that you will not receive any bonuses or dividends which we may declare.

This is not a savings or investment product

Your FWD Big 3 Critical Illness insurance policy is not a savings or investment product. We will not pay any money under this policy other than for the big 3 benefit or death benefit.

Your FWD Big 3 Critical Illness insurance policy is an insurance contract between you and us. Your policy pack is made up of the documents listed below.

- This policy contract,
- The policy schedule,
- Your application form and any documents you provided with it, and
- Any endorsement to your policy, if applicable.

By reading your policy contract carefully, you'll know exactly what you're covered for, and how to make a claim.

> A policy endorsement is the document we provide that records any official change to your policy.

Easy to read

We're here to change the way you feel about insurance – starting with this document. We've made it easy to read, so you can understand your benefits and what you're covered for.

> We highlight important information like this. Read these carefully.

Words with special meaning

Some words in this policy contract have special meaning. We show those meanings on page 14 (important words and phrases). Please refer to this section when you need to.

- Age
- Application form
- Cancer
- Coverage start date
- Coverage end date
- Endorsement
- Heart attack of specified severity
- Medical practitioner
- Period of insurance
- Policy
- Policy issue date
- Premium
- Policy illustration
- Policy schedule
- Stroke with permanent neurological deficit
- We, our, FWD, us
- You, your, yourself, Person insured

Policy information statement

Paying your premium

In return for paying your premiums, we provide the cover you have chosen.

For details about how to pay your premiums, and what happens if you don't pay, see page 11 (your premiums).

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

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

Choosing who receives the benefits

Big 3 benefit

This benefit will be paid to you in a lump sum equivalent to 100% of the sum insured for the big 3 benefit or the total premiums paid, whichever is higher, as stated in your policy schedule.

Death benefit

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

Any amount due to us under this policy will be deducted from any benefit that becomes payable within the grace period.

When insurance cover begins

This is a one-year policy, providing insurance cover for the period of insurance. This policy starts on the coverage start date as shown in the policy schedule or on the date we receive the first premium, whichever is later.

Renewal

We will automatically renew this policy by one more year at the end of the period of insurance, until you reach 85 years old, if this policy is valid at the end of the period of insurance.

The premium we charge you for the subsequent year(s) will be the same as the premium that we charge other people who have the same age, gender, sum insured and smoking status as yourself on the day this policy is renewed. We will not take into account any changes in your health, but any conditions we imposed when we first issued this policy will apply to your policy.

You can choose not to renew this policy by writing to us 30 days before the end of the period of insurance.

Nomination

You can choose one nominee or more to receive the death benefit. See page 8 (the main people under your policy) for more details on your different choices.

Exclusions and conditions

This policy has certain exclusions, meaning situations where we won't pay a benefit. The specific and general exclusions and/or conditions are set out throughout this policy.

Surrender values

If you surrender (cancel) your policy, you:

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

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

14-day free-look period

If you aren't completely satisfied with your policy, and you haven't made a claim under it, you have 14 calendar days from the date you receive your policy to cancel it and receive your premiums back after deducting any fees we have paid and/or expenses incurred (if any). We consider this policy delivered from the time we email it to You.

What you need to do

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

What we will do

After receiving your notice, we will refund you any premiums paid after deducting any fees we have paid and/or expenses incurred (if any). Thereafter, we will cancel your policy, and you will not be able to claim any benefits under it.

You cannot cancel your policy if you have made a claim under your policy during the 14-day free-look period.

Tell us about any changes

You should tell us about any important changes to your personal details (address or contact number) or if you want to change who will receive the death benefit.

How to contact us if you have any questions or to make a claim

Call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)) if you have any questions about your policy, or if you need to make a claim. See page 9 (how to notify us of a claim) for more details on making a claim.

How to resolve a concern or complaint

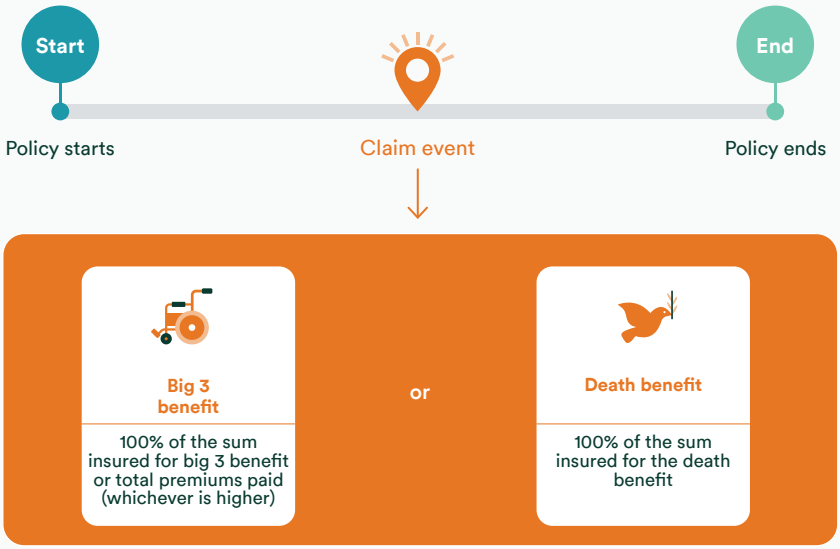
We want to resolve any concerns or complaints you may have as quickly as possible. You should follow the steps below to resolve your concerns.

