Singapore College of Insurance

Health INSURANCE

7TH EDITION
Version 1.4

IMPORTANT NOTICE

Any website references are correct as of the time of publication.

WARNING TO ALL EXAMINATION CANDIDATES

You **WILL NOT BE ADMITTED** into the examination room (whether virtual or on-site) if you:

1. Produce unacceptable identification documents (IDs).
2. Your name/ID Number on the acceptable ID DOES NOT MATCH EXACTLY THE NAME (including Hanyu Pinyin name) and ID NUMBER provided to us by either you/whoever has assisted you to register at the time of examination registration on our examination site.

   Please bring along the ID that you used during your examination registration for your admission. If the name/ID number on the ID that you bring to the examination room differs from the name/ID number that you had keyed in at the point of registration, notwithstanding that it may be a valid acceptable ID that you had brought, you WILL BE TURNED AWAY from the examination room. No appeals for refunds or reschedule of examinations will be entertained. You will need to re-register for the examination and pay all fees again.

   (If you are unsure of which ID you had used during your examination registration, you can email SCI at talk2us@scidomain.org.sg during office hours to check at least ONE WORKING DAY before the examination day.)
3. Are late for the examination. No reasons are entertained.

Candidates **must** produce the **same Registration ID** as the one that they had registered with, before they can be allowed to sit for the examination:

- **For Singapore Citizens or Singapore Permanent Residents**, the acceptable IDs are valid NRIC/Passport/Singapore Driving License.
- **For Foreigners**, the acceptable IDs are valid Passport, Employment Pass, Work Permit OR S Pass* (*S Pass does not refer to Student Pass)

For Regulars or Full-time National Servicemen (NSFs) belonging to (Singapore Armed Forces/Singapore Police Force/Singapore Civil Defence), the acceptable IDs are valid and original SAF/SPF/SCDF Card, respectively.

Note: WE DO NOT ACCEPT 11B Card for those who are NO LONGER REGULARS OR FULL-TIME NATIONAL SERVICEMEN (NSFs).

No soft copies are allowed. No other forms of identification are allowed.
SCI does not accept police reports of lost IDs as a document for admission.
No appeals for refunds or reschedule of examinations will be entertained. You will need to re-register for the examination and pay all fees again.

Candidates who arrive more than **30 minutes after** the commencement of the examination will **NOT** be allowed to sit for the examination and will be recorded as being "Absent". If candidates are refused admission, their examination fees are **non-refundable, non-deferrable, and non-transferable.**

HEALTH INSURANCE

7th Edition, Version 1.0 – 1 July 2020
7th Edition, Version 1.1 – 25 August 2020
7th Edition, Version 1.2 – 26 March 2021
7th Edition, Version 1.3 – 15 February 2022
7th Edition, Version 1.3a – 15 April 2022
7th Edition, Version 1.4 – 1 October 2022

First Edition published in 2001.
Second Edition published in 2004.
Third Edition published in 2007.
Fourth Edition published in June 2010.
Fifth Edition published in June 2013.
Sixth Edition published in October 2016.

Table of Act Changes

Except for the Notices which were extracted in full from the MAS website, amendments were only made to the title of the Acts in the relevant paragraphs of the study text.

As the respective notices are still pending release from MAS, they will be updated once MAS has published them.

Version 1.2:	Version 1.3 Amended to:
Enlistment Act (Cap. 93)	Enlistment Act 1970
Sections 35TA and 64(2) of the Insurance Act (Cap. 142)	Sections 71 and 154(4) of the Insurance Act 1966
Part IIIC of the Insurance Act (Cap. 142)	Part 3C of the Insurance Act 1966
Trust or Irrevocable Nomination (Section 49L of the Act)	Trust or Irrevocable Nomination (Section 132 of the Act)
Revocable Nomination (Section 49M of the Act)	Revocable Nomination (Section 133 of the Act)
Insurance Act (Cap. 142)	Insurance Act 1966
Section 25(5) of the Insurance Act (Cap. 142)	Section 23(5) of the Insurance Act 1966
Sections 35P, 35TA and 64(2) of the Insurance Act (Cap. 142)	Sections 67, 71 and 154(4) of the Insurance Act 1966
Financial Advisers Act (Cap. 110)	Financial Advisers Act 2001
Section 55(2) of the Insurance Act (Cap. 142)	Section 142(3) of the Insurance Act 1966

Please note that there are no changes in the Table of Acts in V1.4

Chapter 1 **Overview Of Healthcare Environment In Singapore** **1**
Chapter Outline
Learning Outcomes
1. Introduction
2. Singapore's Healthcare Philosophy
3. Healthcare 2020 Masterplan
4. Healthcare System In Singapore

Chapter 2 **Medical Expense Insurance** **11**
Chapter Outline
Learning Outcomes
1. Introduction
2. Health Insurance
3. Key Features Of Medical Expense Insurance
4. Underwriting
5. Healthcare Subsidy Level
6. Termination Of Cover
7. Claims
8. Notice No: MAS 117 - Training and Competency Requirements – Health Insurance

Appendix 2A – Sample Medical Expense Insurance Benefit Schedule
Appendix 2B – Sample Schedule Of Surgical Benefits
Appendix 2C – Table Of Healthcare Subsidy Level
Appendix 2D – Notice No: MAS 117 - Training and Competency Requirement: Health Insurance

Chapter 3 **Group Medical Expense Insurance** **50**
Chapter Outline
Learning Outcomes
1. Introduction
2. Group Insurance
3. Individual & Group Medical Expense Insurance
4. Portable, Transferable Medical Benefits & Shield Plans For Employees

Appendix 3A - Transferable Medical Insurance Certification

Chapter 4 **Disability Income Insurance** **64**
Chapter Outline
Learning Outcomes
1. Introduction
2. What Is Disability Income Insurance?
3. Disability Income Insurance & Total And Permanent Disability
4. Computation Of Disability Income Insurance Benefit
5. Definitions
6. Benefits Offered Under Disability Income Insurance
7. Features Of A Disability Income Insurance Policy
8. Underwriting

Contents

9. Cessation Of Benefits
10. Exclusions
11. Termination Of Cover
12. Group Disability Income Insurance
13. General Underwriting Principles For Group Disability Income Insurance
14. Disability Income Claims
15. Conclusion
Appendix 4A - Clinical Abstract Form

Chapter 5 Long-Term Care Insurance 88
Chapter Outline
Learning Outcomes
1. Introduction
2. What Is Long-Term Care (LTC) Insurance?
3. Benefits Offered Under LTC Insurance
4. Other Benefits Provided Under LTC Insurance
5. Maximum Benefit
6. Benefit Payment Term
7. ElderShield
8. CareShield Life

Chapter 6 Critical Illness Insurance 101
Chapter Outline
Learning Outcomes
1. Introduction
2. Critical Illness (CI) Insurance
3. LIA Critical Illness Framework
4. Benefits Offered Under Critical Illness Insurance
5. Variation Of Illness Insurance
6. Underwriting
7. Factors To Consider In Determining Adequacy of Critical Illness Coverage
8. Exclusions
9. Termination Of Cover
10. Claims
11. Group Critical Illness Insurance Policy
Appendix 6A – Standard Definitions for Severe Stage of 37 Critical Illnesses: Version 2019
Annex 1 - List of changes to the standard list of 37 critical illness under the Critical Illness Framework 2019

Chapter 7 Other Types Of Health Insurance 140
Chapter Outline
Learning Outcomes
1. Introduction
2. Hospital Cash (Income) Insurance
3. Medical Expense Benefits Under Travel Insurance
4. Group Dental Care Insurance

Contents

Appendix 7A – Sample Schedule Of Allowances Under Group Dental Insurance

Chapter 8 Managed Healthcare 155
Chapter Outline
Learning Outcomes
1. Introduction
2. What Is Managed Healthcare (MHC)
3. How Does MHC Work?
4. What Are The Common Types Of MHC Plans?
5. Choice Of Providers Versus Cost Control
6. Managed Healthcare (MHC) Insurance
7. MHC Model In Singapore

Chapter 9 Part I Healthcare Financing 167
Chapter Outline
Learning Outcomes
1. Introduction
2. Healthcare Subsidies
3. MediSave
4. MediShield Life
5. Integrated Shield Plans (IPs)

Appendix 9A – Withdrawal Limits for Inpatient, Outpatient, Long-Term Care and Insurance Premiums
Appendix 9B – MediShield Life Benefits
Appendix 9C – LIA Standardise Pre-Authorisation Form

Chapter 9 Part II Healthcare Financing 203
Chapter Outline
Learning Outcomes
6. ElderShield & ElderShield Supplements
7. CareShield Life & CareShield Life Supplements
8. Other Healthcare Financing Schemes Set Up By The Singapore Government

Chapter 10 Common Policy Provisions 221
Chapter Outline
Learning Outcomes
1. Introduction
2. Sections Of A Policy Contract
3. Policy Schedule
4. Insuring Clause & Definitions
5. General Conditions
6. Benefit Provisions
7. Exclusions
8. Claim Conditions
9. Endorsements
10. Conclusion

Appendix 10A - Policy Schedule

Contents

Chapter 11 **Health Insurance Pricing** **246**
Chapter Outline
Learning Outcomes
1. Introduction
2. Key Factors Used In Premium Computation
3. Parameters For Premium Rating

Chapter 12 **Health Insurance Underwriting** **254**
Chapter Outline
Learning Outcomes
1. Introduction
2. What Is Underwriting?
3. Underwriting Factors That Affect The Risk
4. Sources Of Underwriting Information
5. How An Insurance Representative Can Help In The Underwriting Process
6. Final Underwriting Decision
7. Commencement Of Risk
8. Conclusion

Appendix 12A – Sample Supplementary Lifestyle Questionnaire
Appendix 12B – Sample Individual Hospital & Surgical Insurance Proposal Form
Appendix 12C – Sample Group Hospital & Surgical Insurance Proposal And Health Declaration Form

Chapter 13 **Notice No: MAS 120 – Disclosure And Advisory Process Requirements For Accident And Health Insurance Products** **280**
Chapter Outline
Learning Outcomes
1. Introduction
2. Scope Of Notice No: MAS 120
3. Structure Of Notice No: MAS 120

Appendix 13A – Notice No: MAS 120

Chapter 14 **Financial Needs Analysis** **313**
Chapter Outline
Learning Outcomes
1. Introduction
2. Needs Selling Versus Product Selling
3. What Is Fact Finding?
4. Identifying & Quantifying Needs
5. Product Recommendations
6. Presenting Your Recommendations
7. Periodic Client Review

Appendix 14A – Top 10 Conditions Of Hospitalisation
Appendix 14B – Hospital Bill Size By Conditions/Procedures

Contents

Chapter 15 Case Studies **337**
Chapter Outline
Learning Outcomes
1. Introduction
2. Case Study 1 – Individual Health Insurance
3. Case Study 2 – Group Health Insurance
Appendices 15A & 15B – Mr Tang's Existing Health Insurance Policies

Tables **356**

LIST OF CHANGES

Contents

CHAPTER 1
OVERVIEW OF HEALTHCARE ENVIRONMENT IN SINGAPORE

CHAPTER OUTLINE

1. Introduction
2. Singapore's Healthcare Philosophy
3. Healthcare 2020 Masterplan
4. The Healthcare System In Singapore

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- understand the Singapore Government's healthcare philosophy
- know the key goals of the Healthcare 2020 Masterplan
- understand the differences between primary healthcare services, hospital services, and Intermediate and Long-Term Care services
- know the other healthcare services provided – dental, traditional chinese medicine and support services

Contents

CHAPTER OUTLINE 1
LEARNING OUTCOMES 1
1. INTRODUCTION 3
2. SINGAPORE'S HEALTHCARE PHILOSOPHY 3
A. Enhancing Accessibility 3
B. Enhancing Quality Of Care 4
C. Ensuring Healthcare Remains Affordable 4
3. HEALTHCARE 2020 MASTERPLAN 5
A. Better Access 5
B. Higher Quality 5
C. More Affordable 6
D. Living Well 6
4. HEALTHCARE SYSTEM IN SINGAPORE 7
A. Primary Healthcare Services and Facilities 7
B. Hospital Services 8
C. Intermediate & Long-Term Care (ILTC) Services 9
D. Other Healthcare Services 10

1. INTRODUCTION

1.1 Rising healthcare costs is a concern for most governments. Advances in medical sciences, the greater use of expensive medical technology and drugs, as well as an ageing population with longer life expectancy, are some reasons that contribute to rising healthcare costs. In most developed countries, healthcare expenditure has grown much faster than the economy, and absorbs an increasing share of the nation's resources. This is a concern, as the resources that countries can devote to healthcare are finite, and there is a limit to the financial burden that households can bear. At the same time, consumers have rising expectations that the quality of healthcare must improve or at least be maintained. The challenge faced by most governments is how to balance the rising expectations for quality healthcare and yet keep the costs affordable.

2. SINGAPORE'S HEALTHCARE PHILOSOPHY

2.1 Singapore's healthcare philosophy is anchored on individual responsibility and affordable healthcare for all.

2.2 The philosophy consists of **three pillars**:

(a) Building up a healthy population with preventive health care and encouraging healthy lifestyles.

(b) Emphasising personal responsibility towards healthy living through the "3M" (Medisave, Medishield and Medifund) system.

(c) Keeping healthcare costs down by controlling the supply of healthcare services and providing heavy subsidies in respect of fees charged by public healthcare institutions.

A. Enhancing Accessibility

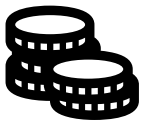
2.3 Singapore's healthcare infrastructure will be ramped up, with plans to increase the number of acute general hospital and community-hospital beds. These beds will come from the new hospitals which will be constructed across the country. The increase in community hospitals will allow more patients to recover in a more appropriate setting.

2.4 MOH is actively building up its manpower capability and building a strong core of locals among healthcare professionals to support its infrastructural expansions. This is carried out through various initiatives, such as providing more opportunities for flexible, part-time work in the community through its "Place and Train" Programme in the aged care sector, as well as implementing a new remuneration framework for senior public sector doctors, to better recognising doctors for their diverse roles in clinical care, education, research and administration. At the same time, MOH actively drives innovation and productivity in both the public and ILTC sectors to simplify workflow processes, so that healthcare workers can focus on caring for the patients.

B. Enhancing Quality Of Care

2.5 Singapore's ageing population is a strong driver for healthcare demand. As patient needs become more complex, MOH will have to move away from doctor-centric services and adopt a multi-disciplinary team approach to enhance chronic disease management. The healthcare clusters are embarking on new programmes, so that Singaporeans can access quality care in the most suitable setting, including in the comfort of their own homes.

2.6 The elderly are four times more likely than younger people to need hospital care. Demand for hospital and nursing home care will rise. Hence, it is important to make changes to how we organise and deliver healthcare, to ensure good quality care for Singaporeans. As Singapore's population ages, MOH is enhancing primary care, so that residents can be better cared for in the community. One such move is to strengthen primary healthcare providers, such as polyclinics and General Practitioners (GPs). MOH is planning and constructing more polyclinics, and will also be stepping up efforts to work with the GPs to explore different models of care and collaboration.



C. Ensuring Healthcare Remains Affordable

2.7 As Singapore's population ages and families become smaller, there is a need for greater collective responsibility to ensure that Singaporeans do not face life's uncertainties alone.

2.8 The Government has enhanced support for Singaporeans in the following ways:

(a) Increasing the Government's share of national healthcare expenditure – through enhanced subsidies for services in the Specialist Outpatient Clinics (SOCs) and drugs in public hospitals, as well as a list of subsidised drugs.

(b) Gradually expanding MediSave use to even more types of outpatient treatment, further reducing out-of-pocket costs for outpatient care.

(c) Extending CHAS to cover all Singaporeans for selected chronic conditions, regardless of income.

(d) Enhancing collective responsibility for healthcare – MediShield Life, a basic hospitalisation insurance scheme meant to cover large hospital bills and selected costly outpatient treatments, was launched on 1 November 2015 to provide lifetime peace of mind for all Singaporeans, including the elderly and those with pre-existing conditions. The Government bears most of the costs of providing coverage for those with pre-existing conditions. CareShield Life was launched in 2020. This new long-term care insurance scheme is an enhancement of the ElderShield scheme, and will provide better protection against long-term care costs, especially in old age.

(e) Providing seniors in the Pioneer Generation (PG) and Merdeka Generation (MG) more support for their healthcare costs. These seniors receive MediSave top-ups, additional subsidies for outpatient care, and additional premium subsidies for MediShield Life. PG and MG seniors who join

CareShield Life also receive additional participation incentives for doing so.

2.9 For more details of the above mentioned support and schemes, please refer to **Chapter 9** of this study guide.

3. HEALTHCARE 2020 MASTERPLAN

3.1 The Ministry of Health (MOH) had put together a "Healthcare 2020" Masterplan in 2012 to improve the provision of healthcare for Singaporeans. It aims to shape the future of healthcare in Singapore by identifying, developing and experimenting with game-changing systems-level concepts and innovations in the key areas of health promotion, illness prevention and the delivery of care.

3.2 Its goals were to improve access, affordability and quality of healthcare services for Singaporeans. Many improvements have since been made.

A. Better Access

3.3 MOH is expanding its services and building new facilities to make it easier for Singaporeans to seek healthcare. These include developing new polyclinics and clinics nearer our homes.

B. Higher Quality

3.4 Singapore's healthcare professional workforce had expanded by 9,000 between 2011 and 2014. It was on track to expand by another 11,000 by 2020. The government enhanced salaries across all professions, with additional funding from government, and improved career progression to improve retention.

3.5 In 2015, local medical and nursing intakes were up by 29% and 17% compared to 2012. Other initiatives included the establishment of Singapore's third medical school, the Lee Kong Chian School of Medicine and new allied health degree programmes at the Singapore Institute of Technology from 2016.

3.6 There have been also initiatives related to better career development. For example, the National Nursing Taskforce came up with recommendations to boost nursing profession. The role of Assistant Nurse Clinician was introduced and greater support was rendered to encourage doctors to undergo post-graduate training in family medicine.

3.7 In terms of enhancement of recognition, there has been salary increases for public healthcare and MOH funded intermediate and long-term care sector staff.

3.8 Initiatives relating to building further skills and knowledge have also been introduced such as increased funding, training and a dedicated AIC Learning Institute for staff working in long-term care.

C. More Affordable

3.9 More subsidies have been rolled out for lower to middle income patients.

3.10 Higher subsidies have been granted for long-term care services, with more patients able to enjoy subsidies. For subsidised specialist care in the public hospitals —patient pays up to 40% less. For standard outpatient drugs in the public hospitals and polyclinics—patient pays up to 50% less.

3.11 The government has introduced universal healthcare insurance for lifelong protection. MediShield Life gives better protection, for all Singaporeans, for life. This is part of a more inclusive society, where Singapore residents look after one another.

3.12 Other initiatives to make healthcare costs more affordable are expanded Medisave use to reduce out-of-pocket payment. For example, Flexi-Medisave affords seniors to use additional $200/ year for outpatient medical treatment. It gives $300/ year for outpatient scans and 19 chronic conditions (up from 10 conditions in 2011) are covered at $400/ year.

3.13 To help Singaporeans build up more Medisave for their healthcare needs, an additional 1% point Medisave contribution from employers have been implemented since Jan 2015. There has been Government top-ups for lower-income, elderly under the GST-Voucher scheme not to mention an increase from $3,000 to $4,000[1] in Medisave Grant for newborns born on or after 1 Jan 2015.

D. Living Well

3.14 MOH has been expanding home care services and eldercare centres so that it can help seniors to be cared for at home. Nursing home care will also be expanded for seniors who cannot be cared for at home.

3.15 Enhanced standards for nursing homes and guidelines for eldercare centres, home care and end-of life care ensure that Singapore seniors receive better, more holistic and safer care.

3.16 The Ministerial Committee on Ageing unveiled key new features of a $3 billion national plan to help Singaporeans age confidently and lead active lives, with strong bonds with family and community.

3.17 Other supportive measures include the Seniors' Mobility and Enabling Fund which provides subsidies for seniors in the community for:

- wheelchairs, pressure relief cushions, commodes and other devices
- diapers, wound dressings and other consumables
- transport to eldercare and dialysis centres

[1] If the child is not a Singapore Citizen at birth, the grant amount will depend on the date that he/she becomes a Singapore Citizen.

3.18 There is also the Foreign Domestic Worker grant of $120 for families with an elderly with moderate disability, to help with the cost of employing a foreign domestic worker.

3.19 Launched in 2014, the Healthy Living Master Plan promotes healthy living as accessible, natural, and effortless for all Singaporeans. It encourages Singaporeans to adopt healthy behaviours by bringing healthy living options to the "doorstep" of every home, workplace, and school by 2020.

4. HEALTHCARE SYSTEM IN SINGAPORE

4.1 There are three main types of healthcare services :
(a) primary healthcare services and facilities
(b) hospital services
(c) Intermediate and Long Term Care (ILTC) services.

A. Primary Healthcare Services and Facilities

4.2 Primary healthcare services are provided by professionals—usually general practitioners — in polyclinics and private medical clinics within the community. These healthcare professionals are often the first point of contact with patients.

4.3 Primary healthcare involves the provision of basic medical treatment, preventive healthcare and health education. In Singapore, primary healthcare services are provided by the public sector, as well as the private sector. They provide holistic and personalised care for patients of different age groups. They treat acute conditions such as upper respiratory tract infections, manage chronic illnesses such as diabetes, and keep the population healthy through preventive measures such as targeted health screening. They also help to coordinate patients' care with other providers and help patients who require more specialised medical attention to navigate the healthcare system.

4.4 In the public sector, primary healthcare services are provided through a network of outpatient polyclinics.

4.5 Under the Community Health Assist Scheme (CHAS), eligible Singapore Citizens can also receive subsidised treatments at participating GPs and dental clinics, without the need to travel to the polyclinics. CHAS enables all Singapore Citizens, including and Merdeka Generation (MG) and Pioneer Generation (PG) cardholders, to receive subsidies for medical and/or dental care at participating General Practitioner (GP) and dental clinics.

4.6 Besides subsidies for care at CHAS clinics, CHAS, MG and PG cardholders enjoy subsidised referrals to public Specialist Outpatient Clinics (SOCs), as well as subsidised referrals to the National Dental Centre Singapore and National University Centre for Oral Health Singapore*, if required. The colour of the CHAS card indicates the subsidy tier that cardholders are entitled to, namely the CHAS Blue, Orange or Green tier.

*Only for CHAS Blue, CHAS Orange, MG and PG cardholders

4.7 Clinics participating in CHAS partner with MOH to provide common outpatient medical treatments and basic dental services to eligible patients. The scheme also covers treatments for chronic diseases under the Chronic Disease Management Programme (CDMP), such as diabetes mellitus and hypertension. To find out more, visit: www.chas.sg.

B. Hospital Services

4.8 MOH's role as the dominant health care provider allows her to influence the supply of hospital beds, the introduction of high-tech/high-cost medicine and the rate of cost increases in the public sector, which sets the bench mark in terms of pricing for the private sector. The general hospitals provide multi-disciplinary acute inpatient and specialist outpatient services and a 24-hour emergency department. In addition, there are national specialty centres for cancer, cardiac, eye, skin, neuroscience and dental care, as well as medical centres for multiple disciplines (e.g. Jurong Medical Centre, Admiralty Medical Centre).

4.9 There are ten public hospitals, also known as restructured hospitals comprising eight general hospitals, a women's and children's hospital, and a psychiatry hospital. General hospitals provide multi-disciplinary inpatient and specialist outpatient services, and 24-hour emergency departments.

4.10 There are six national specialty centres that provide cancer, cardiac, eye, skin, neuroscience and dental care.

4.11 The government has also introduced community hospitals for intermediate healthcare for the convalescent sick and aged who do not require the care of the general hospitals. There are currently nine community hospitals in Singapore.

4.12 Within the public hospitals, patients have a choice of the different types of ward accommodation on their admission and subsidies provided differ according to the ward class. The wards with basic amenities like C class wards are heavily subsidised up to 80% while B2 is subsidised from 50-65%. Whereas those who desire more amenities can choose a higher ward class but will receive less subsidies with Class B1 admissions subsidised at 20% while there is no subsidy for Class A ward admissions. However, patients will be able to receive up to 80% in subsidies regardless of whether they are admitted to B2 or C class wards from 1 November 2022[2].

4.13 The Government has restructured all its acute hospitals and specialty centres to be run as private companies wholly owned by the Government. This is to enable the public hospitals to have the management autonomy and flexibility as well as the ability to respond more promptly to the needs of the patients. In the process, commercial accounting systems have been introduced, providing a more accurate picture of the operating costs and instilling greater financial

[2] https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/subsidies-for-acute-inpatient-care-at-public-healthcare-institutions

discipline and accountability. The public hospitals are different from the other private hospitals in that they receive an annual Government subvention or subsidy for the provision of subsidised medical services to the patients. They are managed like not-for-profit organisations. The public hospitals are subject to broad policy guidance by the Government through MOH.

4.14 The public hospitals are structured by regions split into three clusters: National University Health System (NUHS), National Healthcare Group (NHG) and SingHealth. The last reorganisation of these clusters was announced in January 2017, with six clusters merged into three, based on location.

4.15 For more information on the regions and the healthcare institutions under each, please visit the MOH website at: https://www.healthhub.sg/directory/hospitals

C. Intermediate & Long-Term Care (ILTC) Services

4.16 These continuing care facilities are for patients who no longer require the level of care dispensed by a hospital, but nevertheless require continued care. ILTC comprise:

- Residential ILTC services care, for patients who stay in these facilities both in the day and at night.
- Community-based ILTC services, both centre-based and home-based, provided to patients during the day.

4.17 ILTC services are typically required for persons who need further care and treatment after being discharged from an acute hospital, as well as community-dwelling seniors who may be frail and need supervision or assistance with their activities of daily living. The types of ILTC services are:

(a) Home-based services, which are provided within the homes of frail and home-bound elderly. These services address the health and social needs of these elderly and support families in the care of their seniors with the aim to help seniors age in peace;

(b) Centre-based healthcare services, which cater to elderly who require care services during the day, usually on a regular basis. These centres are mostly located within the community, enabling those in need to receive services in a familiar environment close to their homes, and allow working caregivers to conveniently drop off their seniors during work; and

(c) Residential ILTC services, which comprise community hospitals, chronic sick hospitals, nursing homes, inpatient hospices, rehabilitation homes and sheltered homes for persons in mental health recovery.

D. Other Healthcare Services

(a) Dental Services

Public dental services are available through the National Dental Centre and in some polyclinics and hospitals. The Health Promotion Board primarily focuses on preventive dentistry, targeted mainly at school pupils.