Step 1 Talk to us	The first thing you should do is talk to one of our consultants about your concerns or complaints. Call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)). The consultant may be able to resolve your concerns or complaints. If not, they may refer you to a manager. The consultant will try to resolve your complaints or concerns as soon as possible.
Step 2 Call or write to our Customer Engagement Department	If you feel that your complaint has not been resolved, you can write to **FWD Singapore Pte. Ltd.** **6 Temasek Boulevard,** **#18-01 Suntec Tower Four,** **Singapore 038986** **Tel: +65 6820 8888** **E-mail: contact.sg@fwd.com** **Website: www.fwd.com.sg** We will respond to your complaint within 3 working days of us receiving it.
Step 3 Seek an external review from the Financial Industry Dispute Resolution Centre (FIDReC)	If we cannot arrive at a mutual agreement, you may approach the FIDReC, a free, independent and fair dispute resolution centre for resolution of disputes between financial institutions and consumers. You can lodge your concerns or complaints by post, online, or in-person. The FIDReC's details are: **Financial Industry Dispute Resolution Centre** **36 Robinson Road** **#15-01 City House** **Singapore 068877** **Tel: +65 6327 8878** **Email: info@fidrec.com.sg** **Website: www.fidrec.com.sg** You need to remember to quote your policy number in any communication with us or with FIDReC.

Quick summary of your benefits

This section describes the main benefits of your policy. It is a guide to your policy coverage. To understand the full details about what we pay and how we pay it, you should go to page 5 (what you're covered for).

Your benefits at a glance



What you're covered for

In this section, we explain what benefits you are covered for, and any specific exclusions or conditions that apply to those benefits. General exclusions may also apply.

Summary of your policy benefits

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

Big 3 benefit

If during the time this policy is in force and after the waiting period:

- you experience symptoms that may be related to cancer, heart attack of specified severity or stroke with permanent neurological deficit; and
- a medical practitioner subsequently confirms that you suffer from cancer, heart attack of specified severity or stroke with permanent neurological deficit,

we will pay the big 3 benefit equivalent to 100% of the sum insured for the big 3 benefit or the total premiums paid, whichever is higher, as stated in the policy schedule. The policy will end after this benefit is paid.

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

When we won't pay

We won't pay the big 3 benefit if any of the following happens:

- Your policy has ended. See page 7 (when your policy ends).
- We have already paid the death benefit.
- An exclusion applies. See page 9 (when we will not pay any benefit).

Death benefit

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

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

When we won't pay

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

- Your policy has ended. See page 7 (when your policy ends).
- We have already paid the big 3 benefit.
- An exclusion applies. See page 9 (when we will not pay any benefit).

Starting, changing or ending your policy

This section explains when your policy starts and ends, and how to make changes to your policy. We also outline when you can reinstate your policy after it has ended.

When your policy starts

Your cover starts on the coverage start date shown in your policy schedule.

> You are not covered before the coverage start date.

Your policy anniversary

When we refer to a policy anniversary, we mean the same date and month as the coverage start date, in the next year (i.e. counted 12 months from the coverage start date).

Changes to your policy

You can ask us to make the following changes to your policy, and we will make the changes by providing an official written change confirmation (called an endorsement).

We are not bound by any change until we have issued such written confirmation.

Changing your address, contact details or who will receive the death benefit

You can change your address, contact details, or who you have chosen to receive the death benefit.

It is important that you tell us immediately about any of these changes, so that you keep enjoying the benefits of your policy cover.

What you need to do

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

What we will do

- Review your request.
- Make the change, and tell you in writing, along with the date the change will take effect from.

Changing your premium payment method or frequency

You can change:

- how often you pay your premiums (your premium payment frequency); or
- the method of paying your premiums, by telling us in writing.

What you need to do

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

What we will do

- Review your request.
- Make the change, and tell you in writing, along with the date the change will take effect from.

Changing your nominees

You may nominate one or more persons to receive the death benefit under your policy. See page 8 (the main people under your policy) for more details on your different choices.