(b) Traditional Chinese Medicine

MOH bases its healthcare services on Western medical science. However, the ethnic groups in Singapore occasionally consult traditional medicine practitioners for general ailments. Interest in Traditional Chinese Medicine (TCM) and other traditional or alternative medical treatments is increasing both here and around the world. MOH is therefore reviewing standards of training and practice of TCM in Singapore. Its aim is to ensure a higher quality of TCM practice, for the benefit of patients who consult TCM practitioners.

(c) Support Services

Support services to hospitals and primary healthcare programmes include forensic pathology, pharmaceutical services and blood transfusion service.

CHAPTER 01

OVERVIEW OF HEALTHCARE ENVIRONMENT IN SINGAPORE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Singapore Government's healthcare philosophy	Singapore's healthcare philosophy is anchored on individual responsibility and affordable healthcare for all. The philosophy consists of **three** pillars: 1. Building up a healthy population with preventive health care and encouraging healthy lifestyles. 2. Emphasising personal responsibility towards healthy living through the "3M" (Medisave, Medishield and Medifund) system. 3. Keeping healthcare costs down by controlling the supply of healthcare services and providing heavy subsidies in respect of fees charged by public healthcare institutions.
Three key strategies for the Healthcare 2020 Masterplan	• Enhancing Accessibility. • Enhancing Quality of Care. • Ensuing Healthcare Remains Affordable.
Primary healthcare services	Primary healthcare services are provided by professionals—usually general practitioners — in polyclinics and private medical clinics within the community. These healthcare professionals are often the first point of contact with patients.
Hospital services	There are ten public hospitals comprising eight general hospitals, a women's and children's hospital, and a psychiatry hospital. General hospitals provide multidisciplinary inpatient and specialist outpatient services, and 24-hour emergency departments. Six national specialty centres provide cancer, cardiac, eye, skin, neuroscience and dental care.
Intermediate and Long-Term Care services	These continuing care facilities are for patients who no longer require the level of care dispensed by a hospital, but nevertheless require continued care. ILTC comprises: • Residential ILTC services care, for patients who stay in these facilities both in the day and at night. • Community-based ILTC services, both centre-based and home-based, provided to patients during the day.

CHAPTER 2
MEDICAL EXPENSE INSURANCE

CHAPTER OUTLINE

1. Introduction
2. Health Insurance
3. Key Features Of Medical Expense Insurance
4. Underwriting
5. Healthcare Subsidy Level
6. Termination Of Cover
7. Claims
8. Notice No: MAS 117 - Training and Competency Requirements – Health Insurance

Appendix 2A – Sample Medical Expense Insurance Benefit Schedule
Appendix 2B – Sample Schedule Of Surgical Benefits
Appendix 2C – Table Of Healthcare Subsidy Level
Appendix 2D – Notice No: MAS 117 - Training and Competency Requirements – Health Insurance

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- describe the three categories of Health Insurance
- know the types of coverage provided under a Medical Expense Insurance policy
- understand the various benefits offered by insurers under a Medical Expense Insurance policy
- describe the key features of Medical Expense Insurance:
  - stand-alone or a rider
  - choice of plans
  - family coverage
  - reimbursement of expenses
  - expense participation (deductible, co-insurance and pro-ration factor)
  - benefit limits
  - covered charges
  - geographical limit
  - waiting period
  - age limits
  - premiums
  - renewability
- know the common exclusions and limitations (co-ordination of benefits) under Medical Expense Insurance
- know the sources of underwriting information for both individual and group covers

- know the rationale for the subsidy distinction between citizens and non-citizens
- know when the coverage of an insured person under a Medical Expense Insurance policy will terminate
- know the documents to be furnished in the event of a claim
- know the training and competency requirements for health insurance as stated in Notice No.: MAS 117 - Training and Competency Requirements - Health Insurance.

Contents

CHAPTER OUTLINE 11
LEARNING OUTCOMES 11
1. INTRODUCTION 15
2. HEALTH INSURANCE 15
A. What Is Medical Expense Insurance? 15
A1. What Is Covered Under Medical Expense Insurance? 16
A2. Inpatient Expenses 17
A3. Outpatient Expenses 20
A4. Catastrophic Outpatient Expenses 20
B. Other Benefits Under Medical Expense Insurance 21
B1. Specific Disease Insurance 21
B2. Miscarriage Benefit 22
B3. Private Nursing Home Care 22
B4. Daily Hospital Cash 22
B5. Emergency Medical Evacuation 22
B6. Final Expenses Benefit 22
C. What Are The Limits On The Covered Expenses? 23
3. KEY FEATURES OF MEDICAL EXPENSE INSURANCE 23
A. Stand-alone Or Rider 23
B. Choice Of Plans 23
C. Family Coverage 24
D. Reimbursement Of Expenses 24
E. Expense Participation 25
E1. Deductible 25
E2. Co-insurance 27
E3. Pro-ration Factor 27
F. Benefit Limits 28
G. Covered Charges 29
H. Geographical Limit 29
I. Waiting Period 30
J. Age Limits 30
K. Premiums 30
L. Renewability 31
M. Exclusions & Limitations 31
M1. Exclusions 31
M2. Limitations (Co-ordination Of Benefits) 32

4. UNDERWRITING 32
5. HEALTHCARE SUBSIDY LEVEL 32
6. TERMINATION OF COVER 33
7. CLAIMS 33
8. NOTICE No.: MAS 117 - TRAINING AND COMPETENCY REQUIREMENTS – HEALTH INSURANCE 34
APPENDIX 2A 35
APPENDIX 2B 36
APPENDIX 2C 40
APPENDIX 2D 41

1. INTRODUCTION

1.1 As mentioned in **Chapter 1** of this Study Guide, like in other countries, rising medical costs are a major concern in Singapore, particularly in view of a growing ageing population. Today, many people may be relying on their Medisave and MediShield Life to pay the costs of their medical needs and treatments. However, these schemes may not be sufficient to pay for the costs of prolonged hospital treatment or a major surgery, particularly those who choose to stay in a B1 or A class ward or in a private hospital, since these medical bills are higher with little to no government subsidy. As such, there is a need to have other sources of funds to help to pay for one's medical expenses, especially in the event of serious illness requiring prolonged and expensive treatments.

1.2 Insurers have developed a range of Medical Expense Insurance products designed to provide benefits for specific medical expenses that an insured person incurs. In this chapter, we will discuss what general Medical Expense Insurance is, its common characteristics, and the general supplementary benefits offered.

2. HEALTH INSURANCE

2.1 Health Insurance provides the individual and his family with financial benefits which will help to defray some of the incurred medical costs, or recover some or all of the financial losses suffered as a result of an injury, illness or disability.

2.2 There are broadly three categories of Health Insurance which can provide for:

- a reimbursement for the cost of medical treatment or nursing care; or
- a periodic income upon disability or hospitalisation; or
- a fixed cash amount upon disability or suffering from a major illness.

2.3 Insurers and their financial adviser representatives providing advice on or arranging contracts of insurance or both, in respect of Health Insurance products, must comply with Notice No: MAS 117 on "Training And Competency Requirement: Health Insurance". This Notice essentially covers minimum examination requirements, and Continuing Professional Development (CPD) requirements in respect of shield plans.

2.4 In this chapter, we will cover Medical Expense Insurance. The other types of Health Insurance will be covered in the next few chapters.

A. What Is Medical Expense Insurance?

2.5 Medical Expense Insurance, also known as Hospital and Surgical (H&S) Insurance, provides inpatient and some outpatient benefits. Besides covering common expenses which are listed below, it also provides cover for complex surgical procedures like heart by-pass surgery and organ transplant, and other costly outpatient treatments, such as kidney dialysis and cancer chemotherapy. Examples of Medical Expense Insurance include Medisave-approved Integrated

Shield Plans (IPs) offered by private insurers, MediShield Life Scheme and Managed Healthcare Schemes. **Appendix 2A** gives an example of the Medical Expense Insurance benefit schedule.

A1. What Is Covered Under Medical Expense Insurance?

2.6 Most of the Medical Expense Insurance plans in Singapore generally cover the basic benefits as described below:

(i) Inpatient Expenses

- daily room and board charges;
- intensive care unit charges;
- short stay ward;
- hospital miscellaneous expenses;
- surgeon's fees;
- anaesthetist's fees;
- surgical implant and prosthesis charges;
- stay in community hospitals;
- inpatient psychiatric treatment;
- congenital anomalies;
- inpatient pregnancy complications;
- radiosurgery;
- stem cell transplant;
- emergency overseas inpatient treatment;
- accident inpatient dental treatment;
- major organ transplant;
- living donor organ transplant.

(ii) Outpatient Expenses

- pre-hospitalisation diagnostic and laboratory tests charges;
- pre-hospitalisation specialist consultation charges;
- post-hospitalisation specialist consultation charges;
- accident and emergency (A&E) treatment;
- emergency accidental treatment charges.

(iii) Catastrophic Outpatient Expenses

- outpatient kidney treatment charges;
- outpatient cancer treatment charges;
- major organ transplant approved immunosuppressant drugs.

2.7 Some policies also extend cover to include:

- emergency medical evacuation; and
- private nursing home care.

2.8 Let us now look at each of the covered expenses in turn.

A2. Inpatient Expenses

2.9 If inpatient treatment is received in a luxury or deluxe suite or any other special room of a hospital, the inpatient bill will be pro-rated based on the actual charges that the insured person would have paid under his plan type. The lower of either the reasonable expenses or the pro-rated amount of the total bill, will be paid.

(a) Daily Room & Board Charges

This refers to the charges for a **standard room** accommodation, meals and general nursing services incurred by the insured person, while he is hospitalised. The reimbursement is on a per day basis up to a specified maximum number of days per hospitalisation. This also includes charges for a high dependency ward accommodation.

(b) Intensive Care Unit (ICU) Charges

This refers to charges incurred during confinement in the ICU of the hospital.

Like Daily Room & Board, the reimbursement for ICU charges is also on a per day basis up to a specified maximum number of days per hospitalisation.

(c) Short-stay Ward

This refers to charges incurred during confinement in the short-stay ward in an accident and emergency department of a hospital, where the patient needs a short period of inpatient observation, monitoring and treatment, usually up to 24 hours. This will allow the attending doctor to decide whether the patient is fit for discharge, or he should be further admitted as an inpatient.

(d) Hospital Miscellaneous Expenses

This refers to the services and supplies (other than room and board and general nursing care) furnished during a hospital stay, and will usually include the following:

- laboratory services;
- X-ray examinations;
- medicines and drugs;
- surgical dressings;
- operating room expenses;
- oxygen and its administration; and
- ambulance services.

(e) Surgeon's Fees

This refers to the surgeon's fees for surgery. Charges for day surgery and gamma knife are also payable. The level of reimbursement in the surgical schedule varies, or depends on the type and complexity of the specific surgery. To find out how much MediShield Life reimburses this benefit, just refer to the website of the Ministry of Health (MOH) at www.moh.gov.sg, to view a full list of the types of Surgical Operations and the Medisave withdrawal limits for each category. In some insurance policies, there is also a limit on the maximum number of days from the date of surgery that the insurer will pay for the surgeon's visits and post-operative care. For Group Hospital and Surgical (H&S) Insurance, reimbursement for surgical fees is usually set out in a Schedule of Surgical Benefits attached to such a Group H&S Insurance policy. A sample in **Appendix 2B** shows a Schedule of Surgical Benefits with limits.

While there are Medical Expense Insurance policies in the market that still impose sub-limits on different surgical procedures, the majority of insurers have started to offer plans with "as charged" benefits.

(f) Anaesthetist's Fees

This refers to the fees for the supply and administration of anaesthesia by an anaesthetist for a surgery.

(g) Surgical Implant & Prosthesis Charges

This refers to the actual costs of surgical implant or prosthesis[1].

(h) Stay In Community Hospital

This refers to charges incurred in a community hospital for accommodation, meals and general nursing services. A referral from the attending physician from the hospital, where the insured person has received inpatient treatment is usually required, and admission to the community hospital must be within a time frame following his discharge from the hospital.

(i) In-hospital Psychiatric Treatment

This refers to charges for psychiatric treatment received as an inpatient of the hospital. All treatments must be administered under the direct control of a registered psychiatrist. A waiting period may apply before this benefit is payable. Treatment for self-inflicted injury, suicide, drug addiction, or abuse of drug or alcohol is excluded.

(j) Congenital Anomalies

This refers to charges for inpatient treatment of any congenital anomalies, including hereditary conditions. A waiting period may apply before this benefit is payable.

(k) Inpatient Pregnancy Complications

This refers to charges for inpatient treatment for pregnancy complications. A waiting period may apply before this benefit is payable.

[1] Prosthesis is an artificial device used to replace a missing part of the body.

Note that not every pregnancy complication is covered. This benefit may be restricted to a pre-defined list of pregnancy complications, including but not limited to:

- ectopic pregnancy;
- pre-eclampsia or eclampsia;
- disseminated intravascular coagulation;
- miscarriage after 13 weeks of pregnancy (not resulting from voluntary or malicious act);
- antepartum haemorrhage;
- intrauterine death;
- choriocarcinoma and hydatidiform mole, which is the occurrence of a histologically confirmed choriocarcinoma and/or molar pregnancy;
- acute fatty liver pregnancy;
- breech delivery;
- placenta previa; and
- postpartum haemorrhage.

(l) Radiosurgery

This refers to charges for Gamma Knife and Novalis radiosurgery (including day surgery) by a surgeon in a hospital.

(m) Stem Cell Transplant

This refers to charges for stem cell transplant surgery. All other costs incidental to the stem cell transplant, such as costs of harvesting, laboratory tests, investigations, storage, transport and cell culture, as well as outpatient therapies, where there is no surgery or admission, are not covered.

(n) Emergency Overseas Inpatient Treatment

This refers to charges for inpatient treatment resulting from an emergency while overseas. It pays the lower of either the actual charges or reasonable expenses for equivalent medical treatment in Singapore. Pre- and post-hospital treatments which are given before and after emergency overseas treatment are not covered.

(o) Accident Inpatient Dental Treatment

This refers to charges to remove, restore or replace sound natural teeth which have been lost or damaged in an accident. Treatment must be received within 14 days following the accident.

(p) Major organ transplant

This refers to the costs of surgeries for the transplantation of kidneys, lungs, heart, liver or cornea, where the insured person is the recipient of any of the organs.

(q) Living donor organ transplant

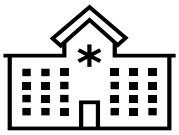
This refers to charges for major organ transplants of the kidney or liver, where the life insured is a living donor, provided that:

(i) the transplantation is carried out at a hospital in Singapore;

(ii) the recipient of the kidney or liver must be the insured person's family member (i.e. parent, sibling, spouse or child); and

(iii) the recipient's kidney or liver failure is first diagnosed by the attending physician, or the symptoms of which first appeared, after a waiting period of 24 months as specified in the policy.

This benefit is not payable if the transplantation is illegal or arises from any illegal transaction or practice involved.



A3. Outpatient Expenses

2.10 **(a) Pre-hospitalisation Diagnostic & Laboratory Test Charges**

This refers to the charges incurred by the insured person for diagnostic and laboratory tests as prescribed by the attending physician or specialist. This benefit is payable if incurred within a specified number of days before the date of hospitalisation.

(b) Pre-hospitalisation Specialist Consultation Charges

This refers to the charges incurred by the insured person for consultation of a specialist as recommended by the attending physician. This benefit is payable only if the insured person is hospitalised, or undergoes day surgery within a specified number of days from the date of consultation of the specialist.

(c) Post-hospitalisation Specialist Consultation Charges

This refers to the expenses incurred by the insured person for follow-up treatments after hospitalisation, e.g. physiotherapy after an arthroscopy surgery. This benefit is payable for up to a specified number of days after his discharge from the hospital.

(d) Accident & Emergency (A&E) Treatment

This refers to treatment in the accident & emergency department of a hospital up to 24 hours, before an inpatient treatment for the same injury or illness.

(e) Emergency Accidental Treatment Charges

This refers to the charges incurred for emergency outpatient treatment of accidental bodily injuries of the insured person, within 24 hours of the accident.

A4. Catastrophic Outpatient Expenses

2.11 **(a) Outpatient Kidney Treatment Charges**

This refers to the charges incurred for kidney dialysis at a legally registered dialysis centre. Cover may also include examination and tests ordered by the attending physician for the course of treatment, as well as

erythropoietin, as part of the treatment for chronic renal failure and ambulatory peritoneal dialysis ordered by the attending physician.

Any additional formulated solution not prescribed by the attending physician or other prescribed medications (apart from erythropoietin) will not be covered. In addition, the cost of purchase or rental of the dialysis machine will not be covered.

(b) Outpatient Cancer Treatment Charges

This refers to the charges incurred for chemotherapy, radiotherapy, immunotherapy and/or stereotactic radiotherapy treatment (or any other cancer treatment approved by the insurer) provided by the hospital or at a legally registered cancer treatment centre, including examinations and tests ordered by the attending physician for the course of treatment.

(c) Major Organ Transplant Approved Immunosuppressant Drugs

This refers to costs of immunosuppressant drugs approved by the Health Science Authority as part of necessary medical treatment, as an outpatient after a major organ transplant to reduce the rate of rejection episodes.

The list of covered drugs includes, but is not limited to:

(i) Cyclosporin;

(ii) Tacrolimus;

(iii) Azathioprine;

(iv) Prednisolone; and/or

(v) other approved immunosuppressant drugs for Major Organ Transplant.

The major organ transplant must first be approved under the policy.

B. Other Benefits Under Medical Expense Insurance

2.12 Insurers may also provide additional benefits, such as the following:

- specific disease insurance;
- miscarriage benefit;
- private nursing home care;
- daily hospital cash;
- emergency medical evacuation benefit; and
- final expenses benefit.

2.13 Let us look at the benefits provided by the above additional covers in detail.

B1. Specific Disease Insurance

2.14 Specific Disease Insurance provides for a lump sum payment (e.g. S$50,000) in the event that the insured person is diagnosed to be suffering from the specific disease (e.g. cancer) covered by the policy.

B2. Miscarriage Benefit

2.15 This refers to the costs incurred in a miscarriage or ectopic pregnancy. However, the coverage is not applicable to wilful termination of a pregnancy requested by the insured person that is not medically necessary.

B3. Private Nursing Home Care

2.16 This refers to the costs incurred in hiring the services of a full-time or part-time registered and qualified nurse in the insured person's home. It is for the continuing treatment of a medical condition that is covered under the policy for which the insured person has been hospitalised.

B4. Daily Hospital Cash

2.17 This refers to a daily cash benefit payable directly to the insured person if he is hospitalised as a result of an injury or illness.

2.18 In Singapore, in order for insurers to keep medical claims costs low, especially in private hospitals, daily hospital cash is often packaged in Medical Expense Insurance and payable only upon hospital or ward downgrade. This is to encourage the insured person to stay in a public hospital, or a ward that is lower than his covered plan.

B5. Emergency Medical Evacuation

2.19 Normally provided for in global medical plans, this refers to the costs of getting the insured person to a place for accessibility to medical treatment because of a serious injury or serious sickness while overseas. It must be medically appropriate and safe to move him to another location or to return him to Singapore for treatment. The evacuation method may include air ambulance, surface ambulance, regular air transportation, railroad or any other appropriate means. The final destination will be made by the treating doctor and the emergency medical assistance company, and this will be based solely on medical necessity.

B6. Final Expenses Benefit

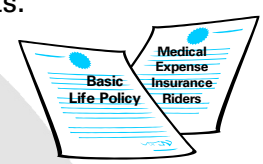
2.20 In the event of death occurring during hospitalisation or within a specified number of days after hospital discharge, and provided that death is a result of the cause of the hospitalisation, a final expenses benefit is payable. In the case of an Integrated Shield Plan (IP), the final expenses benefit is usually a waiver of deductible and co-insurance components up to the stated amount in the policy schedule.

2.21 **Note:** Different insurers may have varying definitions of each of the above described benefits. Hence, insurance representatives should check their own insurers' definitions.

C. What Are The Limits On The Covered Expenses?

2.22 Medical **Expense** Insurance policies provide separate benefits for the different expenses covered. While most insurers now offer plans that have "as charged" benefits, there are still many plans that impose sub-limits, e.g. based on a table of surgical operations and a maximum limit on Room & Board benefit, etc. MediShield Life is just one of the Medical Expense Insurance schemes with limits imposed. Besides the limits, deductibles and co-insurance are also common features of these policies. Also, all policies are subject to per policy year/period and lifetime claimable limits.

2.23 Note that the payment of this Medical Expense Insurance policy is on a reimbursement basis. Hence, the insurer will reimburse the actual amount incurred (for "as charged" plans) or the maximum limit as stated in the Schedule of Benefits, whichever is lower. The policy owner may not get a full reimbursement for the medical expenses incurred by the insured person in some cases. It is important to highlight this clearly to the prospective client and explain what is precisely covered in the Schedule of Benefits.



3. KEY FEATURES OF MEDICAL EXPENSE INSURANCE

3.1 Although the Medical Expense Insurance policies offered in the market vary in coverage and limits, they generally share the common features as described below:

A. Stand-alone Or Rider

3.2 Medical Expense Insurance can be offered as a rider or a stand-alone policy. If issued as a rider, it is often attached to a permanent Life Insurance policy. Note that it is not common in Singapore for Medical Expense Insurance to be offered as a rider.

B. Choice Of Plans

3.3 Insurers normally offer Medical Expense Insurance with a variety of plans, giving the policy owner the option to choose a plan that best meets his needs and budget in terms of the following:

- amount of general medical expenses provided by the policy, such as hospital type and/or room and board charges;
- per policy year, per disability and per lifetime limits; and/or
- amount of deductible and/or co-insurance which he needs to bear.

3.4 These plans are designed to cover the different amounts that the hospital charges for its various wards. Plans with higher benefits will cost more premiums. Lower plans are meant for people who prefer to stay in the four to six bedded wards in a public hospital, while the higher plans are for those who wish to stay in double or single-bedded wards. Usually, the insured person is free to choose the hospital or ward type when he is hospitalised.

3.5 However, the insurer will reimburse the policy owner based only on the plan under which the insured person is insured. Should the insured person wish to stay in a higher ward (i.e. from Ward B to Ward A), the insurer will apply the pro-ration factor accordingly.

C. Family Coverage

3.6 Unlike other types of Health Insurance, most Medical Expense Insurance policies allow the policy owner to include immediate family members (i.e. spouse and children) in the policy. Most insurers also give the policy owner the flexibility of selecting different plans for his family members. In addition, some insurers give a family discount (e.g. 5%) if the application is submitted at the same time.

3.7 **Example 2.1** illustrates how the premium for a family coverage plan is arrived at.

Example 2.1: Illustration Of The Calculation Of The Premium For A Family Coverage Plan

Assuming Mr Andy Ang is buying a policy for himself and his wife and two children. The premium is calculated as follows:

Mr Ang	S$800.00
Mrs Ang	S$800.00
Two Children	S$620.00
Total Gross Premium	S$2220.00
Less: 5% Family Discount	(S$111.00)
Premium Payable	S$2,109.00

D. Reimbursement Of Expenses

3.8 Expenses eligible for reimbursement under the Medical Expense Insurance are those incurred during the period of insurance for medically and reasonably necessary treatments resulting from accident, illness or disease.

3.9 Benefits under the Medical Expense Insurance are provided on a reimbursement basis, i.e. the insurer will reimburse the policy owner up to a maximum dollar amount, or limit for each medical expense item covered under the policy which the insured person incurs.

3.10 For plans which do not specify the limits for each treatment, the insurer will reimburse the actual amount of covered medical expenses incurred by the insured person.

3.11 In other words, the policy owner is not allowed to claim more than the actual medical treatment expenses incurred, nor can he claim more than the limits as stated in his policy.

3.12 When the insured person receives medical treatment, he normally has to pay the charges first, and thereafter seek reimbursement from the insurer for the expenses covered under the plan by filing a claim. For any patient claiming under an Integrated Shield Plan approved under Medisave, all he needs to do is to inform the hospital of the name of his insurer, fill in a standard claim form, and the hospital will file the claim on his behalf for inpatient expenses through an online network called MediClaim System. This applies to public hospitals and major private hospitals.

E. Expense Participation

3.13 Some Medical Expense Insurance policies require the policy owner to share in the payment of the medical expenses incurred. This requirement encourages the insured person to keep medical expenses to a minimum, as well as helps to sieve out small claims. In turn, this helps to reduce the premiums payable.

3.14 The three expense participation methods used by insurers are deductibles, co-insurance and pro-ration factor, and all Integrated Shield Plans, including MediShield Life Scheme, come with these features. Some insurers offer plans with no expense participation, and these plans are payable by cash (i.e. not Medisave approved). Obviously, these types of plans will cost a lot more. They are more suitable for self-employed people who most likely will not have any form of Medical Expense Insurance, except maybe for their MediShield Life Scheme and Medisave savings. Such plans will enable them to enjoy maximum reimbursement of their hospitalisation expenses from the first dollar onwards.

3.15 Although the Integrated Shield Plans offered in Singapore come with deductible, co-insurance and pro-ration factor, there are some insurers that will offer a rider (at an extra premium) to cover the deductible and co-insurance components.

E1. Deductible

Claim from Insurer S$3,500
Policy owner pays Deductible S$1,500

3.16 A deductible is a flat dollar amount of medical expenses that the policy owner must pay out of his own pocket, before the insurer will begin making any benefit payment under the policy. It is usually on a per year basis, i.e. it is applicable again on the yearly renewal of the policy.

3.17 As mentioned, deductibles are found in all Integrated Shield Plans. It is common to find that the deductible is tiered to the Class of Ward that the patient stays in. The higher the Class of Ward, the higher the deductible (e.g. Class C - S$1,500, Class B2/B2+ - S$2,000, Class B1 - S$2,500, and Class A and private hospital - S$3,500). The higher deductibles for higher Ward Classes are to ensure that premiums remain affordable and that such insurance focuses on larger bills.

3.18 There are basically three types of deductibles as follows:

- per annum deductible;
- per disability/per year deductible; and
- per disability (or per claim) deductible.

3.19 Under a per annum deductible, all the eligible expenses incurred by the insured person for a variety of covered illnesses or injuries within a policy year will be used to satisfy the deductible amount. This type of deductible is the most common one used by insurers in Singapore.

3.20 As for the per disability/per year deductible, the deductible amount must be satisfied by eligible medical expenses that are attributable to the same illness or injury within the same policy year.

3.21 The per disability deductible is the most restrictive, as the policy owner has to bear the deductible each time that he makes a claim, regardless of whether the claim is made within the same policy year.

3.22 **Example 2.2** illustrates how the three types of deductibles work.