Cancelling your policy

You can cancel (terminate) your policy at any time. If you choose to cancel your policy early and you have paid your premiums, your policy will continue to provide coverage up to the next date in which your premium is due. Your cover will end on the day before the next due date for the premium payment.

After you inform us to cancel your policy, we will not charge you any further for the premiums due.

What you need to do

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

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

What we will do

- Review your request and cancel your policy.
- We will write to you to confirm the cancellation.

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

No reinstatement after cancelling

You will not be able to reinstate (restart) your policy if the policy has been terminated due to a non-payment of premiums. If you wish to continue to receive coverage, you may purchase a new policy, subject to the availability of this product.

When your policy ends

Your policy ends on the earliest of the following dates:

- When we have paid the big 3 benefit or death benefit in full under this policy;
- This policy has reached the coverage end date and is not renewed;
- We do not receive the premium within the 62-day grace period;
- When we receive your notice in writing to terminate your policy; or
- Any other event that leads to a termination, as stated in this policy, such as providing inaccurate information, submitting a fraudulent claim, or if we are required to do so under the laws or regulations of Singapore.

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

The main people under your policy

This section explains who the main people under your policy are, what rights they have, and how they are treated.

Person insured

This is the person insured under your policy. A person insured (other than the policy owner) cannot make changes to your policy.

Policy owner

The policy owner (or policyholder) owns the policy. Details of the policy owner are shown in the policy schedule or any endorsement. The policy owner is the only person who may make changes to or enforce any rights under this policy.

Under FWD Big 3 Critical Illness insurance, you are the policy owner and person insured, unless there were changes made to your policy through an assignment of benefits. See page 8 (assignment of benefits).

You may choose a person to receive the benefits payable upon death under this policy.

Age requirements for policy owner and person insured

Age requirements apply for the policy owner and person insured, which are shown in the following table.

Policy owner / Person insured	
Minimum age when you can apply	Must be at least 18 years old.
Maximum age when you can apply	Must be younger than 65 years old.

Nominees

Nomination of beneficiaries

If you (policy owner) are also the person insured under this policy, you can choose to nominate another person (or people) to receive the death benefit under this policy, and you can decide how much of the death benefit each nominee will receive.

Trust or revocable nomination

You have a choice of either a trust nomination or a revocable nomination under the Insurance Act. Depending on your choice, the nominees may have certain rights under the policy.

For a trust nomination, you will lose all rights to the ownership of the policy. You can only revoke a trust nomination if all nominees consent to the change.

For a revocable nomination, you are free to change, add or remove nominees at any time without their consent.

To make a trust or revocable nomination under this policy, you will have to complete the required form and pass it to us.

You should regularly check if your nominees are still appropriate.

Changing your nominees

Only you (the policy owner) can change the nominees. However, depending on the type of nomination you have selected, the nominees may need to consent to the change.

Assignment of benefits

You can transfer the benefits under your policy to someone else, through an assignment. For us to record this assignment of benefits, you need to provide us the completed required form and necessary documents. We will not be responsible for checking the validity of the assignment.

Making a claim

Need to make a claim? Read this section to find out what you need to do

How to notify us of a claim

You can notify us of a claim online by visiting our website or by contacting our hotline at +65 6820 8888 (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)) and we'll be pleased to assist you.

Tell us as soon as possible

We should be informed as soon as possible if a claim is to be made under this policy.

To make sure we are able to assess claims quickly, we ask that you or the nominee(s) let us know that a claim will be made under the policy and by whom. Claim forms do not have to be sent at this time.

We're here for you

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

Filling-in your claim form

We will provide the relevant claim forms that need to be filled in to make a claim. Claims must be made on forms provided by us together with the supporting documents and any other information and documents that we ask for. We will not be able to process a claim until we receive all documents, information, and the completed claim form.

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

When we will not pay any benefit

This policy has certain exclusions, meaning situations where we won't pay a benefit under your policy. We list below the exclusions that apply to all benefits under your policy.

We may also apply specific exclusions to your policy when we offer to issue your policy. If any specific exclusion applies to certain benefits, we will record the details in a policy endorsement.

Suicide or self-inflicted act	We will not pay any benefit under this policy if the claim arises: ▪ from suicide, attempted suicide or an intentional self-inflicted act; and ▪ is within one year of the start of your policy cover. This applies regardless of the mental state of the person insured. If this happens, the policy will be cancelled.
Unlawful acts	We will not pay any benefit under this policy if the claim arises because you or the person insured deliberately participated in an unlawful act or failed to act in accordance with the law.

We also won't pay the big 3 benefit under your policy if either of the following exclusions apply.