Example 2.2: Illustration Of The Working Of Per Annum Deductible, Per Disability/Per Year Deductible & Per Claim Deductible

Billy had a Medical Expense Insurance policy with a S$2,000 deductible for the period 1 January 2019 to 31 December 2019. He suffered a high fever on 1 June 2019 and was admitted to the hospital for two days. The hospital bill was S$800 which was within the deductible amount. On 16 July 2019, he developed some skin problems and was hospitalised for observation and treatment. The hospital bill was S$1,800.

For per annum deductible, Billy would have met the deductible on the second hospitalisation and able to claim some expenses, as the total eligible expenses from the two causes exceeded the required S$2,000 within the policy year.

For per disability/per year deductible, no amount would be paid from the insurance because for each disability, the bill would be within the S$2,000 deductible.

Similarly, for per disability deductible, Billy would not be able to claim from the insurance.

3.23 The higher the deductible, the cheaper will be the premium. Most insurers do not impose deductibles on outpatient treatments.

3.24 Deductible is applicable separately on each of the family members insured under the policy. For example, a husband cannot combine his medical expenses with his wife's medical expenses, to satisfy the deductible under the policy for the same policy year.

E2. Co-insurance

3.25 Once the policy owner has satisfied the deductible, he is then eligible for reimbursement under the policy. However, if there is co-insurance, he is required to pay a specified percentage (e.g. 10%) of the total covered medical expenses which are in excess of the deductible. This helps to reduce over-consumption.

3.26 **Example 2.3** illustrates how the deductible and co-insurance principles are applied to a Medical Expense Insurance policy.

Example 2.3: Illustration Of The Application Of Deductible & Co-insurance Under A Medical Expense Insurance Policy

Charlie held a Medical Expense Insurance policy with a per annum deductible of S$2,000 and a 20% co-insurance. He met with a car accident in June 2019 and was admitted to the hospital for one day of observation. The hospital charges were S$1,000. As this amount was below the deductible, he had to pay the full cost of S$1,000 from his own pocket. Even though this amount was not claimable, he was advised to file the claim for the insurer, to consider it as fulfilling part of the deductible amount for that policy year.

In August 2019, Charlie was admitted to the hospital for removal of a kidney stone. The total hospital bill was S$5,000. Assuming that the entire S$5,000 fell within the limit allowed under his policy, the amount payable to him by the insurer would be S$3,200, calculated as follows:

Hospital charges	S$5,000
Less: Deductible*	(S$1,000)
Claimable Amount	S$4,000
Less: Co-insurance (20%)	(S$ 800)
Benefits Paid by Insurer	S$3,200

In the 2nd hospitalisation, Charlie would need only to pay S$1,800 out of the S$5,000 that he had incurred, and this could be settled using Medisave and/or cash.

* Having fulfilled a S$1000 deductible during the June 2019 hospital stay, the deductible that Charlie must pay is the difference. (i.e. S$2,000- $1000)

E3. Pro-ration Factor

3.27 When the insured person is admitted to a hospital better than and/or ward higher than what he is entitled to under his existing insured plan, a percentage (expressed as pro-ration factor in the benefit schedule) is applied on the actual charges incurred and covered under the policy. Therefore, the benefit payable is reduced, to take into account the differences in the Government subsidies applicable to the ward type of the insured plan.

3.28 This ensures fairness within the portfolio, such that those who pay lower premiums for lower plans should be encouraged to use the services available only on the selected plans.

3.29 **Example 2.4** illustrates how pro-ration factors, deductible and co-insurance principles are applied to a Medical Expense Insurance policy.

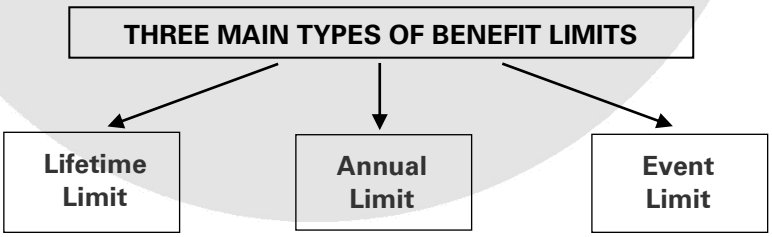
Example 2.4: Illustration Of The Application Of Pro-ration Factors, Deductible and Co-insurance Under A Medical Expense Insurance Policy

Plan Entitlement: Restructured Hospital – any standard B1 ward
Hospitalisation: Private Hospital in Singapore
Pro-ration Factor: 35%
Ward of discharge: Standard Single Bed

Expenses	Limits	Amount incurred	Pro-rated amount	Amount covered by insurance
Daily room, board and medical related services	As charged	S$4,000	S$1,400	S$1,400
Surgical Benefits	As charged	S$20,000	S$7,000	S$7,000
Total Bill		S$24,000	S$8,400	S$8,400
Annual Deductibles		S$3,500		
Co-insurance : 10% x (S$8,400 – S$3,500)		S$490		
You Pay		SS3,500 + S$490 + S$15,600 = S$19,590		
Insurer Pays		S$4,410		

F. Benefit Limits

3.30 Most Medical Expense Insurance plans have maximum limits on the benefits that can be claimed. The three main types of limits are as follows:



3.31 Lifetime limit is often set at a very high amount, e.g. S$1,000,000. This amount is the maximum total amount of all reimbursements that the insurer is liable to the policy owner throughout the life insured's lifetime. Once this limit is reached, the policy will terminate. There is no such limit in some Medical Expense Insurance policies recently issued by some insurers.

3.32 Annual limit, lesser than lifetime limit, is the amount of reimbursable costs payable over an annual period, either a calendar year or a policy year. Simply stated, it is the maximum annual reimbursement for benefits payable by the insurer as stated in the Schedule of Benefits of the policy.

3.33 Event limit is the maximum amount payable per disability or illness as defined in the policy.

3.34 There will also be limits on the individual items of the benefit schedule and these are known as sub-limits. Examples of sub-limits are room and board charges (S$300 per day) or surgical benefits (S$10,000 per claim). For benefits that are represented as "as charged", sub-limits are not applicable, but lifetime and annual limits will still apply.

G. Covered Charges

3.35 All Medical Expense Insurance policies will specify the expenses and its limits that will be covered under the plan. Charges, services and expenses are three interrelated terms used. The covered services and treatments typically include all or some of the following medical expenses:

- room and board;
- intensive care;
- miscellaneous hospital services, such as laboratory fees, X-rays, medication and the use of an operating room;
- surgery (including anaesthesia and oxygen administration);
- hospital consultation;
- ambulance services;
- in-hospital doctor's fees; and
- specified outpatient expenses, such as specialist consultation, emergency accidental treatment and post-hospitalisation treatment, etc.

H. Geographical Limit

3.36 Most Individual Medical Expense Insurance policies will automatically terminate if the insured resides outside of Singapore for more than a specified period of time (e.g. 180 days). However, some insurers will terminate the policy only if the insured is not a Singapore Citizen or Singapore Permanent Resident (SPR).

3.37 In addition, some insurers will still pay for the medical treatments even though the insured has resided outside of Singapore longer than the specified period allowed, but any medical expenses incurred overseas will be based on the reasonable and customary charges for that particular medical treatment in Singapore, and will be subject to the limits as stated in the policy.

3.38 If the insured is a Singapore Citizen or SPR, the insurer will usually allow the policy to renew at an extra premium, even though the insured is stationed overseas after a specified period of time, subject to the insured's written confirmation of the insurance cover for the insured.

3.39 Some high-end Individual Medical Expense Insurance plans also allow the insured to seek medical treatment overseas, although the medical treatment is available in Singapore. However, the reimbursement of such incurred medical expenses will be based on the reasonable and customary charges for that particular medical treatment in the country of treatment, and will be subject to the limits as stated in the policy.

I. Waiting Period

3.40 When an individual signs up for a new Health Insurance policy, the cover may not start on the policy issue date. Some insurers impose a waiting period – a period of time stated in the policy which must pass, before some or all of his Health Insurance coverage can begin. In other words, the insurer is liable to pay any claim amount filed only after this waiting period. The waiting period is not applicable for accidental injury. This means that, in the case of injury caused by an accident, the insured will be covered immediately.

3.41 A waiting period protects members within the portfolio, by ensuring that individuals are not able to make claims shortly after joining and then cancelling their membership. This kind of behaviour will result in increased premiums for all members. Some insurers may impose a waiting period for pre-existing conditions.

J. Age Limits

3.42 Most insurers issue this policy to people who are as young as 15 days old and below a specified maximum age of entry, e.g. 74 or 75 years old. Children are allowed to be insured under the parent’s policy up to the age 18 or 25 years, if he is still pursuing full-time tertiary education.

K. Premiums

3.43 The premiums for Medical Expense Insurance are usually based on age band and increase as one ages, i.e. if a person crosses to the next age band, he has to pay a higher premium upon renewal, based on the new age band that he falls under. Premium rates are not guaranteed and may be adjusted on the premium due date or next renewal date to account for higher claims, medical inflation, etc. However, the insurer will need to give advance notice (e.g. 30 days) to the policy owner before effecting the premium increase.

3.44 Premiums can be payable on a monthly, quarterly, half-yearly or yearly basis, and are normally higher for female lives. Note that insurers may use the same premium tables for male and female lives.

L. Renewability

3.45 Some Medical Expense Insurance policies are issued on a guaranteed renewable basis. This means that the insurer cannot terminate the policy owing to poor claims experience, so long as the policy owner pays his premium to keep the policy in force. All the IP policies are guaranteed renewable.

3.46 However, there are policies which are cancellable at the option of the insurer, by giving a specified number of days' notice (e.g. 60 days) to the policy owner.

M. Exclusions & Limitations

3.47 All Medical Expense Insurance policies have limitations and exclusions that specify the circumstances under which a claim will not be payable.

3.48 Generally, exclusions and limitations are designed for the following reasons:

- to avoid the possibility of a policy owner receiving reimbursement twice for the same charges, or making a profit from his insurance;
- to make the premium more affordable;
- to define more clearly the necessary medical care and treatment; and
- to avoid the policy owner selecting against the insurer (i.e. anti-selection).

M1. Exclusions

3.49 The common exclusions under Medical Expense Insurance policies usually include:

- pre-existing conditions that were present during a specified period (e.g. 12 months) prior to the inception of the insurance;
- congenital anomalies;
- cosmetic surgery, dental treatment and vision care;
- convalescent and special nursing care, general medical check-up;
- pregnancy, infertility, birth control, childbirth and their related complications;
- mental or nervous disorder, drug addiction and alcoholism;
- Acquired Immune Deficiency Syndrome (AIDS) and its related complications, sexually transmitted diseases;
- flying or aerial activity, other than as a fare-paying passenger on a regularly scheduled flight of a commercial aircraft;
- hazardous sports, such as mountaineering, scuba diving, ice skating, bungee jumping, etc.;
- illnesses or injuries arising from war, nuclear, participation in strike, riot or civil commotion;
- self-inflicted injuries and injuries resulting from a criminal or unlawful act;

- purchase of hospital-type equipment, such as wheelchair, dialysis machine, etc.; and
- treatment for obesity, weight reduction or improvement.

3.50 Exclusions vary from insurer to insurer. Clients should be advised and reminded to read the policy documents i.e. they need to understand the specific exclusions imposed by their insurers.

M2. Limitations (Co-ordination Of Benefits)

3.51 Most Medical Expense Insurance policies are issued with the Co-ordination of Benefits Clause. The purpose of this Clause is to ensure that the total claims made by the policy owner cannot exceed the total actual medical expenses incurred.

3.52 Hence, should the policy owner be able to obtain payments from other sources (e.g. employer's Group H&S Insurance policy or Work Injury Compensation Insurance policy, etc.), the amount payable by the insurer under a Medical Expense Insurance policy will be reduced, so that the total benefits received will not exceed the total incurred medical expenses.

4. UNDERWRITING

4.1 The main source of underwriting information for individual Medical Expense Insurance is the proposal form. For group coverage, the employer is required to complete a Group Insurance Fact-Finding (GIFF) Form which is the main source of information for the underwriting assessment. For small groups (e.g. below 10 members/employees), the underwriter may also require the individual employee to complete a health declaration form.

5. HEALTHCARE SUBSIDY LEVEL

5.1 Citizens, SPRs and foreigners in Singapore are charged differently for public healthcare services. Citizens enjoy heavy subsidies in Class B2/B2+ and C wards. SPRs receive significant subsidy, while foreigners are not subsidised at all. The subsidy level distinction reflects the privileges of citizenship, and to further sharpen the distinction between citizens and SPRs. Refer to **Appendix 2C** for the Table of Subsidy Level.

5.2 Owing to the differences in healthcare subsidy for citizens, SPR and foreigners, some insurers apply a citizenship factor on the hospitalisation claims. Citizenship factor means a percentage applied to the medical expenses of an insured person (who is not a Singaporean), that is claimable under the policy.

6. TERMINATION OF COVER

6.1 The coverage for an insured person will terminate when one of the following events occurs:

- death of the insured person;
- date on which the insured person enters into full-time military service, except during National Service reservist duty or training in accordance with the Enlistment Act 1970;
- the end of the policy period during which the insured person attains the maximum age covered under the policy (e.g. 80 years old);
- date on which the policy is terminated;
- date of expiry of the period for which the last premium payment is made on account of the insured person's insurance;
- the total amount of claims made has reached the lifetime limit;

Applicable to both individual and group policies

- date of cessation of the insured person as an employee.

Applicable to group policies only

7. CLAIMS

7.1 In the event of a claim, the insured (policy owner/employer) is required to furnish the following supporting documents to the insurer:

- claim form to be completed by the insured;
- physician's statement by the attending doctor;
- discharge summary; and
- original medical bills.

7.2 These are the standard documents required by the insurer to assess the claim. The insurer reserves the right to call for other necessary documents. As mentioned previously, for any patient claiming under an Integrated Shield Plan approved under Medisave, all he needs to do is to inform the hospital of the name of the insurer, fill in a standard claim form and the hospital will file the claim on his behalf for inpatient expenses, through the MediClaim System. This applies to public hospitals and major private hospitals in Singapore.

7.3 The policy owner is required to notify the insurer within a specified period of time (e.g. 90 days) after the date of incurring the medical costs.

8. NOTICE No.: MAS 117 - TRAINING AND COMPETENCY REQUIREMENTS – HEALTH INSURANCE

8.1 This Notice issued on 26 January 2004 and last revised on 16 April 2020, is issued pursuant to sections 71 and 154(4) of the Insurance Act 1966 and

(a) applies to:

(i) a direct insurer;

(ii) a direct insurance broker;

(iii) an exempt direct insurance broker;

(iv) a licensed financial adviser; or

(v) an exempt financial adviser,

which carries on a business in relation to health insurance products, whether or not it carries on any other business; and

(b) applies to—

(i) any person employed by or who act as an insurance agent for a direct insurer, other than a Trade Specific Agent;

(ii) any person employed by or who act for a direct insurance broker or an exempt direct insurance broker; or

(iii) any person employed by or who acts as an appointed representative for a licensed financial adviser or an exempt financial adviser,

who provides advice on or arranges contracts of insurance or both, in respect of health insurance products.

8.2 This Notice sets out the minimum examination requirements and continuing professional development ("CPD") requirements in respect of shield plans. Please refer to **Appendix 2D for Notice No: MAS 117** which has been entirely extracted from MAS website.

8.3 The last revision of Notice No: MAS 117 on 16 April 2020 also outlined certain relief measures during the COVID-19 situation as detailed in paras 7A to 7D of the Notice as detailed in **Appendix 2D.**

APPENDIX 2A

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

MEDICAL EXPENSE INSURANCE (WITH SUB-LIMITS)

Core Benefits	Benefit Limits
Room & Board Daily Limits (max. 90 days per Disability Period per Policy Year)	$300
Intensive Care Unit (max.15 days per Disability Period per Policy Year)	
In-Patient Doctor/ Specialist Consultation	
Pre-Hospitalisation Benefits (max. 30 days before date of hospitalisation)	
Post-Hospitalisation Treatment (max. 90 days after date of discharge)	As Charged
Surgical Benefits	
Emergency Dental Treatment	
Emergency Outpatient Accidental Treatment	
Emergency Ambulance Service	
Miscellaneous Hospital Expenses	
Annual Limit for Core Benefits	**S$100,000**
Additional Benefits	
Outpatient Kidney Dialysis Treatment (annual limit)	**S$50,000**
Outpatient Cancer Treatment	S$50,000
In-Patient Organ Transplant	S$50,000
Lifetime Limit for Core Benefit & Additional Benefits	**S$500,000**
Emergency Assistance Services	Available

APPENDIX 2B

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

SCHEDULE OF SURGICAL BENEFITS

Hospital ward type	Any standard ward of a private **hospital**	Any standard ward of a **restructured hospital**	Any 4-bed (B1) standard ward of a **restructured hospital**
Inpatient hospital treatment			
Daily room, board and medical related services[1]	As charged		
Intensive care unit (ICU)[1]			
Surgical benefit			
Surgical implants [2]			
Radio**surgery** [3,4]			
Major organ transplant benefit [5]			
Stem cell transplant benefit [4]			
Accident inpatient dental treatment [6]			
Pre-hospital treatment (Accident and emergency (A&E) treatment within 24 hours prior to an **inpatient** treatment for the same **injury** or **illness** is covered.)	As charged up to 90 days prior to admission. or As charged up to 180 days prior to admission (**panel specialist** in a private **hospital** with **certificate of pre-authorisation**, **restructure hospital** or **community hospital**).		
Post-**hospital** treatment[7]	As charged up to 180 days after discharge. or As charged up to 365 days after discharge (**panel specialist**[7] in a private hospital with **certificate of pre-authorisation**, **restructure hospital** or **community hospital**).		
Stay in a **community hospital** [8]	As charged		
Inpatient congenital anomalies (first diagnosed after a **waiting period** of 12 months)	As charged		
Inpatient pregnancy complications [9] (after a **waiting period** of 10 months)	As charged		
Living donor organ transplant [10] (after a **waiting period** of 24 months)	S$50,000 per lifetime	S$30,000 per lifetime	$20,000 per lifetime

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

SCHEDULE OF SURGICAL BENEFITS (CONT'D)

Major outpatient treatment			
Outpatient kidney dialysis	As charged		
Outpatient erythropoietin			
Outpatient cancer treatment[4] which includes: - Chemotherapy - External or superficial radiotherapy - Brachytherapy, with or without external radiotherapy - Immunotherapy - Stereotactic radiotherapy			
Major organ transplant – approved Immunosuppressant drugs			
Special benefits			
Extra **inpatient** benefit for 5 **critical illnesses** – heart attack of specified severity, major cancer[4], stroke, end stage lung disease and end stage liver disease	S$150,000 per **policy year**	S$100,00 per **policy year**	S$50,000 per **policy year**
Inpatient psychiatric treatment[11] (after 10 months of continuous cover)	As charged up to 60 days per **policy year**	As charged up to 45 days per **policy year**	As charged up to 35 days per **policy year**
Inpatient psychiatric treatment[11] (within 10 months of continuous cover)	S$500 per day up to 35 days per **policy year**		
Family discount for child(ren)	Yes	Yes	N.A.
Free new-born benefit[12]	S$50,000 per **policy year**		N.A.
Emergency overseas treatment[13]	As charged (pegged to costs of private **hospital**s in Singapore)	As charged (pegged to costs of **restructured hospital**s in Singapore)	As charged (pegged to costs of restructured **hospital**s in Singapore)
Planned overseas treatment[13]	As charged (pegged to costs of private **hospital**s in Singapore)	As charged (pegged to costs of **restructured hospital**s in Singapore)	As charged (pegged to costs of restructured **hospital**s in Singapore)
Inpatient and outpatient Proton Beam Therapy treatment[14]	S$25,000 per **policy year**	S$15,000 **per policy year**	S$10,000 **per policy year**
Inpatient and outpatient Cell, Tissue and Gene Therapy[14]	S$70,000 per **policy year**	S$45,000 per **policy year**	S$30,000 per **policy year**
Waiver of pro-ration factor benefit for outpatient kidney dialysis	N.A.	As charged (if kidney dialysis is received at a panel private dialysis centre[15])	
Preventive treatment for cancer[16]	As charged		
Final Expenses Benefit[17]	S$10,000		

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

SCHEDULE OF SURGICAL BENEFITS (CONT'D)

Pro-ration factor				
Restructured Hospital	Class A ward / Unsubsidised short stay ward	100%	100%	85%[18]
Private **Hospital**	Inpatient (including day **surgery)**			
	Major outpatient treatment		50%[18]	35%[18]
Community hospital – Unsubsidised ward			100%	85%
Hospital outside Singapore			50%[18]	35%[18]
MyShield annual deductible[20] for life assured age 80 years and below next birthday				
Inpatient				
Class C ward		S$1,500		
Class B2 / B2+ ward		S$2,000		
Class B1 ward		S$2,500		
Class A ward / Private hospital		S$3,500		
Hospital outside Singapore				
Subsidised short stay ward		S$2,000		
Unsubsidised short stay ward		S$3,500		
Day **surgery**		S$3,000	S$3,000	S$3,000
MyShield annual deductible[20] for life assured age 81 years and above next birthday				
Inpatient				
Class C ward		S$2,250		
Class B2 / B2+ ward		S$3,000		
Class B1 ward		S$3,750		
Class A ward / Private **hospital**		S$5,250		
Hospital outside Singapore				
Subsidised short stay ward		S$3,000		
Unsubsidised short stay ward		S$5,250		
Day **surgery**		S$4,500	S$4,500	S$3,000
Co-insurance (applicable to claimable amount <u>after</u> MyShield annual deductible)		10% Maximum S$25,500 per **policy year.**		

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

SCHEDULE OF SURGICAL BENEFITS (CONT'D)

Maximum claim limits			
Policy year limit	S$1,000,000 or S$2,000,000[21] (**Panel specialist** in a private **hospital** with certificate of **pre-authorisation, restructured hospital** or **community hospital**)	S$1,000,000	S$500,000
Lifetime limit	Unlimited		
Age limits (age next birthday)			
Last entry age	75 years old		
Maximum cover age	Lifetime		

APPENDIX 2C

Subsidy Level For Singapore Citizens & SPRs At Public Hospitals

Ward Class/ Service Type	Singapore Citizen Subsidy Level	Singapore Permanent Residents Subsidy Level
Class B2	50-65%	25-40%
Class C	65-80%	32.5-55%

Only Singaporeans and Permanent Residents (PRs) are eligible for hospital subsidies. Subsidy level accorded depend on the choice of ward class and resident status. Subsidy level would also depend on your income level.

With effect from 1 November 2022, subsidies for acute inpatient care will be means-tested based on a patient's per capita household income (PCHI). A single common subsidy framework for C and B2 Wards will also be applied. The revised subsidy framework is as shown below.

Ward Class/ Service Type	Singapore Citizen Subsidy Level	Singapore Permanent Residents Subsidy Level
Class B2/C	50-80%	25-50%

Source: MOH Website

APPENDIX 2D

Notice No : MAS 117
Issue Date : 26 January 2004

Last revised on: 16 April 2020*

(Refer to endnote for history of amendments)

TRAINING AND COMPETENCY REQUIREMENT: HEALTH INSURANCE

Introduction

1. This Notice is issued pursuant to sections 71 and 154(4) of the Insurance Act 1966 ["the Act"] and—

(a) applies to—

(a) a direct insurer;
(b) a direct insurance broker;
(c) an exempt direct insurance broker;
(d) a licensed financial adviser; or
(e) an exempt financial adviser,

which carries on a business in relation to health insurance products, whether or not it carries on any other business; and

(b) applies to—

(i) any person employed by or who act as an insurance agent for a direct insurer, other than a Trade Specific Agent;

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]

(ii) any person employed by or who act for a direct insurance broker or an exempt direct insurance broker; or
(iii) any person employed by or who acts as an appointed representative for a licensed financial adviser or an exempt financial adviser,

[MAS 117 (Amendment) 2010, wef 26 Nov 2010]

who provides advice on or arranges contracts of insurance or both, in respect of health insurance products.

1A. This Notice sets out the following:

(a) minimum examination requirements; and
(b) continuing professional development ("CPD") requirements in respect of shield plans.

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

Definitions

2. For the purpose of this Notice—

"Agents' Registration Board" means the board set up by the General Insurance Association of Singapore ("GIAS") to register any general insurance agent acting for one or more licensed insurers carrying on general business;

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]
[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"business day" means any calendar day, other than a Saturday, Sunday or public holiday;

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

"exempt financial adviser" means a person exempt from holding a financial adviser's licence under section 23(1)(a) to (e) of the Financial Advisers Act (Cap. 110);

"exempt direct insurance broker" means a person exempt from registration as a direct insurance broker under section 35ZN(1)(a) to (ea) of the Act;

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]

"health insurance product" means a life policy with accident and health benefits or an accident and health policy, but excludes such policy where accident and health benefits are paid out only—

(a) in the event of an injury to, or disability of, the insured as a result of an accident;
(b) in the event that the insured becomes total and permanently disabled;
(c) on the death of the insured by accidental cause; or
(d) on the occurrence of a combination of the events set out in (a) to (c);

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]
[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"integrated shield plan" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations;

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"MediShield Life Scheme" means the Scheme established under section 3 of the MediShield Life Scheme Act 2015 (No. 4 of 2015);

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"non-integrated shield plan" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations;

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"relevant date" means the earliest of the dates mentioned in paragraph 7A(c), (d) or (e);

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

"shield plan" means an integrated shield plan or non-integrated shield plan; and

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

"Trade Specific Agent" means an insurance agent for a direct general insurer who is —

(a) not carrying on business in Singapore as his core business; and
(b) registered with the Agents' Registration Board pursuant to paragraph 6 of MAS Notice 211.

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]
[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

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

MINIMUM EXAMINATION REQUIREMENTS

Requirements to pass the health insurance module

4. Subject to paragraphs 6, 7 and 7A, any individual—

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

(a) who—

(i) is employed by or acts as an insurance agent for a direct insurer, other than a Trade Specific Agent;

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]

(ii) is employed by or acts for a direct insurance broker or an exempt direct insurance broker; or

(iii) is employed by or acts as an appointed representative for a licensed financial adviser or an exempt financial adviser;

[MAS 117 (Amendment) 2010, wef 11 Aug 2010]

and

(b) who wishes to provide advice on or arrange contracts of insurance or both, in respect of health insurance products,

is required to pass the health insurance module conducted by the Singapore College of Insurance (SCI).

5. Subject to paragraph 7B, a direct insurer, a direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser shall ensure that any individual it employs or, where applicable, who acts for it, acts as its insurance agent or acts as its appointed representative, complies with the requirement in paragraph 4.

[MAS 117 (Amendment) 2010, wef 26 Nov 2010]
[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

Exclusion

6. Any individual—

(a) who, prior to 1 January 2002,—

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

(ii) is employed by or acts for a direct insurance broker or an exempt direct insurance brokers;

and

(b) who had been providing advice or arranging contracts of insurance or both, in respect of health insurance products that contain what is commonly known as critical illness benefit as the only accident and health benefits in the product,

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

is not required to comply with the requirement in paragraph 4 if he has completed a non-examinable course on critical illness insurance conducted by SCI or an approved in-house course covering SCI's syllabus on critical illness insurance by 1 July 2002.