Pre-existing condition	We will not pay the big 3 benefit for claims that are directly or indirectly caused by, or result from a pre-existing condition. A "pre-existing condition" refers to a medical condition that has one or more of the following characteristics on or prior to the policy issue date: ▪ presented signs or symptoms which you were aware of or should reasonably have been aware of; ▪ treatment was recommended or received from a medical practitioner for the medical condition; or ▪ you have undergone medical tests or investigations.
Waiting period	If you experience first symptoms of cancer, heart attack of specified severity or stroke with permanent neurological deficit within the first 90 days from the policy issue date or date of endorsement, whichever is later, we will not pay the big 3 benefit.

We check the age and gender before paying

We will not pay any benefits under your policy until we have checked that the age and gender of the person insured matches the information we have been given by you.

Costs of preparing claims

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

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

Who do we pay your claim to?

We pay the big 3 benefit to you.

We pay the death benefit to the nominees.

Your premiums

This section explains your premiums and what happens when you miss paying a premium.

Paying your premium

It is important to pay your premiums on time, so your policy stays active and the person insured continues to be covered. Below we outline how you can pay your premiums and what happens if you don't pay on time.

Amount

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

Any amount due to us under this policy will be deducted from any benefit that becomes payable within the grace period.

Payment frequency options

You have the following payment frequency options.

- Annually in one lump sum.
- By monthly instalments.

You can change your chosen method any time. See page 6 (changing your premium payment method or frequency) for how.

Payment method options

You can pay using any of the following options.

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

Premium rates upon renewal of the policy are not guaranteed

The premiums that you pay for this policy are guaranteed during the period of insurance. However, at the policy renewal date, we reserve the rights to adjust subsequent premium(s) which may differ from the illustration in your policy illustration. We will let you know 30 days in advance if your subsequent premiums are revised.

What happens if you don't pay on time

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

First premium	Your first premium is due on the coverage start date.
Annual or monthly premiums	Due at the frequency you choose. You need to keep paying your premiums until the coverage end date as shown in the policy schedule.
If you miss your premium payment	We give you a 62-day grace period after the due date to pay your premium. Your policy ends from the date the premium was due if we do not receive your premium within this period.

Keeping it legal

In this section, we explain the important legal rights and obligations under your policy.

Governing law

Your policy is an insurance contract between you and us and is governed by the laws of the Republic of Singapore. If there is any dispute or disagreement relating to this policy, we and you agree to submit to the exclusive jurisdiction of the Singapore courts.

Changes to your policy to comply with the law

We have the power to make any changes to your policy required to comply with any law (not just Singapore laws). If we need to make a change, we will write to you 30 days in advance.

We rely on your information

Read all parts of your policy to make sure they are correct

This policy is issued based on the information you gave us during the application process. It is important that the information is correct, and you were truthful and accurate with all of the information you provided. This information helped us to decide if you were eligible for the policy, and how much you need to pay.

The law as per Section 25(5) of the Insurance Act requires that we inform you of your duty to fully and faithfully tell us everything you know or could reasonably be expected to know that is relevant to our decision to insure you. Otherwise, we have the right to either decline your claims or terminate this policy and treat it as never having existed. In the event that we decide to maintain your cover, we may charge an additional premium.

You should let us know immediately if the information you gave us during the application, was inaccurate, misleading, or exaggerated. You should also let us know immediately if the information you have given us changes after your policy is active.

Change in residential address:
You must inform us within 60 days if you change your residential address

You need to provide correct and complete information

You and the person insured are responsible for:

- Letting us have the correct and complete information.
- Being careful when answering our questions, or when you or the person insured confirm or amend any information you have given to us.

If you don't, we may not pay your claim, and your benefits under your policy may be affected. In some cases, we may cancel the policy. See page 13 (disputing payments) for more details.

If we were given the wrong age and gender

If we discover that we were given the wrong age or gender, we may adjust the amount of the benefit or premiums to reflect what the benefit or premiums should have been if we were provided with the correct age or gender in the first place.

If we would not have issued this policy if we had known the correct age, gender or any other details, we can declare your policy void. If we do, we will cancel your policy and treat it as never having existed. We will refund any premiums paid without interest, after deducting any benefits we have paid.

If you need to change your information, or if you have any questions, please call our hotline at **+65 6820 8888** (9am to 10pm – Monday to Friday, 9am to 1pm – Saturday (excluding public holidays)).

Disputing payments

We can declare your policy void if you or the person insured:

- made an inaccurate or untrue statement on a material matter; or
- suppressed or omitted a material fact,

within your application.

How we define material matters and facts

A material matter or material fact is one that would have caused us to:

- refuse to issue the policy to you; or
- offer you a policy on different terms,

if you or the person insured had told us about it.

Unless there is fraud, we will not declare your policy void 2 years after the policy issue date.

However, we may not pay a claim if you or the person insured:

- did not provide accurate and truthful information;
- gave us misleading or exaggerated information; or
- made any false statements,

at the time of purchase of this policy.