7. Any individual—

(a) who, —

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

(ii) is employed by or acts for a direct insurance broker or an exempt direct insurance brokers;

(iii) is employed by or acts as an appointed representative for a licensed financial adviser or an exempt financial adviser;

[MAS 117 (Amendment) 2004, wef 13 Feb 2004]
[MAS 117 (Amendment) 2010, wef 26 Nov 2010]

and

(b) who provides advice on or arranges contracts of insurance or both, in respect of health insurance products that contain what are commonly known as critical illness benefit or hospital income benefit or both, as the only accident and health benefits in the product,

is not required to comply with the requirement in paragraph 4 if he has obtained passes in any of the following modules:

(i) Certificate in General Insurance - Basic Insurance Concepts & Principles and Personal General Insurance;
(ii) Capital Markets & Financial Advisory Services Module 9: Life Insurance and Investment-Linked Policies.

[MAS 117 (Amendment) 2004, wef 13 Feb 2004]

Relief Measures During the COVID-19 Situation

7A An individual

(a) who —

(i) is employed by or is appointed to act as an insurance agent for a direct insurer;
(ii) is employed by or is appointed to act for a direct insurance broker or an exempt direct insurance broker; or
(iii) is employed by or is appointed to act as an appointed representative for a licensed financial adviser or an exempt financial adviser, and

(b) who wishes to commence providing advice on or arranging contracts of insurance or both, in respect of health insurance products, between 16 April 2020 and 30 September 2020 (both dates inclusive),

is not required to comply with the requirement in paragraph 4, for a period of six months (or such longer period as may be allowed by the Authority in writing) from the earliest of the following dates:

(a) the date the individual commences providing advice on health insurance products;
(b) the date the individual commences arranging contracts of insurance in respect of health insurance products;
(c) the date the individual commences providing advice on health insurance products and arranging contracts of insurance in respect of health insurance products.

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

7B Any –

(a) direct insurer which employs, or appoints to act as its insurance agent, an individual mentioned in paragraph 7A(a)(i) who wishes to commence activities mentioned in paragraph 7A(b);

(b) a direct insurance broker or exempt direct insurance broker, which employs, or appoints to act for it, an individual mentioned in paragraph 7A(a)(ii) who wishes to commence activities mentioned in paragraph 7A(b);

(c) licensed financial adviser or exempt financial adviser, which employs, or appoints to act as its appointed representative, an individual mentioned in paragraph 7A(a)(iii) who wishes to commence activities mentioned in paragraph 7A(b);

is not required to comply with the requirement in paragraph 5 in respect of that individual for a period of six months from the relevant date (or such longer period as may be allowed by the Authority in writing).

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

7C A direct insurer, a direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser which relies on the exemption under paragraph 7B must for the duration where the individual relies on the exemption under paragraph 7A (called in this paragraph the "relevant individual") –

(a) put in place measures[1] to properly supervise the activities and conduct of the relevant individual, including measures to ensure that all obligations assumed and liabilities incurred by the relevant individual are properly fulfilled, whether actual or contingent and howsoever arising, in relation to the provision of advice on or arrangement of contracts of insurance or both, in respect of health insurance products, by the relevant individual;

and

(b) put in place measures, including proper training, to ensure that the relevant individual understands and complies with all Singapore laws that are relevant to the provision of advice on or arrangement of contracts of insurance or both, in respect of health insurance products, by the relevant individual.

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

---

[1] The direct insurer, direct insurance broker, exempt direct insurance broker, licensed financial adviser and exempt financial adviser may refer to the Frequently Asked Questions (FAQs) on Relief Measures Relating to COVID-19 Situation - General Insurance and Health Insurance Examinations and Continuing Professional Development Requirements.

7D Where a direct insurer, a direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser (called in this paragraph a "relevant person") employs or, where applicable, appoints to act for it, or appoints to act as its insurance agent or appointed representative, as the case may be, an individual who relies on the exemption under paragraph 7A, the relevant person must submit to the Authority all of the following information, within three business days from the relevant date –

(a) the individual's name;
(b) the relevant date;
(c) the individual's representative number, if applicable.

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

Additional requirements

8. A direct insurer shall not accept any business in respect of any health insurance product from any individual whom it employs or who acts as its insurance agent and who has not complied with the requirement in paragraph 4 and does not fall under paragraphs 6, 7 or 7A of this Notice.

[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

9. A direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser shall not pass on any business in respect of any health insurance product to an insurer if it is received from any individual whom it employs or, where applicable, who acts for it or act as its appointed representative, and who has not complied with the requirement in paragraph 4 and does not fall under paragraphs 6, 7 or 7A of this Notice.

[MAS 117 (Amendment) 2010, wef 26 Nov 2010]
[MAS 117 (Amendment) 2015, wef 1 Jan 2016]
[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

CPD REQUIREMENTS IN RESPECT OF SHIELD PLANS

Minimum number of CPD training hours required

9A. Any individual—

(a) who—

(i) is employed by or acts as an insurance agent for a direct insurer, other than a Trade Specific Agent;
(ii) is employed by or acts for a direct insurance broker or an exempt direct insurance broker; or
(iii) is employed by or acts as an appointed representative for a licensed financial adviser or an exempt financial adviser;

and

(b) who wishes to provide advice on or arrange contracts of insurance or both, in respect of shield plans,

is required to complete a minimum of 2 hours of structured CPD training[2] on –

(i) MediShield Life Scheme content;
(ii) shield plan content; or
(iii) a combination of MediShield Life Scheme content and shield plan content,

before the end of each calendar year (or within such longer period as may be allowed by the Authority in writing).

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]
[MAS 117 (Amendment) 2020, wef 16 Apr 2020]

Exclusion

9B. Any individual—

(a) who—

(i) is employed by or acts as an insurance agent for a direct insurer, other than a Trade Specific Agent;

(ii) is employed by or acts for a direct insurance broker or an exempt direct insurance broker; or

(iii) is employed by or acts as an appointed representative for a licensed financial adviser or an exempt financial adviser;

and

(b) who wishes to provide advice on or arrange contracts of insurance or both, in respect of shield plans,

is not required to comply with the requirement in paragraph 9A,

(i) for the calendar year that he passes the health insurance module conducted by SCI; or

(ii) for the calendar year that he was appointed, if he was appointed anytime between 1 October and 31 December (both dates inclusive) of that calendar year.

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

[2]Structured CPD training includes lectures, conferences, workshops and courses, which have clear learning objectives and outcomes, and such learning objectives and outcomes are clearly documented and independently verified. Structured CPD training excludes activities that are part of the job scope of the individual referred to in paragraph 9A such as carrying out research on products and services for clients but will include product seminars prior to the launch of new products and e-learning courses.

9C. A direct insurer, a direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser shall ensure that any individual it employs or, where applicable, who acts as its insurance agent or appointed representative complies with the requirements in paragraph 9A.

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

9D. A direct insurer, a direct insurance broker, an exempt direct insurance broker, a licensed financial adviser or an exempt financial adviser shall obtain, and retain for a period of 5 years from the date of the written records, written records and supporting documents that show that any individual which it employs or who acts as its insurance agent or appointed representative has complied with the requirements in paragraph 9A.

[MAS 117 (Amendment) 2015, wef 1 Jan 2016]

Contravention of requirements imposed

10. Contravention of any requirement imposed under this Notice is an offence and attracts the penalty specified in section 55(2) of the Act.

Commencement and cancellation

11. This Notice shall take effect on 26 January 2004. Notice MAS 117 on "Training and Competency Requirement: Health Insurance Module" dated 31 December 2002 is cancelled.

*Endnotes of History of Amendments

1. MAS Notice 117 (Amendment) 2004 dated 13 February 2004 with effect from 13 February 2004
2. MAS Notice 117 (Amendment) 2010 dated 11 August 2010 with effect from 11 August 2010
3. MAS Notice 117 (Amendment) 2010 dated 26 November 2010 with effect from 26 November 2010
4. MAS Notice 117 (Amendment) 2015 dated 28 December 2015 with effect from 1 January 2016
5. MAS Notice 117 (Amendment) 2020 dated 16 April 2020 with effect from 16 April 2020

CHAPTER 02

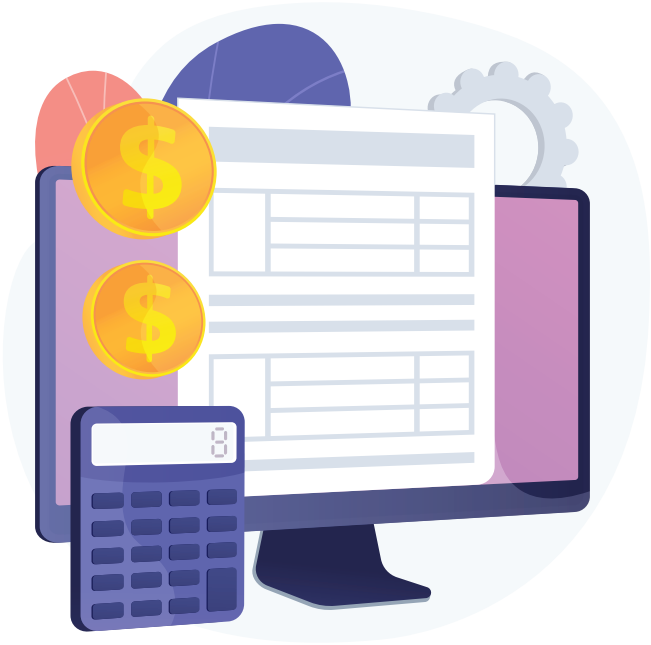
MEDICAL EXPENSE INSURANCE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Three broad categories of Health Insurance	• A reimbursement for the cost of medical treatment or nursing care; or • A periodic income upon disability or hospitalisation; or • A fixed cash amount upon disability or suffering from a major illness.
Types of coverage provided under a Medical Expense Insurance policy	• Inpatient expenses. • Outpatient expenses. • Catastrophic outpatient expenses. Some policies also extend cover to include: • Emergency medical evacuation. • Private nursing home care.
Other benefits offered by insurers under a Medical Expense Insurance policy	• Specific disease insurance; • Miscarriage benefit; • Private nursing home care; • Daily hospital cash; • Emergency medical evacuation benefit; and • Final expenses benefit.

Key features of Medical Expense Insurance

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Stand-alone or a rider	Medical Expense Insurance can be offered as a rider or a stand-alone policy. If issued as a rider, it is often attached to a permanent Life Insurance policy. Note that it is not common in Singapore for Medical Expense Insurance to be offered as a rider.
Choice of plans	Insurers normally offer Medical Expense Insurance with a variety of plans, giving the policy owner the option to choose a plan that best meets his needs and budget.
Family coverage	Unlike other types of Health Insurance, most Medical Expense Insurance policies allow the policy owner to include immediate family members (i.e. spouse and children) in the policy. Most insurers also give the policy owner the flexibility of selecting different plans for his family members. In addition, some insurers give a family discount (e.g. 5%) if the application is submitted at the same time.
Reimbursement of expenses	Benefits under the Medical Expense Insurance are provided on a reimbursement basis, i.e. the insurer will reimburse the policy owner up to a maximum dollar amount, or limit for each medical expense item covered under the policy which the insured person incurs.
Expense participation (deductible, co-insurance and pro-ration factor)	• A deductible is a flat dollar amount of medical expenses that the policy owner must pay out of his own pocket, before the insurer will begin making any benefit payment under the policy. It is usually on a per year basis, i.e. it is applicable again on the yearly renewal of the policy. • Once the policy owner has satisfied the deductible, he is then eligible for reimbursement under the policy. However, if there is co-insurance, he is required to pay a specified percentage (e.g. 10%) of the total covered medical expenses which are in excess of the deductible. This helps to reduce over-consumption. • When the insured person is admitted to a hospital better than and/or ward higher than what he is entitled to under his existing insured plan, a percentage (expressed as pro-ration factor in the benefit schedule) is applied on the actual charges incurred and covered under the policy. Therefore, the benefit payable is reduced, to take into account the differences in the Government subsidies applicable to the ward type of the insured plan.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Benefit limits	• Lifetime limit. This amount is the maximum total amount of all reimbursements that the insurer is liable to the policy owner throughout the life insured's lifetime. • Annual limit. It is the maximum annual reimbursement for benefits payable by the insurer as stated in the Schedule of Benefits of the policy. • Event limit. The maximum amount payable per disability or illness as defined in the policy
Covered charges	All Medical Expense Insurance policies will specify the expenses and its limits that will be covered under the plan. Charges, services and expenses are three interrelated terms used.
Geographical limit	Most Individual Medical Expense Insurance policies will automatically terminate if the insured resides outside of Singapore for more than a specified period of time (e.g. 180 days). However, some insurers will terminate the policy only if the insured is not a Singapore Citizen or Singapore Permanent Resident (SPR).
Waiting period	A period of time stated in the policy which must pass, before some or all of his Health Insurance coverage can begin. In other words, the insurer is liable to pay any claim amount filed only after this waiting period. The waiting period is not applicable for accidental injury. This means that, in the case of injury caused by an accident, the insured will be covered immediately.
Age limits	Most insurers issue this policy to people who are as young as 15 days old and below a specified maximum age of entry, e.g. 74 or 75 years old. Children are allowed to be insured under the parent's policy up to the age 18 or 25 years, if he is still pursuing full-time tertiary education.
Premiums	The premiums for Medical Expense Insurance are usually based on age band and increase as one ages, i.e. if a person crosses to the next age band, he has to pay a higher premium upon renewal, based on the new age band that he falls under. Premium rates are not guaranteed and may be adjusted on the premium due date or next renewal date to account for higher claims, medical inflation, etc.
Renewability	Some Medical Expense Insurance policies are issued on a guaranteed renewable basis. This means that the insurer cannot terminate the policy owing to poor claims experience, so long as the policy owner pays his premium to keep the policy in force. All the IP policies are guaranteed renewable.
Common exclusions under Medical Expense Insurance	• Pre-existing conditions that were present during a specified period (e.g. 12 months) prior to the inception of the insurance; • Congenital anomalies; • Cosmetic surgery, dental treatment and vision care; • Convalescent and special nursing care, general medical check-up; • Pregnancy, infertility, birth control, childbirth and their related complications; • Mental or nervous disorder, drug addiction and alcoholism; • Acquired Immune Deficiency Syndrome (AIDS) and its related complications, sexually transmitted diseases; • Flying or aerial activity, other than as a fare-paying passenger on a regularly scheduled flight of a commercial aircraft; • Hazardous sports, such as mountaineering, scuba diving, ice skating, bungee jumping, etc.; • Illnesses or injuries arising from war, nuclear, participation in strike, riot or civil commotion; • Self-inflicted injuries and injuries resulting from a criminal or unlawful act; • Purchase of hospital-type equipment, such as wheelchair, dialysis machine, etc.; and • Treatment for obesity, weight reduction or improvement. Exclusions vary from insurer to insurer. Clients should be advised and reminded to read the policy documents i.e. they need to understand the specific exclusions imposed by their insurers.



IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Limitations (co-ordination of benefits) under Medical Expense Insurance	• The purpose of this Clause is to ensure that the total claims made by the policy owner cannot exceed the total actual medical expenses incurred. • Should the policy owner be able to obtain payments from other sources, the amount payable by the insurer under a Medical Expense Insurance policy will be reduced, so that the total benefits received will not exceed the total incurred medical expenses.
General guidelines on how group policies can be extended to cover Employees' immediate family members	Unlike other types of Health Insurance, most Medical Expense Insurance policies allow the policy owner to include immediate family members (i.e. spouse and children) in the policy. Most insurers also give the policy owner the flexibility of selecting different plans for his family members. In addition, some insurers give a family discount (e.g. 5%) if the application is submitted at the same time.
Underwriting requirements for both individual and group covers	The main source of underwriting information for individual Medical Expense Insurance is the proposal form. For group coverage, the employer is required to complete a Group Insurance Fact-Finding (GIFF) Form which is the main source of information for the underwriting assessment. For small groups (e.g. below 10 members/employees), the underwriter may also require the individual employee to complete a health declaration form.
Subsidy distinction between citizens and non-citizens	Owing to the differences in healthcare subsidy for citizens, SPR and foreigners, some insurers apply a citizenship factor on the hospitalisation claims. Citizenship factor means a percentage applied to the medical expenses of an insured person (who is not a Singaporean), that is claimable under the policy.
When the coverage of an insured person under a Medical Expense Insurance policy will terminate	• Death of the insured person. • Date on which the insured person enters into full-time military service, except during National Service reservist duty or training in accordance with the Enlistment Act 1970. • The end of the policy period during which the insured person attains the maximum age covered under the policy (e.g. 80 years old). • Date on which the policy is terminated. • Date of expiry of the period for which the last premium payment is made on account of the insured person's insurance. • The total amount of claims made has reached the lifetime limit. • Date of cessation of the insured person as an employee. Applicable to group policies only.
Documents to be furnished in the event of a claim	• Claim form to be completed by the insured; • Physician's statement by the attending doctor; • Discharge summary; and • Original medical bills. These are the standard documents required by the insurer to assess the claim. The insurer reserves the right to call for other necessary documents.

CHAPTER 3
GROUP MEDICAL EXPENSE INSURANCE

CHAPTER OUTLINE

1. Introduction
2. Group Insurance
3. Individual & Group Medical Expense Insurance
4. Portable, Transferable Medical Benefits & Shield Plans For Employees

Appendix 3A - Transferable Medical Insurance Certification

LEARNING OUTCOMES

After studying this chapter, you should be able to:

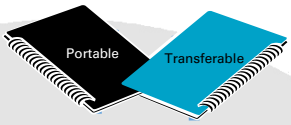
- know the criteria for a group to be eligible for Group Insurance cover
- state the characteristics of a Group Insurance policy
- understand the Medical Insurance requirements for foreign workers
- explain the differences between a compulsory and a voluntary plan
- list the advantages of a compulsory plan and a voluntary plan
- understand the differences between Individual and Group Medical Expense Insurance
- understand how the Portable Medical Benefits Scheme (PMBS) works
- know the advantages of the PMBS
- understand how the Transferable Medical Insurance Scheme (TMIS) works
- know the areas that an employer must do in order to be eligible for the TMIS
- explain the two main features under the TMIS, namely:
  - continuation benefit
  - transferability benefit
- list the medical expenses that qualify under the TMIS Special Benefit
- state the differences between PMBS and TMIS
- understand the provisions of an Integrated Shield Plan on tax deductions

Contents

CHAPTER OUTLINE 50
LEARNING OUTCOMES 50
1. INTRODUCTION 52
2. GROUP INSURANCE 52
A. Medical Insurance Requirement For Foreign Workers 53
3. INDIVIDUAL & GROUP MEDICAL EXPENSE INSURANCE 54
A. Compulsory & Voluntary Plans 54
A1. Advantages Of A Compulsory (Non-Contributory) Plan 55
A2. Advantages Of A Voluntary (Contributory) Plan 55
B. Individual Versus Group Insurance 55
4. PORTABLE, TRANSFERABLE MEDICAL BENEFITS & SHIELD PLANS FOR EMPLOYEES 56
A. Portable Medical Benefits Scheme (PMBS) 57
B. Transferable Medical Insurance Scheme (TMIS) 58
B1. How To Qualify For The TMIS? 58
B2. How Can The Two TMIS Features Benefit The Employees? 58
B3. What Are The Medical Expenses That Qualify Under TMIS Special Benefits? 60
B4. Who Are The Employees Eligible For TMIS Benefits? 60
B5. How Are The Claims Paid? 60
B6. How Do Insurers Verify The Eligibility Of An Employee Under The TMIS? 60
B7. Will It Cost More For A Company To Adopt The TMIS? 61
C. PMBS Versus TMIS 61
D. Provision Of Medisave-Approved Shield Plan 62
E. Ad-hoc Contributions To Employees' Medisave Accounts 62
APPENDIX 3A 63

1. INTRODUCTION

1.1 Medical Expense Insurance (MEI) policies can be issued on an individual or a group basis. Hence, it is important that you know how a group policy works and what the differences are between an individual policy and a group policy. This chapter aims to give you an understanding of these two categories of policies. In addition, you will also learn about two medical benefit schemes, namely the Portable Medical Benefits Scheme and the Transferable Medical Insurance Scheme, introduced by the Government in year 2003.



2. GROUP INSURANCE

2.1 Group Insurance, one example being the Employee Benefit Insurance, provides coverage to many people under one master policy. The requirement is that several people must first be members of a group, before they can be eligible to purchase the insurance. The group must have been formed for some purposes other than to obtain insurance, such as companies, trade unions, professional associations and clubs.

2.2 The characteristics of Group Insurance include:

(a) **Master Contract** – Group Insurance is issued under a single contract called the master contract which is kept by the master, i.e. employer, club or association. Unlike individual insurance, when an insured member of the contract dies or leaves the group, only this member's coverage is terminated. The plan itself will still carry on, because it belongs to the holder of the master contract. For example, under a company's Group Insurance policy, the employer is the policy owner, while the employees or any of their immediate family members (spouse and children) if included are the insured persons.

(b) **Minimal Underwriting Requirements** – If the group size is large enough, the underwriter may either require the members to complete a health declaration form, a simplified application form, or waive all underwriting requirements and rely on the pre-existing condition exclusion clauses in their policies to avoid anti-selection risks.

(c) **Experience-rating** – It is usually underwritten based on the past claims experiences of the group to be insured. Such a practice is called experience-rating.

(d) **Cost Effectiveness** – It provides low-cost protection owing to savings in administrative costs, since only one Group Insurance policy is issued.

(e) **Plan Continuation** – The plan is usually renewable on a yearly basis. As such, at the end of each policy period, your corporate client will need to review the plan to assess the comprehensiveness of the coverage. You have to advise your client on this aspect.

(f) **Eligibility Requirements** – Group Insurance policies usually define eligible members as those in a specified class. For example, most Group Insurance policies state that an employee must work full-time, in order to be eligible for coverage. Part-time workers will be excluded from the class of eligible employees. Others include age specifications, e.g. from the age of 16 to 65 years and that the insured employees have to be Singaporeans, Singapore Permanent Residents (SPRs), or with valid employment passes in order to be eligible.

2.3 In addition, Group Insurance policies have an actively-at-work clause which requires an employee to be actively at work on the day that the insurance coverage takes effect, in order to be eligible for the cover. If an employee is on sick leave or annual leave on the day that the insurance coverage takes effect, he will not be covered by the Group Insurance policy until he returns to work.

2.4 Some employers may also include a probationary period (typically three to six months) requirement that a new employee must wait, before becoming eligible to enrol in the Group Insurance plan. Such an arrangement will avoid the administrative work involved with new employees resigning shortly after joining the company. It also helps to reduce the overall premium payable for the Group Insurance policy.

A. Medical Insurance Requirement For Foreign Workers

2.5 Since 1 January 2008, subsidies on hospital bills for foreigners have been removed. With this revision, the Ministry of Manpower (MOM) requires every employer to buy, pay and maintain a minimum Medical Insurance coverage for its foreign workers and foreign domestic workers (maids) during their employment stay in Singapore This insurance is compulsory to every S Pass holder and Work Permit holder before MOM issues or renews their work permit.

2.6 The insurance coverage must be **at least S$15,000 per year** and covers medical bill incurred for inpatient and day surgery, including hospital bills for conditions that may not be work related.

2.7 A co-payment arrangement may be made with the Work Permit holder if the following conditions are met:

- The co-pay amount is reasonable and does not exceed 10% of the employee's monthly salary.
- The duration co-payment does not exceed six (6) months.- The co-payment option is explicitly in the employment contract or collective agreement and has the worker's full consent.

2.8 For all Work Permit and S Pass holders entering Singapore from 1 January 2021, they are required to have a COVID-19 medical insurance policy before they arrive in Singapore which:

- covers at least $10,000 for their medical expenses if they develop COVID-19 symptoms or test positive within the first 14 days of arrival in Singapore; and
- covers workers on work pass in-principle approvals (IPAs).

3. INDIVIDUAL & GROUP MEDICAL EXPENSE INSURANCE

3.1 Medical Expense Insurance can be issued on an individual or a group basis. Individual insurance policies are issued to individuals. In some instances, such a policy can be extended to include the individual's immediate family members (usually spouse and children).

3.2 Group Medical Expense Insurance policies are more often purchased by employers as part of their employee benefits to attract and retain their employees. Like the individual insurance policies, the coverage of Group Medical Insurance policies can also be extended to cover the employees' immediate family members (spouses and children). An example on how the cover may be arranged for an employee and his immediate family members under a Group Medical Insurance policy is shown in **Table 3.1**.

Table 3.1: Example On How The Cover May Be Arranged For An Employee And His Immediate Family Members Under A Group Medical Insurance Policy

Insured Person	Commencement Date Of Cover
New employees and dependants	Date of employment or date of confirmation upon probation.
New dependants (provided that employees are already insured)	**Spouse** – at any time within a specified period of time (usually 30 days) after marriage. **Child** – at any time between 15 and 30 days after birth.
Employer effects a new Group Medical Insurance policy **Compulsory Plan** – Employee and dependants will be covered from the date of commencement of the policy, as long as the employee is actively at work or on normal paid leave. **Voluntary Plan –** Employee and dependants can join the scheme at any time within a specified period of time (usually 30 days) from the commencement date of the policy or the enrolment period.	

Note: Most insurers will grant the cover only to the employee's dependants who are residing in Singapore.

A. Compulsory & Voluntary Plans

3.3 Group Insurance policies can be issued on a compulsory or voluntary basis. For a compulsory (also known as non-contributory) plan, all the eligible employees must be covered under the plan, and the premiums have to be paid solely by the employer. A voluntary (also known as contributory) plan, on the other hand, does not require full participation from the employees who may be expected to pay part of the premiums. However, the insurer will normally require a minimum number of employees or percentage (e.g. 75%) of participation in the plan. The advantages of both types of plans are described below:

A1. Advantages Of A Compulsory (Non-Contributory) Plan

(a) It provides ease of administration, since there is no regular payroll deduction to monitor.
(b) It comes with lower costs owing to less administrative work involved, and the greater pooling effect of risks as a result of many lives insured.
(c) It helps the employer to retain greater control of the benefit structures and provisions.

A2. Advantages Of A Voluntary (Contributory) Plan

(a) Employer
- Participating employees assume part of the costs of the benefits as provided under the Group Insurance plan.
- It generates interest and appreciation from the participating employees of the Group Insurance plan.

(b) Employees
- It gives the participating employees some control over the Group Insurance plan.
- They can obtain coverage at a lower premium rate than buying it individually.

B. Individual Versus Group Insurance

3.4 There are some differences between Individual and Group Insurance. **Table 3.2** shows the differences between them.

Table 3.2: Differences Between Individual & Group Insurance

	Individual Insurance	Group Insurance
Eligibility	Only the individual who applies for the coverage is covered. An individual needs only to be insurable, in order to be granted the coverage.	Only members who belong to the group and are actively at work are covered. Members under a group must satisfy the eligibility requirements as stated in the Group Insurance policy, before they are granted the coverage.
Contract	Each individual policy owner gets a policy contract.	Only one master contract is issued to the employer or an affiliated organisation. The number of insured members is more than one.
Choice of Plan	An individual policy owner has the right to select the amount of coverage that he wants.	Insured members may or may not have the right to decide on the amount of coverage that they want. In the employer-paid plans/compulsory plans, the

	Individual Insurance	Group Insurance
		amount of coverage is determined by the employer.
Underwriting	Individual's health history, lifestyle and financial status are evaluated.	Group as a whole is evaluated depending on the gender and age distribution of the group, occupation mix and past claims experience.
Termination of Cover	Coverage continues until the individual or insurer chooses to terminate it.	The individual life insured's coverage stops when he leaves the group. However, the insurance plan continues for the remaining members.
Premium	Cost of coverage is higher because of individual underwriting and higher administrative costs. Premium is age-related.	Cost of coverage is lower because of group underwriting and lower administrative costs. Premium is unit-related.

3.5 The above information is a general description of how a Group Insurance policy works. It applies not only to Medical Expense Insurance policies, but also to all other types of Health Insurance policies, which you will learn about in the chapters that follow.

4. PORTABLE, TRANSFERABLE MEDICAL BENEFITS & SHIELD PLANS FOR EMPLOYEES

4.1 With shorter employment tenure and frequent job changes in the tight labour market, employees will need continuous inpatient medical provision, when they change jobs or during the period of unemployment. With each change, the employee may lose his medical benefits provided by the respective employer.

4.2 This will result in the employee being left with no cover while waiting to join his new employer, or he may become uninsurable and unable to be covered under his new employer's Group Medical Expense Insurance policy. To incentivise employers to make the move towards enhancing the portability of inpatient or hospitalisation medical benefits for their employees, the Singapore Government, since 1 April 2004, has revised the tax policy to allow employers implementing any of the following portable medical benefits options to enjoy higher tax deduction for medical expenses of up to 2% of the total employees' remuneration:

- Portable Medical Benefits Scheme (PMBS);
- Transferable Medical Insurance Scheme (TMIS);
- Provision of a Shield Plan ; or
- Ad-hoc Contributions to Employees' Medisave Accounts.

4.3 Let us now look at the two schemes in greater detail.

A. Portable Medical Benefits Scheme (PMBS)

4.4 This scheme rides on the Medisave/MediShield Life framework. Under this scheme, the employers, instead of providing their employees with Group Medical Insurance coverage, make additional monthly contributions to the employees' respective Medisave accounts. Employees can then use the Medisave contributions to purchase MediShield Life or any one of the private insurers' Integrated Shield Plans, to cover their inpatient or hospitalisation needs.

4.5 Any surplus Medisave contribution will accumulate in the employee's Medisave Account and generate interest. Do visit the Central Provident Fund (CPF) Board website at www.cpf.gov.sg to find out the latest Medisave interest rate. The savings in the employee's Medisave Account can be used to meet his future medical needs, as well as the medical needs of his dependants.

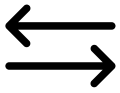
4.6 The advantage of this scheme is that the employee can continue to be medically insured, even though he may be unemployed or is in-between jobs. This is because the coverage will continue as long as the premium is paid, regardless of his employment status. It also reduces duplication of insurance plans and premium payments.

4.7 The employer will enjoy a 2% tax deduction. To be eligible for the tax deduction, the employer must satisfy the following conditions:

- The scheme must cover at least 20% of the local employees[1] recruited as at the first day of financial year being assessed, and all local employees who commence their employment during that financial year;
- For full-time employees, the additional monthly contributions to Medisave accounts should be at least 1% of each employee's gross monthly salary, subject to a minimum amount of S$16 per calendar month; and
- For part-time employees[2], the additional monthly Medisave contributions should be computed based on 1% of their actual gross salary for the calendar month.

4.8 An employer who wishes to make additional Medisave contribution for his employees may register with the Employer Registration Section of the CPF Board with a new CPF Submission Number.

4.9 However, for employers who choose not to implement either the PMBS or TMIS, their tax deductibility in respect of medical expenses will be maintained at the present 1% of the total employees' remuneration.



[1] Local employees refer to Singapore citizens or Singapore Permanent Residents employed on a full-time or part-time contract of employment, regardless of the number of hours worked.

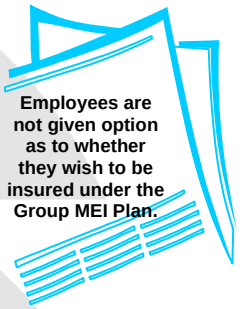
[2] Part-time employees refer to employees who are required under their contract of service with their employers to work regularly for less than 30 hours a week.

B. Transferable Medical Insurance Scheme (TMIS)

4.10 The TMIS is a private hospitalisation insurance arrangement among participating insurers. It is to provide continuous Medical Expense Insurance coverage to an employee, starting from the date of leaving the service of his employer for whatever reasons up to a period of 12 months, as long as the insurance premium is paid.

4.11 A TMIS policy is an enhancement of the existing employer-sponsored Group Medical Expense Insurance outside of the CPF Medisave framework. It is basically an employer-sponsored Group Medical Insurance programme with the following two additional features:

- continuation of coverage; and
- transferability of benefits.



4.12 Let us look at how the TMIS works.

B1. How To Qualify For The TMIS?

4.13 To qualify for the TMIS, the employer must:

- have a group size of 11 or more employees;
- take up a Group Medical Expense Insurance plan;
- insure at least 50% (computed using X/Y x 100%, where X = all local employees who are on the PMBS or TMIS, and Y = total number of local employees in the employing company) of its local employees, subject to a minimum total of 11 employees. The benefits can be provided for pre-defined categories of employees, e.g. rank-and-file employees or executives;
- pay 100% of the premium for the Group Medical Expense Insurance coverage (Note: Employers are allowed to recover the premiums for continuation benefits after the termination of employment, wholly or partly from the employees, based on agreement with the employees); and
- not give their employees the option as to whether they wish to be insured under the Group Medical Expense Insurance plan.

B2. How Can The Two TMIS Features Benefit The Employees?

4.14 **Continuation Of Coverage Benefits**

This feature enables an employee whose employment is terminated either by his employer, or on his own accord, to continue enjoying hospitalisation coverage from the employment termination date up to a period of 12 months (not exceeding the prescribed statutory age).

4.15 **Transferability Of Benefits**

This feature enables an employee who resigns from one employing company which holds a TMIS policy, and joins another which also holds a TMIS policy, to enjoy the following benefits:

(a) automatic coverage under the new employer's Group Medical Expense Insurance plan, without the need to provide evidence of good health; and

(b) waiver of any exclusion on pre-existing medical conditions if the employee has been continuously insured under one or more TMIS plans for 12 months before joining his new employer. If he has not been insured continuously for at least 12 months under the TMIS plans before joining his new employer, he will be entitled to the waiver when he completes the 12 months of continuous coverage under the new employer's TMIS plan.

4.16 However, if the employee is hospitalised for treatment of a condition which is pre-existing when he joins the new employer, he will enjoy a lower benefit within the first 12 months of cover under the new employer's plan. The cover is the lower entitlement of either the:

- new employer's TMIS plan; or
- prior employer's TMIS plan.

4.17 **Example 3.1** illustrates how an employee's medical fees are covered should he contract an illness while working for his previous employer.

Example 3.1

Danny changed his job in year 2019. Below are the details:

Date of termination with Employer A – 1 January 2019
Date of employment with Employer B – 15 January 2019

Benefit Entitlement	Employer A	Employer B
Daily Room & Board	S$250 per day	S$350 per day
Total of eligible benefits	S$5,000	S$8,000

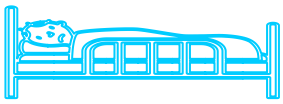
Danny was hospitalised on 1 April 2019 due to an illness while he contracted while in Employer A's employment. He received a total benefit of S$5,000 as he has not been continuously insured by Employer B for 12 months as at 1 April 2019

Should Danny be once again hospitalised on 1 March 2020, the total benefit that he would receive would be S$8,000.

4.18 Note that the transferability of benefits will not be available, if the employee moves from an employer with a non-TMIS group Medical Expense Insurance plan to an employer with a TMIS plan, and vice versa.

B3. What Are The Medical Expenses That Qualify Under TMIS Special Benefits?

4.19 The following are the medical expenses that qualify under the TMIS benefits:



- daily room and board charges;
- intensive care unit charges;
- charges for miscellaneous hospital services;
- charges for in-hospital doctor's visits; and
- charges for inpatient and outpatient benefits.

4.20 All pre/post hospitalisation outpatient, emergency outpatient accident and outpatient kidney dialysis/cancer treatment expenses are not eligible for TMIS benefits, even if they can be reimbursed under the TMIS plan.

B4. Who Are The Employees Eligible For TMIS Benefits?

4.21 To be eligible for the TMIS benefits, an employee must be:

- below the prescribed statutory retirement age;
- a Singapore Citizen or SPR based in Singapore;
- working full-time with the same employer; and
- working on a permanent employment contract, or on a temporary employment contract with a term of 24 months or more.

4.22 At the time of writing, the current statutory minimum retirement age is 63 years old in Singapore. This means that employers are not allowed to dismiss any employee below age 63 because of the employee's age. The retirement age will be raised gradually to 65 by 2030. Currently, employers must offer re-employment to eligible employees who turn 63, up to the re-employment age of 68. This provides older workers with more opportunities to work longer, if they wish to do so. It is not compulsory for workers to continue working until the re-employment age. On the contrary, it is their choice whether they wish to do so. The re-employment age will be raised gradually to 70 by 2030

B5. How Are The Claims Paid?

4.23 Claims for continuation of benefits will be payable from the previous employer's TMIS plan.

4.24 Claims for transferability of benefits on or after the employee has joined the new employer will be payable from the new employer's TMIS plan.

B6. How Do Insurers Verify The Eligibility Of An Employee Under The TMIS?

4.25 An employer has to issue a Transferable Medical Insurance Certification (TMIC) (see **Appendix 3A**) at the request of an employee upon the termination of his employment. The TMIC must be submitted to the insurer when the employee submits a claim for Continuation Benefit, or to the new employer's insurer should a claim arising from a pre-existing condition be made within 12 months

of joining the new employer.

B7. Will It Cost More For A Company To Adopt The TMIS?

4.26 The insurer will charge an additional premium if a policy is issued under the TMIS. However, this will be partially offset by the additional tax deduction (1%) which the employer is entitled to.

C. PMBS Versus TMIS

4.27 The differences between PMBS and TMIS are described below:

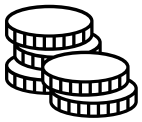
PMBS	TMIS
The employer makes an additional contribution to the Employee's Medisave Account for him to purchase the policy on his own.	The employer purchases the policy.
Can purchase only a Medical Insurance policy approved under the Medisave Scheme (e.g. an Integrated Shield Plan from an approved private insurer).	Can purchase any Group Medical Expense Insurance policy offered in the market other than those approved under the Medisave Scheme.
The coverage is lifetime for most Integrated Shield Plans in the insurance market.	The coverage expires at the prescribed statutory retirement age.
The coverage continues even when the employee is between jobs or out of a job, as long as the premium is paid.	The coverage continues up to a maximum period of 12 months from the date of termination from a job.
There are deductibles and co-insurance features. Riders can be purchased to offset the deductibles and co-insurance.	It is unlikely to have deductibles and co-insurance features, as Group Medical Expense Insurance policies rarely have these features.
Treatment for pre-existing illnesses is typically excluded.	Waiver on pre-existing conditions is allowed, when employees change jobs and where both employers provide TMIS benefits.
The employer has no control over the policy which the employee has purchased.	The employer continues to have full control over the Group Medical Expense Insurance policy, and the level of benefits can be structured according to the corporate employee benefit philosophy.

D. Provision Of Medisave-Approved Shield Plan

4.28 This is a variation of the PMBS, where the employer may choose to pay for a MediShield Life or Integrated Shield Plan (IP) for the employees. An employer providing employees with an IP can claim tax deduction for medical expenses incurred, up to 2% of the total employees' remuneration, upon meeting the following qualifying conditions:

- provide an IP for at least 20% of the local employees as at the first day of the financial year being assessed, and all local employees who commence their employment during that financial year; and
- pay IP premiums on behalf of the employees directly to the approved insurer, or reimburse the premiums into the respective employees' Medisave Accounts.

4.29 However, the additional tax deduction as mentioned above excludes premiums for the "Riders on IPs" that cover deductibles and co-insurance payments. This is because the Singapore Government does not want to incentivise employers to take up such riders that can potentially result in an over-consumption of healthcare services.



E. Ad-hoc Contributions To Employees' Medisave Accounts

4.30 An employer can make ad-hoc Medisave contributions to the employees' Medisave Accounts, even if it is not adopting any of the portable medical benefits options as described earlier.

4.31 To encourage such contributions, the employer can get an additional tax deduction beyond the 1% limit for the amount of ad-hoc Medisave contributions made. Additional contributions are subject to a limit of **$2,730** per employee per year. The overall tax deduction for medical expenses will be subject to the overall cap of 2%.

4.32 If the employer wishes to make additional Medisave contributions for the employees, the employer will need to register with the Employer and Accounts Management Section of the CPF board for a new CPF Submission Number. Such contributions are tax-free, and are subject to a cap per employee per year. Refer to the MOM website under schemes for employers and employees for the cap amount: http://www.mom.gov.sg

APPENDIX 3A

TRANSFERABLE MEDICAL INSURANCE CERTIFICATION
(Important Note: Applicable for TMIS eligible employee only)

Policy Particulars

Name of policy owner _____
Name of Insurer _____
Policy Number _____

Life Insured's (or Insured Member's) Particulars

Name of Life Insured _____
NRIC/Passport No. _____
Date of Birth _____
Date of Employment _____
Date of Termination _____

Period of Employer's Coverage

Commencement Date _____
Termination Date _____

Period of Continuation Coverage

Commencement Date _____
Termination Date _____

Policy Benefits	Maximum Limit
Room & Board (xx days)	S$ _____
Intensive Care Unit (xx days)	S$ _____
Hospital Services	S$ _____
Surgical Benefit	S$ _____
In-hospital Doctor's Visit Per Day	S$ _____

Certification

I/We certify that the information furnished here is true, correct and complete:

_____ _____
Signature of Authorised Officer Company Stamp
Name:
Designation:
Date Issued:

Source: LIA Website – "Transferable Medical Insurance Certificate" (1 January 2004)

CHAPTER 03

GROUP MEDICAL EXPENSE INSURANCE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Criteria for a group to be eligible for Group Insurance cover	The requirement is that several people must first be members of a group, before they can be eligible to purchase the insurance. The group must have been formed for some purposes other than to obtain insurance, such as companies, trade unions, professional associations and clubs.
Characteristics of a Group Insurance policy	• Master Contract. • Minimal Underwriting Requirements. • Experience-rating. • Cost Effectiveness. • Plan Continuation. • Eligibility Requirements. In addition, Group Insurance policies have an actively-at-work clause.
Characteristics of Medical Insurance for foreign workers	Insurance coverage must be at least S$15,000 per year and covers medical bill incurred for inpatient and day surgery, including hospital bills for conditions that may not be work related.
Differences between a compulsory and a voluntary plan	• For a compulsory (also known as non-contributory) plan, all the eligible employees must be covered under the plan, and the premiums have to be paid solely by the employer. • A voluntary (also known as contributory) plan, on the other hand, does not require full participation from the employees who may be expected to pay part of the premiums.
Advantages Of A Compulsory (Non-Contributory) Plan	• It provides ease of administration, since there is no regular payroll deduction to monitor. • It comes with lower costs owing to less administrative work involved, and the greater pooling effect of risks as a result of many lives insured. • It helps the employer to retain greater control of the benefit structures and provisions.
Advantages Of A Voluntary (Contributory) Plan	• Employer » Participating employees assume part of the costs of the benefits as provided under the Group Insurance plan. » It generates interest and appreciation from the participating employees of the Group Insurance plan. • Employees » It gives the participating employees some control over the Group Insurance plan. » They can obtain coverage at a lower premium rate than buying it individually.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Differences between Individual and Group Medical Expense Insurance	• Individual insurance policies are issued to individuals. • Group Medical Expense Insurance policies are more often purchased by employers as part of their employee benefits to attract and retain their employees. • Can be extended to include the individual's immediate family members (usually spouse and children).

	Individual Insurance	Group Insurance
Eligibility	Only the individual who applies for the coverage is covered. An individual needs only to be insurable, in order to be granted the coverage.	Only members who belong to the group and are actively at work are covered. Members under a group must satisfy the eligibility requirements as stated in the Group Insurance policy, before they are granted the coverage.
Contract	Each individual policy owner gets a policy contract.	Only one master contract is issued to the employer or an affiliated organisation. The number of insured members is more than one.
Choice of Plan	An individual policy owner has the right to select the amount of coverage that he wants.	Insured members may or may not have the right to decide on the amount of coverage that they want. In the employer-paid plans/compulsory plans, the amount of coverage is determined by the employer.
Underwriting	Individual's health history, lifestyle and financial status are evaluated.	Group as a whole is evaluated depending on the gender and age distribution of the group, occupation mix and past claims experience.
Termination of Cover	Coverage continues until the individual or insurer chooses to terminate it.	The individual life insured's coverage stops when he leaves the group. However, the insurance plan continues for the remaining members.
Premium	Cost of coverage is higher because of individual underwriting and higher administrative costs. Premium is age-related.	Cost of coverage is lower because of group underwriting and lower administrative costs. Premium is unit-related.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
How the Portable Medical Benefits Scheme (PMBS) works	This scheme rides on the Medisave/MediShield Life framework. Under this scheme, the employers, instead of providing their employees with Group Medical Insurance coverage, make additional monthly contributions to the employees' respective Medisave accounts. Employees can then use the Medisave contributions to purchase MediShield Life or any one of the private insurers' Integrated Shield Plans, to cover their inpatient or hospitalisation needs.
Advantages of the PMBS	• Any surplus Medisave contribution will accumulate in the employee's Medisave Account and generate interest. • Employee can continue to be medically insured, even though he may be unemployed or is in-between jobs. This is because the coverage will continue as long as the premium is paid, regardless of his employment status. It also reduces duplication of insurance plans and premium payments. • The employer will enjoy a 2% tax deduction, subject to conditions.
How the Transferable Medical Insurance Scheme (TMIS) works	The TMIS is a private hospitalisation insurance arrangement among participating insurers. It is to provide continuous Medical Expense Insurance coverage to an employee, starting from the date of leaving the service of his employer for whatever reasons up to a period of 12 months, as long as the insurance premium is paid. A TMIS policy is an enhancement of the existing employer-sponsored Group Medical Expense Insurance outside of the CPF Medisave framework.
Areas that an employer must do in order to be eligible for the TMIS	To qualify for the TMIS, the employer must: • have a group size of 11 or more employees; • take up a Group Medical Expense Insurance plan; • insure at least 50% (computed using X/Y x 100%, where X = all local employees who are on the PMBS or TMIS, and Y = total number of local employees in the employing company) of its local employees, subject to a minimum total of 11 employees. The benefits can be provided for pre-defined categories of employees, e.g. rank-and-file employees or executives; • pay 100% of the premium for the Group Medical Expense Insurance coverage (Note: Employers are allowed to recover the premiums for continuation benefits after the termination of employment, wholly or partly from the employees, based on agreement with the employees); and • not give their employees the option as to whether they wish to be insured under the Group Medical Expense Insurance plan.
Two main features under the TMIS, namely: • **continuation benefit** • **transferability benefit**	**Continuation Of Coverage Benefits** • This feature enables an employee whose employment is terminated either by his employer, or on his own accord, to continue enjoying hospitalisation coverage from the employment termination date up to a period of 12 months (not exceeding the prescribed statutory age). **Transferability Of Benefits** This feature enables an employee who resigns from one employing company which holds a TMIS policy, and joins another which also holds a TMIS policy, to enjoy the following benefits: • automatic coverage under the new employer's Group Medical Expense Insurance plan, without the need to provide evidence of good health; and • waiver of any exclusion on pre-existing medical conditions if the employee has been continuously insured under one or more TMIS plans for 12 months before joining his new employer. If he has not been insured continuously for at least 12 months under the TMIS plans before joining his new employer, he will be entitled to the waiver when he completes the 12 months of continuous coverage under the new employer's TMIS plan.
Medical expenses that qualify under the TMIS Special Benefit	• Daily room and board charges; • Intensive care unit charges; • Charges for miscellaneous hospital services; • Charges for in-hospital doctor's visits; and • Charges for inpatient and outpatient benefits. All pre/post hospitalisation outpatient, emergency outpatient accident and outpatient kidney dialysis/cancer treatment expenses are not eligible for TMIS benefits, even if they can be reimbursed under the TMIS plan.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Differences between PMBS and TMIS</td><td>
<table>
<tr><th>PMBS</th><th>TMIS</th></tr>
<tr><td>The employer makes an additional contribution to the Employee's Medisave Account for him to purchase the policy on his own.</td><td>The employer purchases the policy.</td></tr>
<tr><td>Can purchase only a Medical Insurance policy approved under the Medisave Scheme (e.g. an Integrated Shield Plan from an approved private insurer).</td><td>Can purchase any Group Medical Expense Insurance policy offered in the market other than those approved under the Medisave Scheme.</td></tr>
<tr><td>The coverage is lifetime for most Integrated Shield Plans in the insurance market.</td><td>The coverage expires at the prescribed statutory retirement age.</td></tr>
<tr><td>The coverage continues even when the employee is between jobs or out of a job, as long as the premium is paid.</td><td>The coverage continues up to a maximum period of 12 months from the date of termination from a job.</td></tr>
<tr><td>There are deductibles and co-insurance features. Riders can be purchased to offset the deductibles and co-insurance.</td><td>It is unlikely to have deductibles and co-insurance features, as Group Medical Expense Insurance policies rarely have these features.</td></tr>
<tr><td>Treatment for pre-existing illnesses is typically excluded.</td><td>Waiver on pre-existing conditions is allowed, when employees change jobs and where both employers provide TMIS benefits.</td></tr>
<tr><td>The employer has no control over the policy which the employee has purchased.</td><td>The employer continues to have full control over the Group Medical Expense Insurance policy, and the level of benefits can be structured according to the corporate employee benefit philosophy.</td></tr>
</table>
</td></tr>
<tr><td>Provisions of an Integrated Shield Plan on tax deductions</td><td>An employer providing employees with an IP can claim tax deduction for medical expenses incurred, up to 2% of the total employees' remuneration, upon meeting the following qualifying conditions:
• provide an IP for at least 20% of the local employees as at the first day of the financial year being assessed, and all local employees who commence their employment during that financial year; and
• pay IP premiums on behalf of the employees directly to the approved insurer, or reimburse the premiums into the respective employees' Medisave Accounts.</td></tr>
</table>

CHAPTER 4
DISABILITY INCOME INSURANCE

CHAPTER OUTLINE

1. Introduction
2. What Is Disability Income Insurance?
3. Disability Income Insurance & Total And Permanent Disability
4. Computation Of Disability Income Insurance Benefit
5. Definitions
6. Benefits Offered Under Disability Income Insurance
7. Features Of A Disability Income Insurance Policy
8. Underwriting
9. Cessation Of Benefits
10. Exclusions
11. Termination Of Cover
12. Group Disability Income Insurance
13. General Underwriting Principles For Group Disability Income Insurance
14. Disability Income Claims
15. Conclusion

Appendix 4A - Clinical Abstract Form

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- describe what Disability Income Insurance is
- differentiate between Disability Income Insurance and Total and Permanent Disability Benefit
- understand how Disability Income Insurance works
- briefly describe:
  - total disability
  - partial disability
  - recurrent disability (linked claims)
  - benefit period
  - deferred/elimination period
- know the difference between "own occupation", "modified own occupation", "any occupation" and "severe disability" definitions
- list the eligibility criteria for payment of Disability Income Insurance benefit
- describe the types of benefits offered by Disability Income Insurance:
  - total disability benefit
  - partial disability benefit

  - rehabilitation expense benefit
  - escalation benefit
  - waiver of premium benefit
  - death benefit
- know how to compute the partial disability benefit
- know how the escalation benefit works
- explain how the limitation of disability benefit clause works
- list the features of Disability Income Insurance
- list the documents required for the underwriting of Disability Income Insurance for an individual employee, as well as for the self-employed person
- briefly describe the following underwriting considerations for Disability Income Insurance:
  - occupation
  - benefit amount
  - benefit period
  - deferred/elimination period
- know when the benefits under a Disability Income Insurance policy cease to be payable
- list the exclusions commonly found under Disability Income Insurance
- list the events that will cause a Disability Income Insurance policy to be terminated
- understand the coverage and features of Group Disability Income Insurance
- know the general underwriting principles and claims procedures for both Individual and Group Disability Income Insurance

Contents

CHAPTER OUTLINE 64
LEARNING OUTCOMES 64
1. INTRODUCTION 68
2. WHAT IS DISABILITY INCOME INSURANCE? 68
3. DISABILITY INCOME INSURANCE & TOTAL AND PERMANENT DISABILITY 68
4. COMPUTATION OF DISABILITY INCOME INSURANCE BENEFIT 69
5. DEFINITIONS 71
   A. Total Disability 71
      A1. Own Occupation 71
      A2. Modified Own Occupation 71
      A3. Any Occupation 72
      A4. Severe Disability 72
   B. Partial Disability 72
   C. Recurrent Disability (Linked Claims) 73
   D. Benefit Period 73
   E. Deferred/Elimination Period 73
6. BENEFITS OFFERED UNDER DISABILITY INCOME INSURANCE 74
   A. Eligibility Criteria For Payment Of Disability Income Insurance Benefit 74
   B. Types Of Benefits Offered 74
      B1. Total Disability Benefit 74
      B2. Partial Disability Benefit 75
      B3. Rehabilitation Expense Benefit 76
      B4. Escalation Benefit 76
      B5. Waiver Of Premium Benefit 78
      B6. Death Benefit 78
   C. Limitation Of Disability Benefit Clause 78
7. FEATURES OF A DISABILITY INCOME INSURANCE POLICY 78
8. UNDERWRITING 79
   A. Underwriting Requirements 79
      A1. Individual (Salaried Employee) 80
      A2. Self-employed Person 80
   B. Underwriting Considerations 80
      B1. Occupation 80
      B2. Benefit Amount 82
      B3. Benefit Period 82
      B4. Deferred/Elimination Period 82

9. CESSATION OF BENEFITS 82
10. EXCLUSIONS 82
11. TERMINATION OF COVER 83
12. GROUP DISABILITY INCOME INSURANCE 83
A. Coverage Provided By Group Disability Income Insurance 83
13. GENERAL UNDERWRITING PRINCIPLES FOR GROUP DISABILITY INCOME INSURANCE 84
14. DISABILITY INCOME CLAIMS 84
A. Claims Procedure For Disability Income Policy 84
B. Foreign Residency During Claims Period 85
15. CONCLUSION 86
APPENDIX 4A 87

1. INTRODUCTION

1.1 While it is appropriate for an individual to plan for his retirement and premature death, it is also critical for an individual to protect his earning capacity, whether he is an employee or a self-employed individual. This is because he could lose his earning power should he become disabled as a result of an accident or illness. If that happens, he may be incapable of paying his living and medical expenses, including the premiums to keep his insurance policies in force. On top of this, his family's current expenses need to be paid, and these expenses may even increase as a result of his medical treatments or the need to employ a personal nurse to take care of him. In addition, he may still have outstanding loans to repay. Thus, many families would be financially worse off with the incapacity of the bread-winners, than they would be had the bread-winners passed on.