What we will do

- If we dispute your policy, we will review your policy and decide if we have any reason to declare it void. If we do, we will cancel it and treat it as never having existed.
- We will refund the premiums paid without interest, after deducting any amounts owed. If a benefit has been paid, we will recover that benefit.

Anti-Money Laundering, Anti-Terrorism Financing and proceeds of unlawful activities

We may need to freeze or seize any monies received or payable under your policy:

- at the order of the relevant authorities; or
- if we discover, or if we have reasonable suspicion that you are sanctioned under any competent authorities recognised by us, for money laundering activities or activities relating to financing terrorism.

If this happens, we will end your policy and the cover under it immediately. We will deal with all premiums paid and all amounts payable under your policy in any manner we deem fit, which may include handing it over to the relevant authorities.

Policy owners' protection scheme

This policy is protected under the Policy Owners' Protection Scheme, which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is needed from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us or visit the Life Insurance Association or SDIC websites (www.lia.org.sg) or (www.sdic.org.sg)

Third Party's Rights

Unless it is clearly stated in this policy contract, no one other than you (as the policy owner) can enforce or rely on any terms in this policy or have any rights under the Contracts (Rights of Third Parties) Act (Cap. 53B).

Important words and phrases

The list below explains the meanings of important words and phrases shown in your policy.

Age	Refers to age last birthday.
Application form	Refers to the information you or the person insured (or both) provided to us when applying for this policy. Our decision to issue this policy is based on the information in the application form.
Cancer	Means a malignant tumour characterised by the uncontrolled growth of malignant cells and the invasion of tissue. It includes carcinoma-in-situ, a focal autonomous new growth of carcinomatous cells which have not yet infiltrated normal tissue beyond the epithelial basement membrane. The malignant tumour must be investigated and diagnosed with support by a histopathological biopsy report and confirmed by a medical practitioner. For carcinoma-in-situ of cervix uteri, it must be at a grading of CIN III. We do not cover all neoplasms or tumours which are classified as pre-malignant, having borderline malignancy, having any degree of malignant potential, having suspicious malignancy or of uncertain or unknown behaviour.
Coverage start date	Refers to the date the first premium is due, and the date cover starts under your policy. This date is shown in your policy schedule.
Coverage end date	Refers to the date your policy ends. This date is shown in your policy schedule.
Endorsement	Refers to any additional document attached to this policy outlining adjustments to the standard terms and conditions that we have made as a condition to providing this policy.
Heart attack of specified severity	Means the death of heart muscle due to ischaemia, that is evident by at least three of the following criteria proving the occurrence of a new heart attack: ▪ History of typical chest pain; ▪ New characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block; ▪ Elevation of the cardiac biomarkers, inclusive of CKMB above the generally accepted normal laboratory levels or Cardiac Troponin T or I at 0.5ng/ml and above; ▪ Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. The imaging must be done by a cardiologist specified by us. For the above definition, the following are excluded: ▪ Angina ▪ Heart attack of indeterminate age; and ▪ A rise in cardiac biomarkers or Troponin T or I following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. Explanatory note: 0.5ng/ml = 0.5ug/L = 500pg/ml

Medical practitioner	Refers to a medical examiner or doctor who: ▪ has a recognised medical degree in western medicine; ▪ is authorised to practise in his country; and ▪ has the skill to provide medical services for the illness, disease or condition concerned; or ▪ is in Singapore and is approved by us. This person must not be you, your spouse, relative or business partner.
Period of insurance	Refers to the period of time between the coverage start date and coverage end date (both inclusive) as shown in your policy schedule.
Policy	All of the documents listed below. ▪ the application form and any documents you provided with it; ▪ this policy contract; ▪ the policy schedule; and ▪ any endorsement to your policy, if applicable.
Policy issue date	Refers to the date as shown in the policy schedule.
Premium	Refers to the scheduled premium payments for this policy as shown in the policy schedule or endorsement.
Policy illustration	Refers to the document attached to the policy when you bought this policy. It provides a summary of this product, its benefits, and the premiums that you will need to pay.
Policy schedule	Refers to the documents attached to this policy that shows important information about you and this policy: the policy number, your personal details, period of insurance, sum insured, frequency of premium payment, and premium payable.
Stroke with permanent neurological deficit	Means a cerebrovascular incident including infarction of brain tissue, cerebral and subarachnoid haemorrhage, intracerebral embolism and cerebral thrombosis resulting in permanent neurological deficit. This diagnosis must be supported by all of the following conditions: ▪ Evidence of permanent clinical neurological deficit confirmed by a neurologist at least 6 weeks after the event; and ▪ Findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke. The following are excluded: ▪ Transient Ischaemic Attack; ▪ Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease; ▪ Vascular disease affecting the eye or optic nerve; ▪ Ischaemic disorder of the vestibular system; and ▪ Secondary haemorrhage within a pre-existing cerebral lesion.
We, our, FWD, us	Refers to FWD Singapore Pte. Ltd., the issuer of this insurance policy.
You, your, yourself, person insured	Refers to the person who is the owner of and insured by this policy as shown in the policy schedule and endorsement.

FWD insurance

Celebrate living
fwd.com.sg

FWD Heart & Neurological Disorder add-on rider
Policy contract

This is your contract for your insurance policy.

Read it to understand all the benefits as well as the important terms and conditions that apply to your insurance cover. Don't worry, we've made it as easy to read as possible.

If you need help, call our hotline: +65 6820 8888

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FWD Heart & Neurological Disorder add-on rider

Thank you for choosing FWD Singapore Pte. Ltd. We're pleased to protect you so that you can focus on living life to the fullest. This rider provides additional protection if the person insured suffers one of the covered critical illnesses.

Part of your policy

This rider becomes part of your FWD Big 3 Critical Illness insurance ("base plan") if we have agreed to provide it to you. The details of your rider cover will be shown in this FWD Heart & Neurological Disorder rider contract attached to your base plan.

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

Who's covered under your rider

Person insured

We will pay the heart and neurological disorder benefit in a lump sum equivalent to a 100% acceleration on the sum insured for the big 3 benefit or total premiums paid, whichever is higher, as stated in the policy schedule, if you suffer from a heart and neurological disorder while this rider is in place.

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

Words with special meaning

The section below explains the meanings of words and phrases used in this document.

Heart and neurological disorder	Refers to any of the illnesses defined in page 6 ("definitions of covered critical illnesses").
Pre-existing condition	Refers to a medical condition that has one or more of the following characteristics on or prior to the policy issue date: ▪ presented signs or symptoms which you were aware of or should reasonably have been aware; ▪ treatment was recommended or received from a medical practitioner for the medical condition; or ▪ you have undergone medical tests or investigations.

Your rider benefits

Summary of your benefits

This section describes the main benefits of your rider. To understand the full details about what we pay and how we pay it, you should read the following section (detailed rider benefits).

You can claim the following benefit while the rider is in place.

Heart and neurological disorder benefit

We will pay the heart and neurological disorder benefit in a lump sum equivalent to a 100% acceleration on the sum insured for the big 3 benefit or total premiums paid, whichever is higher, as stated in the policy schedule, if the person insured suffers from a heart and neurological disorder while this rider is in place.

Detailed rider benefits

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

How an accelerating rider works

Your base plan provides the amount of cover ("sum insured") for cancer, heart attack with specified severity or stroke with permanent neurological disorder, as stated in your policy schedule. Any claim made under the base plan or the accelerating rider will be paid from such sum insured.

Once we pay the sum insured on the base plan or this accelerating rider, the base plan and this rider will terminate automatically.

What we pay

Heart and neurological disorder benefit

If during the time the base plan is in force and after the waiting period;

- you experience symptoms that may be related to heart and neurological disorder; and
- a medical practitioner subsequently confirms that you suffer from heart and neurological disorder,

we will pay a 100% acceleration on the sum insured for the big 3 benefit or total premiums paid, whichever is higher.

Unless noted in an endorsement, this rider commences on the coverage start date of the base plan.

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

Waiting period

If you experience symptoms of heart and neurological disorder within the first 90 days from the policy issue date or date of endorsement, whichever is later, we will not pay the heart and neurological disorder benefit.

Covered critical illnesses

1. Amyotrophic lateral sclerosis
2. Minor bacterial meningitis
3. Brain aneurysm surgery (via craniotomy)
4. Brain aneurysm surgery (via endovascular procedure)
5. Cardiac defibrillator insertion
6. Cardiac pacemaker insertion
7. Carotid artery surgery
8. Cavernous sinus thrombosis surgery
9. Cerebral shunt insertion
10. Coronary artery disease
11. Early cardiomyopathy
12. Increased pulmonary blood pressure
13. Keyhole coronary bypass surgery or coronary artery atherectomy or myocardial laser revascularisation or enhanced external counter pulsation
14. Large asymptomatic aortic aneurysm
15. Minimally invasive surgery to aorta
16. Percutaneous valvuloplasty, valvotomy, percutaneous valve replacement, or device repair
17. Pericardectomy
18. Polio induced muscle weakness
19. Primary lateral sclerosis
20. Progressive supranuclear palsy
21. Severe progressive bulbar palsy

Your premiums

Your premiums are the amount you pay for protection. It is important to pay your premiums on time so your rider stays active and the person insured continues to be covered. Below we outline how you can pay your premiums and what happens if you don't pay.

Amount

Your current policy schedule shows the amount you need to pay for this add-on rider.