1.2 Hence, a Disability Income Insurance policy is a useful insurance product to help to safeguard a person's earning capacity in any of the above-mentioned situations. In this chapter, we will look at both Individual and Group Disability Income Insurance, including their underwriting and claim procedures.

2. WHAT IS DISABILITY INCOME INSURANCE?

2.1 Disability Income Insurance is sold as an income-protection product in that it helps to replace a portion of the insured's income that he loses if he becomes incapacitated and unable to work as a result of an accident or illness, subject to certain conditions, as we will see later. It is also known as Permanent Health Insurance because the insurer cannot cancel the policy, no matter how many times the insured makes a claim. The policy will continue to pay out until he returns to work, dies, or the policy ends, whichever happens first. Alternative names for this type of insurance include "Income Protection" Insurance or "Income Replacement" Insurance. For the purpose of this Study Guide, we will use the term "Disability Income" Insurance.

3. DISABILITY INCOME INSURANCE & TOTAL AND PERMANENT DISABILITY

3.1 Many people confuse Disability Income Insurance with the Total and Permanent Disability (TPD) Benefit offered under Life Insurance policies. While both provide the insured with a cash benefit in the event of his disability arising from an accident or illness, there are distinct differences between the two benefits.

3.2 The main difference between Disability Income Insurance and Total and Permanent Disability Benefit lies in the purpose of the insurance and the definition of "disability". Disability Income Insurance provides an income replacement if the insured is unable to work, whereas Total and Permanent Disability Benefit serves to accelerate the death benefit payable under a Life Insurance policy, to alleviate the financial burden or hardship of the insured and his dependants. The benefit under the Total and Permanent Disability Benefit is payable in instalments, or one lump sum, depending on the terms and conditions as specified in the Life Insurance policy. On the other hand, Disability

Income Insurance benefits are payable on a monthly basis for up to a fixed number of years (such as five or ten years), or until the insured reaches a certain age (such as the age of 60 or 65 years). The other differences are shown in **Table 4.1**.

Table 4.1: Other Differences Between Disability Income Insurance & Total And Permanent Disability Benefit

Disability Income Insurance	Total And Permanent Disability Benefit
Disability definition relates to the extent the insured can fulfil the duties of his occupation.	Disability is defined to be total and permanent, such as loss of limbs or loss of eyesight.
It can be purchased as a stand-alone policy or as a rider.	It is usually incorporated into the Life Insurance policies in Singapore.
Maximum sum assured is up to a specified percentage of the salary.	Sum assured is not pegged to salary.
Escalation benefit is available.	There is no escalation benefit.
Partial disability benefit is available.	Partial disability benefit is not available.
Choice of deferred/elimination period is available (e.g. one month, three months, six months, etc.).	No deferred period as specified (but usually there is a 6-month waiting period requirement as proof of permanent disability).
It is usually only available to working adults with earned income/salary.	There is usually no restriction on non-working people, e.g. children and housewives, as it is bundled with the death benefit under a Life Insurance policy.

4. COMPUTATION OF DISABILITY INCOME INSURANCE BENEFIT

4.1 Disability Income Insurance policy pays a monthly income to the insured upon his disability. Let us look at how it actually works, using the case of an employed individual. See **Example 4.1**.

Example 4.1: Example Of Computation Of Disability Income Insurance Benefit

Andrew, aged 30 years, is an assistant accountant in a finance company. His monthly income is S$5,000. He wishes to purchase a Disability Income Insurance policy to provide maximum coverage.

However, the maximum amount of monthly benefit that he can purchase is unlikely to be 100%. Why?

Insurers will allow the benefit amount to cover only up to 75% of the insured's average income over the past 12 months immediately prior to his disability. Most insurers also impose a ceiling on the income to be covered (e.g. S$15,000). Some insurers grant a lower percentage for the self-employed, e.g. 60% of the past 12 months' income. The purpose of replacing only a certain percentage of the insured's income is to ensure that the insured will not be better off financially from the benefit which he receives under his Disability Income Insurance policy, so that he will have the incentive to go back to work.

Details of his policy are as follows:

Male, Age Next Birthday	30 years old
Monthly Income	S$5,000
Monthly Benefit	S$3,750 (75% of his monthly income being the maximum amount as allowed by Alpha Insurance Company and assuming that he has no other disability benefits).
Escalation Benefit	5% per year
Benefit Period	Up to the age of 65 years next birthday
Deferred/Elimination Period	6 months
Annual Premium	S$599.10

4.2 If Andrew becomes disabled (must meet the definition of "disability" as specified in the policy) and is out of work four and a half years after the policy commences, he will receive the benefit amount every month from the insurer after the Deferred/Elimination Period, as long as he is unable to work. Should he be disabled throughout the Benefit Period (30 years), he would receive a total of S$2,989,746 (S$3,750 x 12 x 66.4388*), although he would have paid only five years of premiums amounting to S$2,995.50 (S$599.10 x 5). Premiums are waived upon disability.

4.3 Now that you have seen how a Disability Income Insurance policy works, we will look at the definitions of the various terms used in **Example 4.1**, including the term "disability".

* 66.4388 is the future value annuity interest factor derived from the formula $[(1+i)^n-1]/i$ (where i = escalation benefit, n = number of years). Alternatively, you may refer to **Table A1** on Future Value Of Annuity Factors at the back of this Study Guide.

5. DEFINITIONS

A. Total Disability

5.1 Since the major purpose of a Disability Income Insurance policy is to provide income when an insured is totally disabled and unable to work, the meaning of Total Disability is important. As such, the term "Total Disability" is clearly defined in the policy and may take one of the following forms:

- own occupation disability;
- modified own occupation disability;
- any occupation disability and
- severe disability

5.2 Let us look at each of the definitions in turn.

A1. Own Occupation

5.3 This definition considers the occupation the insured is engaged in. Here, total disability is defined as:

> "the insured's inability to perform the material duties of his own occupation"

5.4 This refers to the insured's own occupation at the time that the disability begins. For example, Penny, a pianist, met with an accident which resulted in two fingers on her left hand and one finger on her right hand being severed. As a result, she was unable to work as a pianist anymore. Thus, she had met the above definition of "disability" and would be able to claim under her Disability Income Insurance policy.

5.5 The policy will state the insured's occupation, and the insurer has to be notified of any occupation change while the policy is in force. Some insurers do not specify the occupation in the policy. However, their definition states that the insured must be unable to follow the occupation engaged in immediately prior to the disability, or work at any other occupation.

A2. Modified Own Occupation

5.6 Here "Total Disability" means:

> "the insured's inability to perform any gainful occupation or a similar occupation for which the insured is reasonably suited by reason of education, training or experience"

5.7 This definition is more stringent than "Own Occupation" in that the definition is extended to include "a similar occupation". Thus, if an insured whose service has been terminated by his former employer because of his disability, but manages to find a job which is similar in nature to the previous occupation after his recovery, he will not be able to meet the definition of "Total Disability".

A3. Any Occupation

5.8 This is a more restrictive definition of Total Disability. It means:

"the insured's inability to perform any occupation"

5.9 Again, consider Penny, the pianist, whose fingers were severed. Under the previous definition, she was totally disabled because she was unable to perform the duties of her own occupation. However, suppose that she is able to teach, i.e. prepare students for the piano theory examination. Under "Any Occupation" definition, she will no longer be considered as being totally disabled.

5.10 Note that the above examples show just how the term "Total Disability" may be defined. The wording used may vary from insurer to insurer, and there are many hybrids in the insurance market, which may not be easy to classify. Therefore, it is important that you find out the exact definition as used by your insurer and be able to explain it clearly to your prospective clients.

A4. Severe Disability

5.11 This definition follows the Long-Term Care Insurance definition where the insured is unable to perform at least three of the six Activities of Daily Living (ADLs) – washing, dressing, feeding, toileting, mobility, and transferring.

5.12 The insurer uses this definition when the insured's disability occurred during a non-working period (a period of time in-between jobs, where the insured is still covered under the plan). When a disability occurs during the non-working period, the benefit amount will not be based on the last drawn salary, but will usually be pre-determined (e.g. S$500 a month) and stated in the policy by the insurer.

B. Partial Disability

5.13 This is when the insured recovers from a total disability to perform some major duties of his occupation, but at a salary which is at least 25% lower than the pre-disability salary. For example, Walter was paid S$2,500 a month as a warehouse worker. His work involved moving materials both with a mechanical forklift and by hand.

5.14 After an accident, Walter's spine was injured resulting in him having weak hands. Since then, he could operate only the forklift, but was not able to move the materials using his hands. As such, he was given a lower pay of S$1,800 (S$1,800 ÷ S$2,500 x 100 = 72% i.e. 28% less than his original pay). In that instance, Walter was considered to be partially disabled.

5.15 Some insurers allow Partial Disability benefit to the insured who works in other occupation (not related to his own occupation) on a part-time or full-time basis, and which pays him a salary of 75% (or less) of his Pre-disability Earnings.

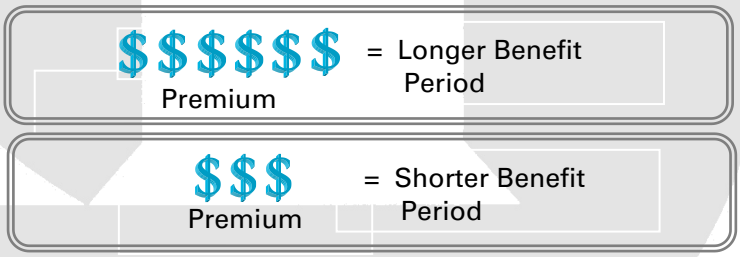
C. Recurrent Disability (Linked Claims)

5.16 If the insured who has been receiving the disability benefits returns to work, but suffers a relapse within a specified period of time (usually 180 days) from the same cause, most insurers will waive the deferred/elimination period, and the benefit payments will re-commence immediately.

5.17 In such a case, the claim will be treated as a continuation of the earlier claim for the purpose of determining the duration of the benefit payment period.

D. Benefit Period

5.18 Benefit period is the maximum period for which disability benefits are payable to the insured for any one episode of disability. It can be short term (e.g. five years) or long term (e.g. up to age of 60 years). Obviously, the shorter the benefit term, the lower will be the premiums.



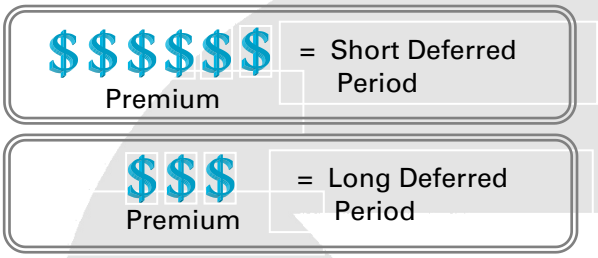
E. Deferred/Elimination Period

5.19 A Disability Income Insurance policy will start paying its benefits after the insured has been disabled for a specified period known as the deferred, elimination or pre-benefit period. The condition for a deferred period eliminates costly claims for disabilities which are only short term. Insurers may offer to the insured different deferred/elimination periods (e.g. 45, 90 or 180 days), or by number of months (e.g. three months).

5.20 Insurers offer these various deferred/elimination periods to meet the different individual's specific needs. For example, a self-employed person may need a short deferred period, as his income may be immediately affected by his inability to work. An employed person, on the other hand, will usually continue to receive his salary for some specified period (e.g. three or six months). As such, you should advise your prospective client to find out from his employing

company or his employment contract to see how long his company will continue to pay him his salary in the event that he is disabled, so that he can select the right deferred period. This will help him to save on the premium, as the longer the deferred period, the cheaper will be the premium, since the duration and frequency of claims are thereby reduced.

5.21 You can also advise prospective clients with financial constraints to purchase a policy with a longer deferred period, where the premium is affordable to them, instead of not having the cover at all.



6. BENEFITS OFFERED UNDER DISABILITY INCOME INSURANCE

A. Eligibility Criteria For Payment Of Disability Income Insurance Benefit

6.1 To be eligible for the disability income benefit payment, the insured MUST:

(a) keep the policy in force;

(b) be working (employed) or in-between jobs when being disabled;

(c) still be disabled after the deferred/elimination period;

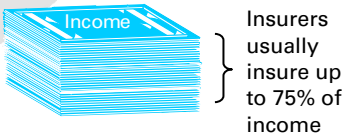
(d) meet the definition of total or partial disability as stated in the policy;

(e) not have reached the expiry age as stated in the policy;

(f) not have resided outside Singapore for more than a certain period of time (usually not more than six months); and

(g) not have other sources of income (e.g. payment from Work Injury Compensation Insurance), which when totalled up, is more than the benefits due to him under his Disability Income Insurance policy.

B. Types Of Benefits Offered



B1. Total Disability Benefit

6.2 The main benefit offered by Disability Income Insurance is obviously the monthly cash benefit payable to the insured to replace his lost income (e.g. up to 75%), when he becomes totally disabled through an accident or illness.

6.3 The benefit will be paid, regardless of whether or not the insured is hospitalised. However, his disability has to be certified by a registered medical practitioner[1]

[1] A registered medical practitioner is a doctor who is qualified by degree in western medicine and is legally licensed to practice medicine and surgery in the geographical area of his country, but does not refer to a medical practitioner who is the insured himself, as well as his spouse, child or parent of the insured.

in order for him to make a claim under his policy.

6.4 If the insured's total disability continues after the expiry of the deferred period, the insurer will pay the monthly benefit at the end of each month. For example, if the policy is issued for a monthly benefit of S$1,000 (as stated in the policy schedule), this will be the amount that the insured will get for that month. If the period of disability is less than one month, the insurer will usually pay a pro-rata amount based on a daily rate of one-thirtieth (1/30) of the disability benefit.

6.5 The benefit ceases when the insured recovers and returns to work, either full-time or part-time, and even to a different occupation.

B2. <u>Partial Disability Benefit</u>

6.6 Partial Disability Benefit is also known as "Rehabilitation Benefit". It provides a reduced benefit to the insured if he is able to return to work at a reduced income of 75% of his Pre-disability Earnings, or lower, even though he has not been fully recovered. The reduced benefit is computed based on the following formula:

$$\frac{\text{Pre-disability Earnings} - \text{Present Earnings}}{\text{Pre-disability Earnings}} \times \text{Total Disability Benefit}$$

6.7 **Example 4.2** shows how the partial disability benefit is arrived at.

Example 4.2: Computation Of Partial Disability Benefit

Larry, a lecturer who earns S$8,000 a month suffered brain injury in a car accident. This caused him to be totally disabled for two years during which he received S$6,000 (75% of his Pre-disability Earnings) a month from his Disability Income Insurance policy. In the third year, he managed to find a job in a printing firm that paid him S$1,000 a month. In view of this, the insurer reduced the monthly benefit to S$5,250, calculated as follows:

$$\frac{S\$(8,000 - 1,000)}{S\$8,000} \times S\$6,000 = \underline{\mathbf{S\$5,250}}$$

Note: You can see that the total monthly benefit and reduced income after the partial disability is S$6,250 (S$5,250 + S$1,000). This is still lower than the original income of S$8,000 a month before the disability.

6.8 The insurer will pay a pro-rata amount, based on a daily rate of one-thirtieth (1/30) of the partial disability benefit if the period of the partial disability is less than a month.

B3. Rehabilitation Expense Benefit

6.9 Insurers encourage the disabled insured to participate in rehabilitation programmes. They will reimburse an insured for the rehabilitation costs incurred. The benefit is limited to a per disability basis and may include items, such as:

- training courses;
- medical aids (e.g. wheelchair, walking frame, crutches); and
- workplace modifications.

6.10 The insured must first get the insurer's approval in writing, before going ahead with any rehabilitation programmes, etc. The rehabilitation benefit may be payable in addition to the monthly disability benefit (e.g. up to three times the monthly benefit).

B4. Escalation Benefit

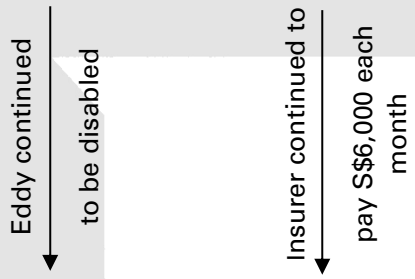
6.11 Escalation benefit is a benefit offered by insurers as a hedge against inflation. With an additional premium, the insured can opt for a 3% or 5% escalation benefit per annum.

6.12 This benefit is useful for long-term disabilities. **Example 4.3** illustrates how the escalation benefit works.

Example 4.3: Illustration Of The Working Of The Escalation Benefit

Eddy, an engineer, became disabled on 30 June 2018. He was insured for S$6,000 (75% of his monthly salary of S$8,000) and had opted for a 3% per annum escalation benefit and a 6-month deferred period.

The events following his disablement were as follows:

Date	Event
1-1-2019	Insurer made the first monthly payment of S$6,000
1-2-2019	Insurer made the second monthly payment of S$6,000
	
1-1-2020	Insurer paid S$6,180 [(S$6,000 + S$6,000 x 3% (escalation benefit)]
1-2-2020	Eddy had since found a job as a clerk which paid him S$2,000 a month. The insurer paid him a partial disability benefit of S$4,635 derived as follows: $\frac{\text{Pre-Disability Earnings – Present Earnings}}{\text{Pre-Disability Earnings}}$ X Disability Benefit = $\frac{\text{S\$(8,000 – 2,000)}}{\text{S\$8,000}}$ X S$6,180 = **S$4,635**

Eddy will continue to receive the Disability Income benefit until he dies or when the benefit period expires, depending on which is earlier.

B5. Waiver Of Premium Benefit

6.13 The premiums due under the Disability Income Insurance policy will be waived during the disability benefit payout period (applies to both total and partial disability). If the insured has paid the premium annually in advance, the waiver of the premium will effect from the next premium due date, even though the disability benefit payment has started. In other words, the premiums paid will not be refunded.

B6. Death Benefit

6.14 Most insurers provide a lump sum amount to be paid to the insured's dependants, in the event of the insured's death.

C. Limitation Of Disability Benefit Clause

6.15 To ensure the insured will not be better off financially by claiming, insurers have a limitation clause in their policies. The purpose is to prevent over-insuring by restricting the monthly benefit payable, so that the total benefit (including other Disability Income policies that the insured may have) shall not exceed the insured's pre-disability earnings or some proportion of it.

6.16 In the event of a claim, the disability benefit payable will be reduced by the following sources of income:

- payments from other insurance policies against disability (except the Total and Permanent Disability Benefit under Life Insurance policies), including Work Injury Compensation Insurance; and
- any continuing salary, commission or other incomes derived from the insured's occupation or business in which he was engaged immediately prior to his disability.

6.17 In other words, the amount of disability income benefit paid together with any of the above sources of income will at no time be more than the amount of monthly benefit insured under the policy. That is why it is important for the insured to select the right deferred/elimination period, especially if his employer will continue to pay him his salary even after he is disabled. If his employer pays him six months' salary in the event that he is disabled, and the deferred/elimination period chosen by him is three months, the insurer will not pay him any benefits after his deferred/elimination period has expired, as long as the employer continues to pay him his full salary.

7. FEATURES OF A DISABILITY INCOME INSURANCE POLICY

7.1 The features of a typical Disability Income Insurance policy are described below:

(a) It can be issued as a stand-alone (for which then, no rider is possible) policy, or as a rider to a basic Life Insurance plan.

(b) It provides a regular monthly income during the insured's total and partial disablement.

(c) The premiums are waived during the benefit period.

(d) The benefits may be level, or may increase at a given rate.

(e) There is a choice of deferred/elimination period.

(f) There is a choice of benefit period.

(g) There is a choice of escalation benefit (if available).

(h) The level premium can be paid on a monthly, quarterly, half-yearly or annual basis, depending on the insurer's practice.

(i) There is payment of partial disability benefits if a person returns to work earning a lower income.

(j) There is provision of rehabilitation expense benefit.

(k) There is provision of death benefit.

(l) There is no restriction on the use of the cash benefits paid.

(m) Disability benefit may discontinue if the insured stays outside Singapore for a specified period.

(n) The cover will be terminated if the insured resides outside Singapore for more than a continuous specified number of days, within any one policy year, unless the insurer grants the insured the continuity of cover (an additional premium may be charged).

(o) The cover will be terminated if the insured is not engaged in any full-time occupation or profession for a continuous period of a specified number of days, when he is not suffering from a disability (see **Section 11** of this chapter for the other causes for the termination of a policy).

(p) The policy is usually guaranteed renewable and non-cancellable (the insurer has the right to adjust the premium rates if the insured changes his occupation to one which is of a higher risk) by the insurer.

(q) There is no surrender value, i.e. the insured cannot return the policy to the insurer for cancellation in exchange for cash payment.

(r) No assignment is allowed.

(s) The policy cannot be written as a third-party policy.

(t) The benefits received are non-taxable.

(u) The policy will lapse if the premium is not paid within the 30 days' grace period.

8. UNDERWRITING

A. Underwriting Requirements

8.1 The underwriting process for Disability Income Insurance is very similar to Life Insurance. The different underwriting tools for individual employees and the self-employed persons are described below:

A1. Individual (Salaried Employee)

8.2 Proposal form (also called Application form) plus:

- computerised payslip; or
- certified letter from company (with company letterhead) or
- Notice of Assessment; or
- Central Provident Fund (CPF) Statement (six months) and large amount questionnaire if the annual benefit is more than a certain amount, e.g. S$60,000; and
- medical test report (e.g. medical examination report, etc.) based on the age and amount of disability benefit proposed.

A2. Self-employed Person

8.3 Proposal form plus:

- Notice of Assessment for the last three years; or
- audited company's accounts for the last three years; and large amount questionnaire if the annual benefit is more than a certain amount (e.g. S$60,000); and
- medical test report (e.g. medical examination report, etc.) based on the age and amount of disability benefit proposed.

8.4 The underwriter will process the proposal form in the same way as explained in later chapter of this Study Guide, except that he will be looking at the risk of the proposer (intending insured) being disabled through an accident or illness, rather than the risk of death.

B. Underwriting Considerations

8.5 The underwriting considerations for Disability Income Insurance are similar to the other classes of Health Insurance. Underwriters will pay more attention to the following factors:

- occupation;
- benefit amount;
- benefit period; and
- deferred/elimination period.

B1. Occupation

8.6 Occupation is a crucial underwriting consideration for two reasons. Firstly, some occupations have a higher risk of disability from accidents (e.g. lorry driver), or illnesses, than others. Secondly, it is easier to return to work with some degree of incapacity in some occupations than in others. For example, not only is a manual worker more likely to be disabled than an accountant, but also is easier for an accountant to work with, say, a broken arm than that for a manual worker. Thus, most insurers have a rating structure depending on the class of occupation. A typical rating structure is as shown in **Table 4.1**.

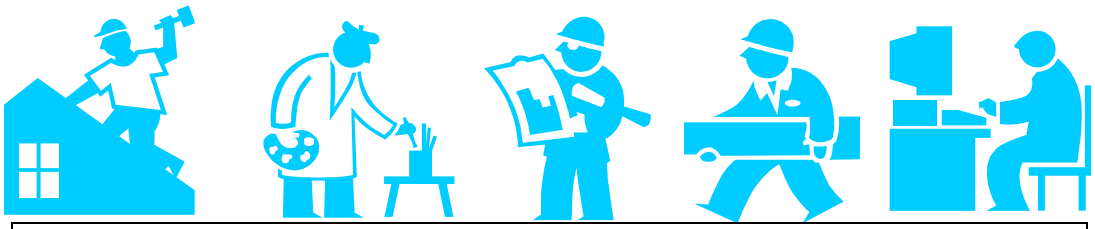


Table 4.2: Rating Structure Based On The Class Of Occupation	
Class I	Professions and occupations involving indoor work mainly of a sedentary (deskbound) nature, e.g. accountants, doctors, and lawyers.
Class II	Office-based occupations with significant travelling to sites or production lines, shop-based jobs involving minimal manual work and senior supervisory positions for light manufacturing companies, e.g. insurance representatives, tour guides, and journalists.
Class III	Occupations involving light skilled manual work, medical related occupations, shop-based occupations involving light manual work, e.g. bakers, deliverymen, and hawkers.
Class IV	Occupations involving semi-skilled or unskilled manual work of a medium to heavy nature, e.g. bus drivers, commercial airline crew, and armed security guards.
Decline (uninsurable)	Occupations involving very heavy manual work, highly specialised skills, dangerous conditions or highly variable income, e.g. construction workers, oil riggers, professional divers, timber loggers, musicians, and authors.

8.7 Rate tables are usually based on Class I with extra premium for the other classes. Many insurers will not grant coverage to those in hazardous jobs, such as motorcycle delivery drivers. Housewives are usually not insurable as they have no regular income, although some insurers may offer a limited benefit.

8.8 Hence, it is a key requirement that the insured should inform the insurer in writing of any change in his occupation, especially if the new occupation is more hazardous, or he has taken on a part-time job which exposes him to accidental or health hazards (e.g. exposure to radiation). In fact, insurers will require the insured to inform them within a specified number of days (e.g. 21 or 30 days) of the change of occupation. The insurer reserves the right to impose a loading, reduce the benefit, or to exclude any claim arising as a result of his new occupation, especially if it is more hazardous than the previous one. Failure to inform the insurer of the change in occupation entitles the insurer to repudiate any claim made under the policy, or to adjust the benefit payable.

B2. Benefit Amount

8.9 The underwriter will assess to ensure the benefits proposed are reasonable for the type of occupation, nature of work involved, and stated earnings.