When you need to pay premiums for your rider

You need to pay your premiums for this rider at the same time as you pay your premiums for your base plan (annually or monthly).

You can change your chosen method any time – if you do, then your premiums for both base plan and rider will be changed. Please refer to 'changing your premium payment method or frequency' in your base plan contract for how to do so.

Premium rates are not guaranteed

The premiums that you pay for this rider are guaranteed during the period of insurance. However, at the policy renewal date, we reserve the rights to adjust subsequent premium(s) which may differ from the illustration in your policy illustration. We will let you know 30 days in advance if your subsequent premiums are revised.

What happens if you don't pay on time?

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

Refund of premiums after we approve a claim

If we accept a claim for the heart and neurological disorder benefit, we will refund prorated premiums paid to us after the confirmed diagnosis.

Any refunded premium amount will be paid on top of the other amounts due to be paid under your rider.

Premiums must be paid until we approve the claim

All premiums due under the base plan and this rider must be paid until we approve the claim for the heart and neurological disorder benefit.

What we don’t cover

What we don’t cover

This rider has certain exclusions, meaning situations where we won’t pay a benefit. We list below the exclusions that apply to the benefits under your rider.

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

Suicide or self-inflicted act	We will not pay any benefit under this rider if the claim arises from suicide, attempted suicide or an intentional self-inflicted act within one year of the policy starting. This applies regardless of the mental state of the person insured. If this happens, the rider will be cancelled.
Unlawful acts	We will not pay any benefit under this rider if the claim arises because you or the person insured deliberately participated in an unlawful act, or failed to act in accordance with the law.
Pre-existing condition	We will not pay the heart and neurological benefit for claims that directly or indirectly caused by, or result from a pre-existing condition.

We won’t pay any benefit if the signs or symptoms leading to diagnosis and claim, became apparent before the rider issue date.

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

Starting, changing or ending your heart and neurological disorder cover

This section explains when your policy starts and ends, and how to make changes to your policy. We also outline when you can reinstate your policy after it has ended.

When cover starts under your rider

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

When your rider cover ends

The rider cover ends on the earliest of the following.

- The coverage end date shown in your policy schedule.
- The end of the 62-day grace period, if we do not receive your due premium before then.
- The day before the next premium due date if you request to cancel (terminate) your rider cover.
- The date we are told to cancel your rider cover by law or regulation.
- The date when 100% of the sum insured under your base plan is paid out.
- The date when the base plan of this rider cover terminates.

You can claim a benefit under your rider after cover has ended if the event happened before the cover ended.

Reinstating your rider

You will not be able to reinstate (restart) your rider if the rider has been terminated due to a non-payment of premiums.

Definitions of covered critical illnesses

Amyotrophic lateral sclerosis	Unequivocal Diagnosis by a medical practitioner who is a neurologist confirming well defined neurological deficit with persistent signs of involvement of the spinal nerve columns and the motor centres in the brain and with spastic weakness and atrophy of the muscles of the extremities. Claims shall only be admitted if the condition is confirmed by a medical practitioner who is a neurologist as progressive and resulting in irreversible damage to the nervous system.
Minor bacterial meningitis	Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord which requires hospitalisation. This diagnosis must be confirmed by: ▪ The presence of bacterial infection in cerebrospinal fluid by lumbar puncture; and ▪ A consultant neurologist. Bacterial Meningitis in the presence of HIV infection is excluded.
Brain aneurysm surgery (via craniotomy)	The actual undergoing of surgical repair of an intracranial aneurysm or surgical removal of an arteriovenous malformation via craniotomy. The surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
Brain aneurysm surgery (via endovascular procedure)	The actual undergoing of surgical repair of an intracranial aneurysm or surgical removal of an arteriovenous malformation via endovascular procedures. The surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
Cardiac defibrillator insertion	Insertion of a permanent cardiac defibrillator as a result of cardiac arrhythmia which cannot be treated via any other method. The surgical procedure must be certified to be absolutely necessary by a specialist in the relevant field. Cardiac defibrillator insertion in the presence of HIV infection is excluded.
Cardiac pacemaker insertion	Insertion of a permanent cardiac pacemaker that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The insertion of the cardiac pacemaker must be certified to be absolutely necessary by a specialist in the relevant field. Cardiac pacemaker insertion in the presence of HIV infection is excluded.
Carotid artery surgery	The actual undergoing of Endarterectomy of the carotid artery which has been necessitated as a result of at least 80% narrowing of the carotid artery as diagnosed by an arteriography or any other appropriate diagnostic test that is available. Endarterectomy of blood vessels other than the carotid artery are specifically excluded. Percutaneous carotid angioplasty is excluded.

Cavernous sinus thrombosis surgery	The actual undergoing of a surgical drainage for cavernous sinus thrombosis. The presence of Cavernous Sinus Thrombosis as well as the requirement for surgical intervention must be certified to be absolutely necessary by a specialist in the relevant field.
Cerebral shunt insertion	The actual undergoing of surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid. The need of a shunt must be certified to be absolutely necessary by a specialist in the relevant field.
Coronary artery disease	The narrowing of the lumen of two coronary arteries by a minimum of 60%, as proven by coronary arteriography, regardless of whether any form of coronary artery surgery has been recommended or performed. Coronary arteries herein refer to right coronary artery, left main stem, left anterior descending and left circumflex, but not their branches. Note that any non-invasive method of determining coronary artery stenosis is not acceptable.
Early cardiomyopathy	The unequivocal diagnosis of cardiomyopathy which has resulted in the presence of permanent physical impairments to at least Class III of the New York Heart Association (NYHA) classification of Cardiac Impairment. The diagnosis must be confirmed by a specialist in the relevant field. Cardiomyopathy that is directly related to alcohol misuse is excluded. The NYHA Classification of Cardiac Impairment: Class I: No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, or anginal pain. Class II: Slight limitation of physical activity. Ordinary physical activity results in symptoms. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest. Early cardiomyopathy in the presence of HIV infection is excluded.
Increased pulmonary blood pressure	Primary or Secondary pulmonary hypertension with established right ventricular hypertrophy leading to the presence of permanent physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The diagnosis must be established by cardiac catheterisation by a specialist in the relevant field.

Definitions of covered critical illnesses

Keyhole coronary bypass surgery or coronary artery atherectomy or myocardial laser revascularisation or enhanced external counter pulsation	The actual undergoing for the first time for the correction of the narrowing or blockage of one (1) or more coronary arteries via "Keyhole" surgery, Atherectomy, Myocardial laser revascularisation or Enhanced external counterpulsation. All other surgical procedures will be excluded from this benefit.
Large asymptomatic aortic aneurysm	Asymptomatic abdominal or thoracic aortic aneurysm or dissection greater than 55mm in diameter as evidenced by appropriate imaging technique, and confirmed by a specialist in the relevant field.
Minimally invasive surgery to aorta	The actual undergoing of surgery via minimally invasive or intra-arterial techniques to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta, as evidenced by a cardiac echocardiogram and confirmed by a specialist in the relevant field. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.
Percutaneous valvuloplasty, valvotomy, percutaneous valve replacement or device repair	The actual undergoing of Valvotomy or Valvuloplasty or percutaneous valve replacement necessitated by damage of the heart valve as confirmed by a specialist in the relevant field and established by a cardiac echocardiogram. The procedure should be performed totally via intravascular catheter based techniques. Any procedure on heart valves that involves opening or entering the chest by any thoracotomy incision is excluded.
Pericardectomy	The undergoing of a pericardiectomy or undergoing of any surgical procedure requiring keyhole cardiac surgery as a result of pericardial disease. Both these surgical procedures must be certified to be absolutely necessary by a consultant cardiologist. Pericardiectomy in the presence of HIV infection is excluded.
Polio induced muscle weakness	Unequivocal Diagnosis of infection with the poliovirus leading to paralytic disease as evidenced by impaired motor function or respiratory weakness. In respect of this definition, claims shall only be admitted if poliomyelitis causes neurological deficit resulting in paralysis in Limbs that is permanent. The Unequivocal Diagnosis must be made by a Specialist in the relevant medical field.
Primary lateral sclerosis	A progressive degenerative disorder of the motor neurons of the cerebral cortex resulting in widespread weakness on an upper motor neuron basis. Clinically it is characterized by progressive spastic weakness of the limbs, preceded or followed by spastic dysarthria and dysphagia, indicating combined involvement of the corticospinal and corticobulbar tracts. The Unequivocal Diagnosis must be made by a neurologist and confirmed by appropriate neuromuscular testing such as electromyogram (EMG). The condition must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least three (3) consecutive months.

Progressive supranuclear palsy	A degenerative neurological disease characterized by supranuclear gaze paresis, pseudobulbar palsy, axial rigidity and dementia. The Unequivocal Diagnosis of Progressive Supranuclear Palsy must be confirmed by a medical practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least three (3) consecutive months.
Severe progressive bulbar palsy	Neurological disorder with paralysis in the head region, difficulties in chewing and swallowing, problems in speaking, persistent signs of involvement of the spinal nerves and the motor centres in the brain and spastic weakness and atrophy of the muscles of the extremities. The disease must be Unequivocally Diagnosed by a medical practitioner who is a neurologist. The condition must result in the permanent inability to perform, without assistance, at least three (3) of the six (6) Activities of Daily Living. These conditions have to be medically documented for at least three (3) consecutive months.