B3. Benefit Period

8.10 The benefit period is the duration that the insurer needs to pay out the benefit. Underwriters may use this to determine the terms of acceptance.

B4. Deferred/Elimination Period

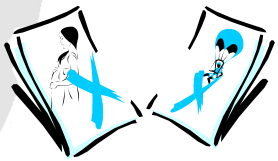
8.11 The deferred/elimination period chosen helps the underwriter to determine whether there is any moral hazard involved. For example, if an employee opts for a short deferred/elimination period, the underwriter, before making a decision on the terms of acceptance, may wish to find out the period for which the employer will continue to pay the employee in the event of a disability.

9. CESSATION OF BENEFITS

9.1 The benefits under a Disability Income Insurance policy will cease upon the occurrence of any one of the following events:

- when the insured is fit to return to work;
- when death occurs; or
- when the benefit period has expired.

9.2 If the Disability Income Insurance cover is issued as a rider, the cover will cease upon the expiry of the basic plan, or when one of the above-mentioned events occurs.



10. EXCLUSIONS

10.1 Most Disability Income Insurance policies do not pay the disability benefit or waive the premiums if the disability is directly or indirectly due to:

(a) self-inflicted injury, while sane or insane;

(b) indulgence in alcohol or drug taking, unless taken under the directions of a registered medical practitioner;

(c) invasion, strike, riot, civil commotion, war (declared or undeclared) or act of war or warlike operation;

(d) illness or injury sustained while the insured is in the service of the armed forces of any country, except for reservist in-camp training during peacetime operation in accordance with the Enlistment Act 1970;

(e) pregnancy or childbirth or any complication arising there from, except in the case of pregnancy, where the disability continues for more than 90 days after the termination of pregnancy, the disability will be deemed to have commenced 90 days after the termination of the pregnancy;

(f) participation in any aerial activity, including parachuting and sky-diving or travel in any type of aircraft, other than as a fare paying passenger on a regularly scheduled flight of a commercial airline;

(g) sexually transmitted disease, or any disability, illness or injury or any condition or complication arising from or caused by (whether directly or indirectly) the human immunodeficiency virus (HIV), including Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related conditions;

(h) participation in any professional sports or hazardous sports, including racing of any kind on horse or wheels, mountaineering, rock climbing and scuba diving;

(i) any pre-existing condition (i.e. condition occurring before the payment of the initial payment).

The above list of exclusions may differ from insurer to insurer.

11. TERMINATION OF COVER

11.1 The Disability Income Insurance policy will terminate upon the happening of one of the following events:

(a) the policy has reached its expiry date;

(b) the premiums due are not paid within the grace period;

(c) the insured dies;

(d) the insured reaches the expiry age as stated in the policy schedule;

(e) the insured resides outside Singapore for an aggregate period of more than a specified number of days (e.g. 300 days) within one policy year, without seeking the insurer's prior written approval for continuation of cover; or

(f) the insured is not employed in a full-time occupation or profession for a continuous period of a specified number of days (except if he is disabled).

12. GROUP DISABILITY INCOME INSURANCE

12.1 Group Disability Income Insurance is usually purchased by the employer as an employee benefit for its employees. It can be issued on a stand-alone basis or as a rider.

12.2 Insurers will only issue a Group Disability Income policy if the employer has a Group Term Life Insurance policy with them, or they may also issue it as a rider to a Group Term Life Insurance policy.

A. Coverage Provided By Group Disability Income Insurance

12.3 The cover provided by a Group Disability Income Insurance policy works in the same way as an individual Disability Income Insurance policy. The benefits and exclusions are also the same. Hence, we will not repeat them here.

13. GENERAL UNDERWRITING PRINCIPLES FOR GROUP DISABILITY INCOME INSURANCE

13.1 The selection process in Group Disability Insurance policies is similar to that for the individual disability plans. As the group must have a Group Term Life Insurance policy before they are eligible for this disability policy, most of the underwriting criteria will have already been met. The additional factors that the underwriters will need to take into consideration are:

(a) nature of the company's business;

(b) age of the individual employee;

(c) exact nature of work of each employee;

(d) salary of each employee;

(e) benefit period applied for;

(f) benefit amount applied for; and

(g) claims experience of the group under the previous Group Disability Income Insurance policy.

13.2 The above information will enable the underwriter to determine the occupational class that each employee falls under, and whether the benefit amount applied for is justifiable. The past claims experience will enable the underwriter to determine the overall terms of acceptance.

13.3 Note that some insurers may issue this policy only for white-collar occupations.

14. DISABILITY INCOME CLAIMS

A. Claims Procedure For Disability Income Policy

14.1 Claims procedures for individual or group disability income are similar. In the event of a claim, the insured must notify the insurer within a specified period of time (e.g. 60 days) from the date of commencement of the disability. Failure to comply with this requirement might cause the claim to be invalidated, unless the insured could prove that it was not possible for him to notify the insurer within the specified period, and that he had tried his best to do so.

14.2 The documents that the insurer normally asks for are as follows:

(a) claim form giving the personal particulars of the insured, as well as details of his occupation and disability;

(b) claimant's statement;

(c) Clinical Abstract form (see **Appendix 4A**);

(d) physician's statement/doctor's statement to be completed by the insured's attending physician giving full details of his disability;

(e) NRIC or birth certificate for verification of the insured's age;

(f) evidence of earnings, which can be in the form of income tax returns (IR8A form), copies of payslips for the 12 months prior to the commencement of

disability, and letter from employer to certify that the claimant (insured) is not being paid during the period of disability;

(g) letter from company certifying that the insured's service has been terminated (if available);

(h) copies of Medical Certificates;

(i) all available Laboratory and Tests results;

(j) a copy of the Police Report if the cause of the disability is due to an accident; and

(k) a copy of the Incident Report (required to be submitted to the Ministry of Manpower if the incident occurs at the workplace).

14.3 The insurer may request for any other relevant supporting documents or information not listed above, on a case-by-case basis.

14.4 Some insurers may set a deadline for the submission of the evidence of disability or may require the insured to bear the cost of the evidence (e.g. medical reports) used to support his claim.

14.5 For long-term disabilities, the insurer may request, at specified times, evidence to prove that the insured is still disabled.

B. Foreign Residency During Claims Period

14.6 If the insured resides outside Singapore while the policy benefits are payable, the insurer may impose some or all of the conditions as specified below:

(a) The insurer must be notified of the change of residence within 30 days of the change.

(b) The insurer has approved the new country of residence.

(c) The insurer has determined that the evidence, which can be submitted to make or support a claim under the policy from the new country of residence, is of similar (or better) standard, in terms of quality and reliability, as compared to that which would be available if the insured were to remain in Singapore.

(d) The insurer has determined that the expertise and facilities for the care, treatment and rehabilitation of the insured in the new country of residence are of a similar (or better) standard, as compared to those which would be available in Singapore.

(e) The insurer reserves the right to require an independent examination of the insured by its preferred doctor as and when reasonable.

14.7 If any of these conditions are not satisfied, the insurer reserves the right to suspend the benefits payable under the policy until such time that the insured returns to Singapore, and that the insurer receives satisfactory evidence to resume payment of benefits.

15. CONCLUSION

15.1 As you can see, a Disability Income Insurance policy provides benefits that are not available under other types of policies. The regular monthly income provided by a Disability Income Insurance policy, to replace a portion of the insured's lost income, in the event that he is disabled and is not able to work, helps to ease the financial difficulties that the insured and his family may face in such a situation. The fact that the policy also pays a reduced benefit if the insured is able to return to work after a disability, but has to accept a job with lower pay, helps the family to maintain more or less the same standard of living immediately prior to his disability. In addition, as there is no specification on how the income received should be used, it could thus be used for any purpose, such as repaying an outstanding loan.

15.2 As this policy contains a Limitation Clause to prevent over-insuring, you must ensure that the deferred period and percentage of salary to be insured are correct, so that in the event of a claim, your client will not be subject to the Limitation Clause. Besides, you must ensure that the cover will continue for the whole of the insured's working life. As such, a thorough fact-finding or advisory process is important.

APPENDIX 4A

ABC Insurance Company (Singapore) Ltd
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

Clinical Abstract Form

Important Notes:

1. This form is required for the application of medical report from hospital/clinic and should be completed by the patient or the patient's parent (if patient is below 21 years of age) or the patient's next-of-kin (if patient is deceased)
2. For request of medical report from hospital, this form is to be submitted to the Medical Records Department of the hospital.

Date (dd/mm/yyyy) _____

To: Doctor-In-charge

Dear Sir/Madam

Name of Patient_____ NRIC No._____

Re: Application for Medical Report

I hereby authorise you to furnish ABC Insurance Company (Singapore) Ltd, 21 Any Street Centre, Singapore 654321, with a detailed medical report on the above-named patient. This report is required for insurance purposes. I agree that a photocopy of this form shall be as valid as the original.

Yours sincerely

_____ _____

Signature of Patient

Signature of Patient's Parent/Patient's Spouse/Next-of-kin[1]
(if patient is below 21 or is deceased)

Particulars of Patient

Name (as shown in NRIC)
NRIC No.
Address

Particulars of Patient's Parent/Patient's Spouse/Next-of-kin (if patient is below 21 or is deceased)

Name (as shown in NRIC)
NRIC No.
Address
Relationship to patient

CHAPTER 04

DISABILITY INCOME INSURANCE

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>What is Disability Income Insurance?</td><td>It is sold as an income-protection product in that it helps to replace a portion of the insured's income that he loses if he becomes incapacitated and unable to work as a result of an accident or illness, subject to certain conditions.</td></tr>
<tr><td>Differentiate between Disability Income Insurance and Total and Permanent Disability Benefit</td><td>
<table>
<tr><th>Disability Income Insurance</th><th>Total And Permanent Disability Benefit</th></tr>
<tr><td>Provides an income replacement if the insured is unable to work.</td><td>Serves to accelerate the death benefit payable under a Life Insurance policy, to alleviate the financial burden or hardship of the insured and his dependants.</td></tr>
<tr><td>Benefits are payable on a monthly basis for up to a fixed number of years (such as five or ten years), or until the insured reaches a certain age (such as the age of 60 or 65 years).</td><td>Benefit under the Total and Permanent Disability Benefit is payable in instalments, or one lump sum, depending on the terms and conditions as specified in the Life Insurance policy.</td></tr>
<tr><td>Disability definition relates to the extent the insured can fulfil the duties of his occupation.</td><td>Disability is defined to be total and permanent, such as loss of limbs or loss of eyesight.</td></tr>
<tr><td>It can be purchased as a stand-alone policy or as a rider.</td><td>It is usually incorporated into the Life Insurance policies in Singapore.</td></tr>
<tr><td>Maximum sum assured is up to a specified percentage of the salary.</td><td>Sum assured is not pegged to salary.</td></tr>
<tr><td>Escalation benefit is available.</td><td>No escalation benefit.</td></tr>
<tr><td>Partial disability benefit is available.</td><td>Partial disability benefit is not available.</td></tr>
<tr><td>Choice of deferred/elimination period is available (e.g. one month, three months, six months, etc.).</td><td>No deferred period as specified (but usually there is a 6-month waiting period requirement as proof of permanent disability).</td></tr>
<tr><td>It is usually only available to working adults with earned income/salary.</td><td>There is usually no restriction on non-working people, e.g. children and housewives, as it is bundled with the death benefit under a Life Insurance policy.</td></tr>
</table>
</td></tr>
<tr><td>How Disability Income Insurance works?</td><td>
• Insurers will allow the benefit amount to cover only up to 75% of the insured's average income over the past 12 months immediately prior to his disability.
• Most insurers also impose a ceiling on the income to be covered (e.g. S$15,000).
• Some insurers grant a lower percentage for the self-employed, e.g. 60% of the past 12 months' income.
• The purpose of replacing only a certain percentage of the insured's income is to ensure that the insured will not be better off financially from the benefit which he receives under his Disability Income Insurance policy, so that he will have the incentive to go back to work.
</td></tr>
</table>

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Total disability	Term "Total Disability" is clearly defined in the policy and may take one of the following forms: 1. Own occupation disability; 2. Modified own occupation disability; 3. Any occupation disability and 4. Severe disability.
Partial disability	When the insured recovers from a total disability to perform some major duties of his occupation, but at a salary which is at least 25% lower than the pre-disability salary.
Recurrent disability (linked claims)	• The insured who has been receiving the disability benefits returns to work but suffers a relapse within a specified period of time (usually 180 days) from the same cause, most insurers will waive the deferred/elimination period, and the benefit payments will re-commence immediately. • In such a case, the claim will be treated as a continuation of the earlier claim for the purpose of determining the duration of the benefit payment period.
Benefit period	• It is the maximum period for which disability benefits are payable to the insured for any one episode of disability. • It can be short term (e.g. five years) or long term (e.g. up to age of 60 years). • The shorter the benefit term, the lower will be the premiums.
Deferred/elimination period	• A Disability Income Insurance policy will start paying its benefits after the insured has been disabled for a specified period known as the deferred, elimination or pre-benefit period. • The longer the deferred period, the cheaper will be the premium, since the duration and frequency of claims are thereby reduced.
Difference between "own occupation", "modified own occupation", "any occupation" and "severe disability" definitions	**Own Occupation** • "The insured's inability to perform the material duties of his own occupation" **Modified Own Occupation** • "The insured's inability to perform any gainful occupation or a similar occupation for which the insured is reasonably suited by reason of education, training or experience" **Any Occupation** • This is a more restrictive definition of Total Disability. It means: "the insured's inability to perform any occupation" **Severe Disability** • This definition follows the Long-Term Care Insurance definition where the insured is unable to perform at least three of the six Activities of Daily Living (ADLs) – washing, dressing, feeding, toileting, mobility, and transferring.
Eligibility criteria for payment of Disability Income Insurance benefit	• Keep the policy in force; • Be working (employed) or in-between jobs when being disabled; • Still be disabled after the deferred/elimination period; • Meet the definition of total or partial disability as stated in the policy; • Not have reached the expiry age as stated in the policy; • Not have resided outside Singapore for more than a certain period of time (usually not more than six months); and • Not have other sources of income (e.g. payment from Work Injury Compensation Insurance), which when totalled up, is more than the benefits due to him under his Disability Income Insurance policy.

Types of benefits offered by Disability Income Insurance

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Total disability benefit	The main benefit offered by Disability Income Insurance is the monthly cash benefit payable to the insured to replace his lost income (e.g. up to 75%), when he becomes totally disabled through an accident or illness.
Partial disability benefit	Partial Disability Benefit is also known as "Rehabilitation Benefit". It provides a reduced benefit to the insured if he is able to return to work at a reduced income of 75% of his Pre-disability Earnings, or lower, even though he has not been fully recovered.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Rehabilitation expense benefit	Insurers encourage the disabled insured to participate in rehabilitation programmes. They will reimburse an insured for the rehabilitation costs incurred.
Escalation benefit	It is a benefit offered by insurers as a hedge against inflation. With an additional premium, the insured can opt for a 3% or 5% escalation benefit per annum.
Waiver of premium benefit	The premiums due under the Disability Income Insurance policy will be waived during the disability benefit payout period (applies to both total and partial disability).
Death benefit	Most insurers provide a lump sum amount to be paid to the insured's dependants, in the event of the insured's death.
How to compute the partial disability benefit?	$\frac{\text{Pre-disability Earnings - Present Earnings}}{\text{Pre-disability Earnings}}$ X Total Disability Benefit
How the escalation benefit works?	Eddy, an engineer, became disabled on 30 June 2018. He was insured for S$6,000 (75% of his monthly salary of S$8,000) and had opted for a 3% per annum escalation benefit and a 6-month deferred period. The events following his disablement were as follows: 1-1-2019: Insurer made the first monthly payment of S$6,000 1-2-2019: Insurer made the second monthly payment of S$6,000 Eddy continued to be disabled. Insurer continued to pay S$6,000 each month. 1-1-2020: Insurer paid S$6,180 [(S$6,000 + S$6,000 x 3% (escalation benefit)] 1-2-2020: Eddy had since found a job as a clerk which paid him S$2,000 a month. The insurer paid him a partial disability benefit of S$4,635 $\frac{\text{Pre-disability Earnings - Present Earnings}}{\text{Pre-disability Earnings}}$ X Disability Benefit = $\frac{\text{S\$(8,000 - 2,000)}}{\text{S\$8,000}}$ X S$6,180 = **S$4,635**
How the limitation of disability benefit clause works?	Purpose is to prevent over-insuring by restricting the monthly benefit payable, so that the total benefit (including other Disability Income policies that the insured may have) shall not exceed the insured's pre-disability earnings or some proportion of it. In the event of a claim, the disability benefit payable will be reduced by the following sources of income: 1. Payments from other insurance policies against disability (except the Total and Permanent Disability Benefit under Life Insurance policies), including Work Injury Compensation Insurance; and 2. Any continuing salary, commission or other incomes derived from the insured's occupation or business in which he was engaged immediately prior to his disability.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Features of Disability Income Insurance	• Can be issued as a stand-alone (for which then, no rider is possible) policy, or as a rider to a basic Life Insurance plan. • Provides a regular monthly income during the insured's total and partial disablement. • Premiums are waived during the benefit period. • Benefits may be level, or may increase at a given rate. • A choice of deferred/elimination period. • A choice of benefit period. • A choice of escalation benefit (if available). • Level premium can be paid on a monthly, quarterly, half-yearly or annual basis, depending on the insurer's practice. • Payment of partial disability benefits if a person returns to work earning a lower income. • Provision of rehabilitation expense benefit. • Provision of death benefit. • No restriction on the use of the cash benefits paid. • Disability benefit may discontinue if the insured stays outside Singapore for a specified period. • Cover will be terminated if the insured resides outside Singapore for more than a continuous specified number of days, within any one policy year, unless the insurer grants the insured the continuity of cover (an additional premium may be charged). • Cover will be terminated if the insured is not engaged in any full-time occupation or profession for a continuous period of a specified number of days, when he is not suffering from a disability (see Section 11 of this chapter for the other causes for the termination of a policy). • Policy is usually guaranteed renewable and non-cancellable (the insurer has the right to adjust the premium rates if the insured changes his occupation to one which is of a higher risk) by the insurer. • No surrender value, i.e. the insured cannot return the policy to the insurer for cancellation in exchange for cash payment. • No assignment is allowed. • Policy cannot be written as a third-party policy. • Benefits received are non-taxable. • Policy will lapse if the premium is not paid within the 30 days' grace period.
Documents required for the underwriting of Disability Income Insurance for an individual employee, as well as for the self-employed person	**Individual (Salaried Employee)** Proposal form (also called Application form) plus: 1. Computerised payslip; or 2. Certified letter from company (with company letterhead) or 3. Notice of Assessment; or 4. Central Provident Fund (CPF) Statement (six months) and large amount questionnaire if the annual benefit is more than a certain amount, e.g. S$60,000; and 5. Medical test report (e.g. medical examination report, etc.) based on the age and amount of disability benefit proposed. **Self-employed Person** Proposal form plus: 1. Notice of Assessment for the last three years; or 2. Audited company's accounts for the last three years; and large amount questionnaire if the annual benefit is more than a certain amount (e.g. S$60,000); and 3. Medical test report (e.g. medical examination report, etc.) based on the age and amount of disability benefit proposed.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Underwriting considerations for Disability Income Insurance: • **Occupation**	Occupation is a crucial underwriting consideration for two reasons: 1. Some occupations have a higher risk of disability from accidents (e.g. lorry driver), or illnesses, than others. 2. It is easier to return to work with some degree of incapacity in some occupations than in others. Typical rating structure as follows: 1. Class I. 2. Class II. 3. Class III. 4. Class IV. 5. Decline (uninsurable).
Underwriting considerations for Disability Income Insurance: • **Benefit amount**	Underwriter will assess to ensure the benefits proposed are reasonable for the type of occupation, nature of work involved, and stated earnings.
Underwriting considerations for Disability Income Insurance: • **Benefit period**	Benefit period is the duration that the insurer needs to pay out the benefit. Underwriters may use this to determine the terms of acceptance.
Underwriting considerations for Disability Income Insurance: • **Deferred/ elimination period**	The deferred/elimination period chosen helps the underwriter to determine whether there is any moral hazard involved.
When would the benefits under a Disability Income Insurance policy cease to be payable?	• When the insured is fit to return to work; • When death occurs; or • When the benefit period has expired.
Exclusions commonly found under Disability Income Insurance	1. Self-inflicted injury, while sane or insane; 2. Indulgence in alcohol or drug taking, unless taken under the directions of a registered medical practitioner; 3. Invasion, strike, riot, civil commotion, war (declared or undeclared) or act of war or warlike operation; 4. Illness or injury sustained while the insured is in the service of the armed forces of any country, except for reservist in-camp training during peacetime operation in accordance with the Enlistment Act 1970; 5. Pregnancy or childbirth or any complication arising there from, except in the case of pregnancy, where the disability continues for more than 90 days after the termination of pregnancy, the disability will be deemed to have commenced 90 days after the termination of the pregnancy; 6. Participation in any aerial activity, including parachuting and sky-diving or travel in any type of aircraft, other than as a fare paying passenger on a regularly scheduled flight of a commercial airline; 7. Sexually transmitted disease, or any disability, illness or injury or any condition or complication arising from or caused by (whether directly or indirectly) the human immunodeficiency virus (HIV), including Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related conditions; 8. Participation in any professional sports or hazardous sports, including racing of any kind on horse or wheels, mountaineering, rock climbing and scuba diving; 9. Any pre-existing condition (i.e. condition occurring before the payment of the initial payment). The above list of exclusions may differ from insurer to insurer.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Events that will cause a Disability Income Insurance policy to be terminated	• Policy has reached its expiry date; • Premiums due are not paid within the grace period; • Insured dies; • Insured reaches the expiry age as stated in the policy schedule; • Insured resides outside Singapore for an aggregate period of more than a specified number of days (e.g. 300 days) within one policy year, without seeking the insurer's prior written approval for continuation of cover; or • Insured is not employed in a full-time occupation or profession for a continuous period of a specified number of days (except if he is disabled).
Coverage and features of Group Disability Income Insurance	Cover provided by a Group Disability Income Insurance policy works in the same way as an individual Disability Income Insurance policy. The benefits and exclusions are also the same
General underwriting principles for both Individual and Group Disability Income Insurance	The selection process in Group Disability Insurance policies is similar to that for the individual disability plans. As the group must have a Group Term Life Insurance policy before they are eligible for this disability policy, most of the underwriting criteria will have already been met. The additional factors that the underwriters will need to take into consideration are: 1. Nature of the company's business; 2. Age of the individual employee; 3. Exact nature of work of each employee; 4. Salary of each employee; 5. Benefit period applied for; 6. Benefit amount applied for; and 7. Claims experience of the group under the previous Group Disability Income Insurance policy.
General claims procedures for both Individual and Group Disability Income Insurance	Claims procedures for individual or group disability income are similar. • In the event of a claim, the insured must notify the insurer within a specified period of time (e.g. 60 days) from the date of commencement of the disability. • Failure to comply with this requirement might cause the claim to be invalidated, unless the insured could prove that it was not possible for him to notify the insurer within the specified period, and that he had tried his best to do so. • If the insured resides outside Singapore while the policy benefits are payable, the insurer may impose conditions.
General claims documents for Disability Income Policy	• Claim form giving the personal particulars of the insured, as well as details of his occupation and disability; • Claimant's statement; • Clinical Abstract form (see Appendix 4A); • Physician's statement/doctor's statement to be completed by the insured's attending physician giving full details of his disability; • NRIC or birth certificate for verification of the insured's age; • Evidence of earnings, which can be in the form of income tax returns (IR8A form), copies of payslips for the 12 months prior to the commencement of disability, and letter from employer to certify that the claimant (insured) is not being paid during the period of disability; • Letter from company certifying that the insured's service has been terminated (if available); • Copies of Medical Certificates; • All available Laboratory and Tests results; • A copy of the Police Report if the cause of the disability is due to an accident; and • A copy of the Incident Report (required to be submitted to the Ministry of Manpower if the incident occurs at the workplace).

CHAPTER 5
LONG-TERM CARE INSURANCE

CHAPTER OUTLINE

1. Introduction
2. What Is Long-Term Care (LTC) Insurance?
3. Benefits Offered Under LTC Insurance
4. Other Benefits Provided Under LTC Insurance
5. Maximum Benefit
6. Benefit Payment Term
7. ElderShield
8. CareShield Life

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- explain Long-Term Care (LTC) Insurance
- know the types of LTC Insurance
- know the benefits offered under LTC Insurance
- know the eligibility criteria for payment of LTC benefits
- know what are considered as "Activities of Daily Living (ADLs)" and how they are related to the benefit payment under LTC Insurance
- know the other benefits provided under LTC Insurance
- explain maximum benefit sum payable and benefit payment term under LTC Insurance
- know what is ElderShield
- know the persons covered under ElderShield
- know how to check ElderShield coverage
- know the scope of protection under ElderShield and its premiums
- explain when an insured is eligible to claim under ElderShield
- know how to make a claim under ElderShield
- know what is CareShield Life and how it provides better protection
- know the differences between ElderShield and CareShield Life
- explain the features of MediSave Care

Contents

CHAPTER OUTLINE 88
LEARNING OUTCOMES 88
1. INTRODUCTION 90
2. WHAT IS LONG-TERM CARE (LTC) INSURANCE? 90
3. BENEFITS OFFERED UNDER LTC INSURANCE 91
A. Types Of LTC Policies 91
B. Eligibility Criteria For Payment Of LTC Benefits 92
B1. Meets The Definition Of Inability To Perform Activities Of Daily Living (ADLs) Or Advanced Dementia 92
B2. Meets The Deferred Period Requirement 93
B3. Does Not Cover Pre-existing Conditions 94
4. OTHER BENEFITS PROVIDED UNDER LTC INSURANCE 94
5. MAXIMUM BENEFIT 95
6. BENEFIT PAYMENT TERM 95
7. ELDERSHIELD 95
A. What is ElderShield? 95
A1. Overview 95
A2. Monthly pay-outs 96
A3. Fixed premiums 96
A4. Government administration of ElderShield 96
B. The Persons Covered Under ElderShield 96
B1. The Persons Enrolled 96
B2. Checking on ElderShield Coverage 96
B3. Protection Afforded Under ElderShield 97
B4. Premiums of ElderShield 97
B5. When The Insured Is Eligible to Claim 97
B6. Making A Claim 98
8. CARESHIELD LIFE 98
A. A Comparison Between CareShield Life And ElderShield 100
B. MEDISAVE CARE 100

1. INTRODUCTION

1.1 Growing old gracefully and leading a healthy, independent lifestyle is the desire of most people. However, age-related illnesses and injuries may be serious enough to prevent them from being able to take care of themselves independently. Chronic medical conditions like diabetes, stroke, hypertension, dementia, Alzheimer's disease, and the complications that arise from these medical conditions may render the elderly people unable to care for themselves independently. They will need help with Activities of Daily Living (ADLs), such as feeding, bathing, dressing, using the toilet, and moving around. Some may even require special care in a facility, such as a nursing home. The costs of such care can strain one's financial resources and, therefore, become a financial burden to one's family.

1.2 Singapore's population is ageing rapidly, and the repercussions are being felt across the country. An ageing population coupled with increased longevity will lead to higher national healthcare and long-term care expenditure for the elderly. National expenditure on healthcare will rise, given that there will be three times the number of Singapore citizens aged 65 years and above by 2030. With fewer children to support parents and grandparents, and the increasing numbers of elderly people living alone, more paid help, such as domestic workers, home-based caregivers and nurses, will also be needed. This will be a growing and worrying concern for the Singapore Government, as it will have to ensure that this group of elderly will have enough protection against the cost of long-term care when such needs arise.

1.3 In this chapter, we will look at how Long-Term Care Insurance can help to provide funds to supplement the cost of financing an individual's long-term care needs.

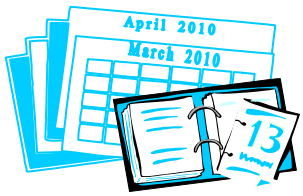
2. WHAT IS LONG-TERM CARE (LTC) INSURANCE?

2.1 LTC Insurance is designed to meet the costs of care for a person who, because of an accident, illness, frailty or a combination of these, is physically unable to function independently. Instead, he must depend on others to help him to perform most basic ADLs. In the next section of this chapter, we shall see what constitutes ADLs.

2.2 Even though people of all ages may require long-term care at some point of time in their life, this product is usually positioned as a vehicle to provide funds for long-term care for the elderly people. However, there are two key advantages of buying LTC, while clients are still young and healthy, with no existing medical disabilities.

- Firstly, the product will cost less as the premiums will rise considerably with age.
- Secondly, buying at a younger age also means that there is less risk of being rejected for cover owing to existing disabilities or medical history.

2.3 Although LTC is a complex and relatively high-cost product, it offers customers an alternative to supplement any public benefit or other sources of funds that they may have. LTC Insurance covers care generally not covered by other Medical Insurance. It will pay in addition to other insurance policies that the insured has, e.g. MediShield Life, Hospital Income and Critical Illness Insurance policy.



3. BENEFITS OFFERED UNDER LTC INSURANCE

A. Types Of LTC Policies

3.1 Two types of LTC policies are available and they are:

(a) **"Service-based"** policy pays a benefit when an insured incurs costs for a service covered under the policy (e.g. home care or nursing care) and satisfies the benefit trigger. This type of policy can pay benefits in two ways:

- Expense incurred method where the insurer will reimburse the insured for the cost incurred in using one of the services covered under the policy, up to the covered amount.
- Indemnity method pays the covered amount, regardless of the actual cost of the services received.

(b) **"Disability-based"** policy pays a benefit when an insured meets the benefit trigger, regardless of the service use. The benefit trigger may be based on limitations in ADLs and/or degree of cognitive impairment. This means that the benefits may be paid if the insured is diagnosed to be suffering from advanced dementia (including Alzheimer's disease), or when the insured is assessed to be suffering significant limitations in ADLs, or where there is a deterioration or loss of intellectual capacity resulting in a significant reduction in mental and social functioning, and the need for continuous supervision.

3.2 Benefits are usually paid daily or monthly:

(a) The "daily benefit" policy provides up to the fixed benefit amount per day (e.g. up to S$300 per day) usually to cover costs incurred on nursing home care services. Such policies may also include home care benefits which are usually expressed as a percentage (e.g. 50%) of the nursing care benefit. This type of policy may be issued on a "service-based" or "disability-based" basis.

(b) The "monthly benefit" policy is the most common type of LTC plan found in Singapore. This policy pays a monthly cash benefit to the insured upon being certified by an approved and registered medical practitioner to be unable to perform the specified minimum number of defined ADLs after a prescribed period. Some insurers pay 100% of the LTC monthly benefit if the insured is unable to perform at least the minimum number of ADLs, whereas others pay on a graduated scale, e.g. if the insured cannot perform two of the six ADLs, only 50% of the LTC monthly benefit is payable, whereas if the insured cannot perform four out of the six ADLs, 100% of the LTC monthly benefit will then be payable.

B. Eligibility Criteria For Payment Of LTC Benefits

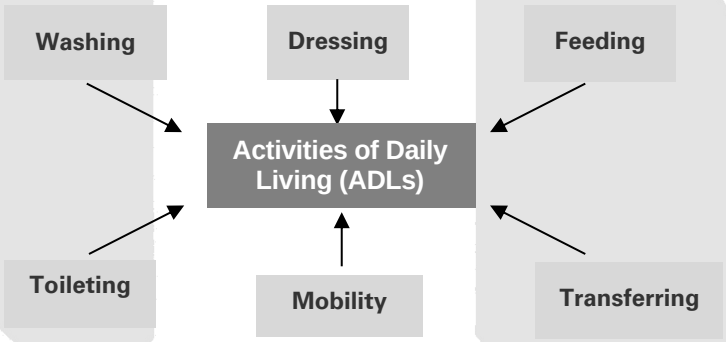
3.3 The insured need not be hospitalised to be eligible for the LTC benefits. He can use the benefits received under his LTC to pay for the costs of engaging a domestic helper (maid), to pay for the costs of staying in a nursing home, or to provide coverage of expenses in an assisted-living facility or home-care programme.

3.4 However, he must meet certain other criteria, before he can be eligible to claim for the LTC benefits.

B1. Meets The Definition Of Inability To Perform Activities Of Daily Living (ADLs) Or Advanced Dementia

3.5 **Inability To Perform ADLs**

(a) One of the key criteria for paying the benefits in LTC policies is the insured's inability to perform certain specific actions, which are essential, if an individual is to be able to live independently without support from others. These are known as "Activities of Daily Living" (ADLs). Insurers offering LTC Insurance typically adopt the following ADLs, which is in line with the ADLs used in internationally recognised functional assessments:

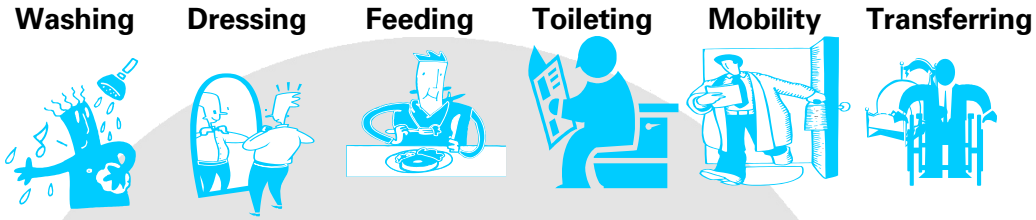


(b) The definitions of these ADLs are important. Some policies will pay benefits if, for example, three out of the specified list of ADLs cannot be performed, while others may insist on five or six. The premiums will obviously be higher, the lower the number of ADLs which the insured is required to be unable to perform, to qualify for the benefits.

(c) The ADLs are generally defined as follows:

- Washing: the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.
- Dressing: the ability to put on, or take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical or medical appliances.
- Feeding: the ability to feed oneself after the food has been prepared and made available.

- Toileting: the ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments (e.g. diapers) or surgical appliances (e.g. urinary catheters) if appropriate.
- Mobility: the ability to move indoors from room to room on level surfaces.
- Transferring: the ability to move from a bed to an upright chair or wheelchair, and vice versa.



(d) Failure to perform any of the above ADLs means that the insured will be unable to perform the task, even with the aid of assistive devices (e.g. wheelchair, clutches) on his own and always require the assistance of another person throughout the entire activity.

3.6 **Advanced Dementia**

(a) Advanced dementia means that the insured is suffering from deterioration or loss of intellectual capacity or abnormal behaviour as evidenced by the clinical state and accepted standardised questionnaires or tests, arising from Alzheimer's disease or irreversible organic disorders, excluding neurosis and psychiatric illness, resulting in significant reduction in mental and social functioning requiring the continual supervision of the insured to prevent the insured from harming others or himself.

(b) The important issues are that the dementia must arise from an organic reason, and that the insured requires continual supervision.

B2. <u>Meets The Deferred Period Requirement</u>

3.7 Besides failure to perform the ADLs, the insured may also need to fulfil a deferred period requirement before being eligible to receive the LTC benefits. Most insurers have a deferred period of 90 days, i.e. the insured will receive the benefits only if he is still unable to perform the specified minimum number of ADLs after the lapse of 90 days, with the deferred period commencing from the first day of any continuous period of inability to perform the ADLs. Many elderlies may suffer short periods of dependence after a stay in hospital for an illness or injury, and a deferred period will ensure that short-term claims are avoided and, therefore, reduce the premium costs. Insurers that offer hospital benefits as an extension to the LTC cover may impose a shorter deferred period for such benefits to take effect.

B3. Does Not Cover Pre-existing Conditions

3.8 LTC policy would not pay if the claim arose from a pre-existing condition that was not disclosed in the proposal form. If disclosed, the insurer may accept the application at standard premium rates, or at sub-standard premium rates, i.e. may charge a higher premium, accept the application with exclusions, or reject the application. The decisions taken on the application and premium rates charged are largely dependent on the severity of the conditions of the proposer (also called the applicant or the intending insured).

3.9 The purpose of the provision is to guard against people buying the coverage knowing that they have a condition that is likely to lead to a claim. This is also known as anti-selection against the insurer.

3.10 The insurer may also impose other policy conditions for the insured to comply with, before they are eligible to claim the benefits.

4. OTHER BENEFITS PROVIDED UNDER LTC INSURANCE

4.1 Insurers also usually include a death benefit which is payable to the insured's beneficiaries upon the death of the insured. However, the quantum is small, ranging from an indicative amount of S$5,000 to six times the LTC monthly benefit for example. Upon paying out the death benefit, the cover ceases.

4.2 Some insurers, in addition to LTC and death benefits, may also package it with other benefits, such as:

(a) Hospital Room And Board Benefit – a daily rate for each day is payable if the insured is hospitalised;

(b) Surgical Procedure Benefit – a specified amount is payable if the insured goes for surgical procedures that are medically necessary;

(c) Financial Assistance With Adaptation Benefit – a specified sum, such as two times of the monthly benefit, is payable if the use of assistive devices (e.g. wheelchair) is deemed necessary by a doctor, to assist the insured to perform an ADL;

(d) Extended Care Benefit – an extra specified sum, such as an extra monthly benefit, is payable every three or five years; and

(e) Rehabilitation Benefit – a reduced benefit (e.g. 50% of the insured amount) when the insured makes partial recovery (such as if he is unable to do two instead of three ADLs).

4.3 These benefits are subject to limits on the maximum sum that can be claimed, as well as limits on the benefit payment period. Otherwise, the product will become prohibitively expensive. The main purpose of LTC Insurance is not to fulfil the need of income protection, or for reimbursement of medical expenses, e.g. hospital and surgical bills. Such needs are better met by other policies, such as Disability Income Insurance and/or Hospital and Surgical Insurance.

5. MAXIMUM BENEFIT

5.1 For LTC benefits, depending on the plan that the insured chooses, he may claim, for example, between S$300 and S$5,000 per month, as long as he is unable to perform the specified number of ADLs, and meets the other policy conditions. Some insurers may limit the maximum benefit sum payable.

5.2 For policies packaged with hospital benefits, there is usually a maximum amount that can be claimed per day (the hospital stay must also exceed a specified number of hours, e.g. 12 hours, for the benefit payments to be claimable), subject to a maximum number of days per year of hospitalisation.

5.3 For those with Surgical Benefits, the insured, again depending on the plan that he has purchased, can claim only a maximum amount per surgery. All the benefits may then be subject to a maximum combined (i.e. combining LTC and Hospital and Surgical benefits) limit. Once the insured has claimed the maximum limit (or combined limit), the policy expires.

6. BENEFIT PAYMENT TERM

6.1 While most insureds prefer the policy benefits to be payable as long as they live, the premiums for such plans may be too expensive for them to buy. Some insurers allow customers to choose the benefit payment term. This means that the benefits will be payable for the chosen period (e.g. 12 years of benefits). The premiums payable for a shorter benefit payment term will be cheaper and more affordable. During the benefit payment period, premiums payable are waived.

6.2 Notwithstanding the above, there are LTC insurance schemes (with affordable premiums) that offer lifetime cash pay-outs for as long as the insured is severely disabled such as CareShield Life which we shall examine in a later part of this chapter.

7. ELDERSHIELD[1]

A. What is ElderShield?

7.1 ElderShield is a long-term care insurance scheme targeted at severe disability, especially during old age.

A1. Overview

7.2 When it was introduced in 2002, ElderShield provided pay-outs of $300 per month for up to five years upon severe disability. It was subsequently reviewed in 2007 to provide better benefits of $400 per month for up to six years. The benefits the insured will receive depends on which scheme he joined. Please note that the ElderShield scheme is no longer open for new applications.

[1] https://www.cpf.gov.sg/member/healthcare-financing/eldershield

A2. Monthly pay-outs

7.3 ElderShield provides monthly cash pay-outs for up to 72 months to help pay out-of-pocket expenses for the care of the severely disabled.

A3. Fixed premiums

7.4 Premiums are determined when the insured enters the scheme, and the premiums remain fixed. The insured must pay the premium each year until the policy anniversary after turning age 65, or when the insured makes a successful claim.

A4. Government administration of ElderShield

7.5 From 1 November 2021, the Government has taken over the administration of ElderShield from private insurers (Singlife with Aviva, Great Eastern Life Assurance Co Ltd, and Income Insurance Limited).

B. The Persons Covered Under ElderShield

B1. The Persons Enrolled

7.6 Until 2019, all Singapore Citizens and Permanent Residents with MediSave Accounts were enrolled in ElderShield at the age of 40, unless they opted out.

7.7 Since 2020, auto-enrolments into ElderShield were discontinued. Singapore Citizens and Permanent Residents who turned 40 in 2020 were instead enrolled into CareShield Life.

7.8 For those born on 30 September 1932 or before, or had a pre-existing disability as of 30 September 2002, they would not have been able to join ElderShield in 2002. Instead, they may be eligible for assistance under the Interim Disability Assistance Programme for the Elderly (IDAPE) if they become severely disabled.

7.9 To learn more about IDAPE, please visit this website: https://www.aic.sg/financial-assistance/interim-disability-assistance-programme-elderly

B2. Checking on ElderShield Coverage

7.10 The following steps should be performed in checking on one's coverage:

(a) Log in to one's CPF Digital Services using one's Singpass.
(b) Hover over "my cpf" and click on "Healthcare" under "My dashboards".
(c) Click on "Long-term care insurance" on the anchor links or scroll down to the "Long-term care insurance" section.

7.11 If the person is not covered, no information on ElderShield will be reflected. To check one's coverage, he or she should visit the CPF website at Central Provident Fund Board (CPFB).

B3. Protection Afforded Under ElderShield

7.12 ElderShield provides the following protection and benefits:

(a) Lifetime coverage – The insured continues to be covered for life once he has completed paying all his premiums at age 65.

(b) Up to 72 months of cash pay-outs – The insured stands to receive a monthly cash pay-out for up to five or six years, depending on the plan chosen. With ESH400, he will get $400 per month for up to 72 months, and with ESH300, he will get $300 per month for up to 60 months.

(c) Fully payable with MediSave – The insured can use his MediSave to pay his ElderShield premiums. Family members can help the insured by paying from their own MediSave or topping up the insured's account with cash.

(d) Worldwide coverage – The insured will remain covered, be able to make a claim, and receive pay-outs no matter where he lives in the world.

B4. Premiums of ElderShield

7.13 The premium payment for ElderShield is up to age 65, with a coverage for life. ElderShield premiums are based on the age at which the insured joins the scheme and are payable until the policy anniversary after his 65th birthday.

7.14 To learn more about ElderShield premiums, please visit this website: https://www.cpf.gov.sg/member/healthcare-financing/eldershield/eldershield-premiums.

B5. When The Insured Is Eligible to Claim

7.15 One can apply to receive ElderShield pay-outs if he is determined by an MOH-accredited assessor to be unable to carry out three of the six activities of daily living (ADL) listed below:

(a) Washing – The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.

(b) Dressing – The ability to put on, take off, secure, and unfasten all garments and, as appropriate, any braces, artificial limbs, or other surgical or medical appliances.

(c) Feeding – The ability to feed oneself food after it has been prepared and made available.

(d) Toileting – The ability to use the toilet or manage bowel and bladder function using protective undergarments, such as diapers or surgical appliances, if appropriate.

(e) Mobility – The ability to move indoors from room to room on level surfaces.

(f) Transferring – The ability to move from a bed to an upright chair or wheelchair, and vice versa.

B6. Making A Claim

7.16 To make a claim, one should complete the claim assessment. First, the insured needs to arrange for a disability assessment which can be conducted by any MOH-accredited severe disability assessor. For a list of assessors, please visit this link:
https://www.aic.sg/financial-assistance/Documents/ApplicationForms/IDAPE Assessor List.pdf

7.17 The assessment costs $100 for a clinic assessment and $250 for a house call, both of which are payable to the assessor at the time of assessment. The full fee will be reimbursed if the insured is assessed to be severely disabled and will be reimbursed with the first pay out.

7.18 Next, the insured needs to log in to AIC's e-Service portal (eFASS) with his Singpass to submit a claim. The insured can access the link: AIC eFinance to learn more about submitting a claim.

8. CARESHIELD LIFE[2]

8.1 An enhanced version of ElderShield – known as CareShield Life was launched on 1 October 2020. CareShield Life is a long-term care insurance scheme that supports the basic long-term care needs of Singaporeans with severe disability.

8.2 CareShield is compulsory for all Singaporeans born in 1980 or later. Those born 1980 to 1989 were automatically enrolled in 2020 at one go, while those born 1990 onwards will be automatically enrolled under the scheme upon turning 30. Those with pre-existing disability and illnesses will still be covered under CareShield Life.

8.3 For a person born in 1979 or earlier:

(a) His current ElderShield plans will continue to protect him.

(b) He could choose to join CareShield Life when the scheme was launched in 2021 if he was not severely disabled (defined as the inability to perform at least three out of six ADLs).

(c) He can enjoy participation incentives of up to $2,500, if he joins by end-2023. The Merdeka and Pioneer Generation seniors will receive an additional $1,500.

8.4 For a person born in 1980 or later:

(a) Universal coverage – he will be covered even if he has pre-existing medical conditions and/or disabilities.

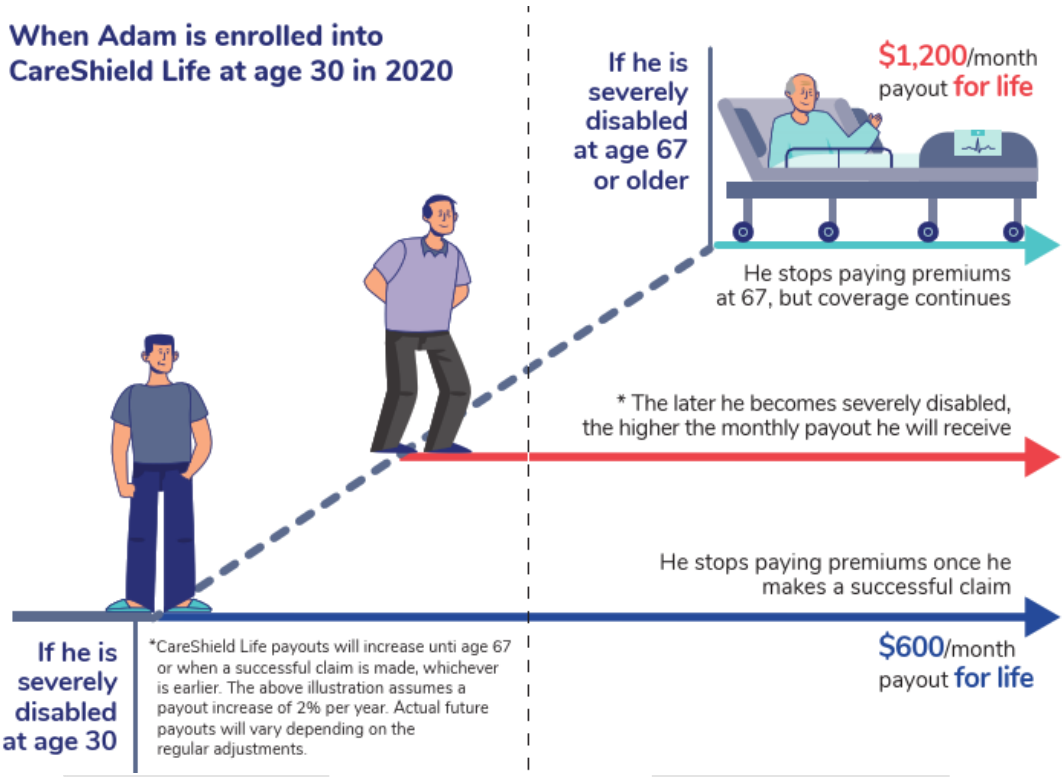
(b) If he was born between 1980 and 1990, he would have automatically joined CareShield Life in 2020.

(c) If he was born after 1990, he will join CareShield Life when he turns 30.

[2] https://www.careshieldlife.gov.sg

(d) Transitional subsidies were available from 2020 onwards and these subsidies end in 2024.

8.5 The figure below shows an example of Adam, a Singaporean who is enrolled into CareShield Life at 30 years old.



Source:
https://www.careshieldlife.gov.sg/content/dam/cshl/pdf/CareShield%20Life%20Welcome%20Booklet.pdf

8.6 CareShield Life provides better protection and assurance in four ways:

(a) Lifetime cash pay-outs for as long as the insured is severely disabled

(b) Pay-out starting at $600 per month in 2020 and increases annually until age 67 or when a successful claim is made

(c) Government subsidies are given to make premiums affordable i.e. no one will lose coverage because of an inability to pay premiums

(d) Premiums can be fully paid by MediSave

8.7 In addition to CareShield Life, Singaporeans will benefit from two new schemes starting in 2020:

(a) MediSave Care which was launched on 1 October 2020. Singaporeans who are severely disabled can make a cash withdrawal up to $200 per month from MediSave.

(b) ElderFund which was launched on 31 January 2020. It serves as an assistance for lower-income Singaporeans who are severely disabled, where they can claim up to $250 per month to help with long-term care needs.

A. A Comparison Between CareShield Life And ElderShield

8.8 The table below shows how CareShield Life compares against ElderShield.

	ElderShield300	ElderShield400	CareShield Life
Pay-out Amount	$300	$400	Pay-outs start at $600 per month in 2020 and increase over time
Pay-out Duration	60 months	72 months	For entire duration of disability
Government Subsidies and Incentives	None		Yes, depending on circumstances
Payable by MediSave	Yes	Yes	Yes
Pay-out Criteria	Unable to perform 3 or more of the 6 activities for daily living		

B. MEDISAVE CARE

8.9 MediSave Care is a long-term care scheme which was launched on 1 October 2020. Under MediSave Care, Singapore Citizens and Permanent Residents aged 30 and above who are severely disabled will be able to make monthly cash withdrawals from their own and/or their spouse's MediSave for their long-term care needs.

8.10 After setting aside a minimum amount to ensure adequacy for other medical expenses, severely disabled Singapore Citizens and Permanent Residents will be able to withdraw up to a total of $200/month from their own and/or their spouse's MediSave.

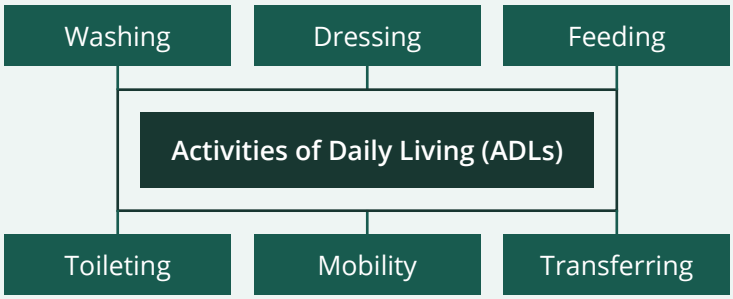
8.11 The table below shows the MediSave balances and corresponding monthly withdrawal quantum.

MediSave Balance	Monthly Withdrawal Quantum
S20,000 and above	$200
S15,000 and above	$150
$10,000 and above	S100
$5,000 and above	$50
Below $5,000	N.A.

8.12 A Singaporean citizen or a Permanent Resident is eligible to withdraw under MediSave Care if he or she is assessed by an MOH-accredited assessor to be unable to perform three or more of the six activities of daily living.

CHAPTER 05

LONG-TERM CARE INSURANCE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
What is Long-Term Care Insurance (LTC)?	LTC Insurance is designed to meet the costs of care for a person who, because of an accident, illness, frailty or a combination of these, is physically unable to function independently. Instead, he must depend on others to help him to perform most basic Activities of Daily Living (ADLs).
Benefits offered under Long-Term Care Insurance	• "Service-based" policy pays a benefit when an insured incurs costs for a service covered under the policy (e.g. home care or nursing care) and satisfies the benefit trigger. This type of policy can pay benefits in two ways: » Expense incurred method where the insurer will reimburse the insured for the cost incurred in using one of the services covered under the policy, up to the covered amount. » Indemnity method pays the covered amount, regardless of the actual cost of the services received. • "Disability-based" policy pays a benefit when an insured meets the benefit trigger, regardless of the service use. The benefit trigger may be based on limitations in ADLs and/or degree of cognitive impairment. This means that the benefits may be paid if the insured is diagnosed to be suffering from advanced dementia (including Alzheimer's disease), or when the insured is assessed to be suffering significant limitations in ADLs, or where there is a deterioration or loss of intellectual capacity resulting in a significant reduction in mental and social functioning, and the need for continuous supervision.
Eligibility criteria for payment of Long-Term Care Insurance benefit	• Meets The Definition Of Inability To Perform Activities Of Daily Living (ADLs) Or Advanced Dementia. • Meets The Deferred Period Requirement. • Does Not Cover Pre-existing Conditions.
"Activities of Daily Living (ADLs)" and how they are related to the benefit payment under Long-Term Care Insurance.	One of the key criteria for paying the benefits in LTC policies is the insured's inability to perform certain specific actions, which are essential, if an individual is to be able to live independently without support from others. These are known as "Activities of Daily Living" (ADLs). 
Other benefits are available under Long-Term Care Insurance	• Usually include a death benefit which is payable to the insured's beneficiaries upon the death of the insured. However, the quantum is small. • Hospital Room And Board Benefit. • Surgical Procedure Benefit. • Financial Assistance With Adaptation Benefit. • Extended Care Benefit. • Rehabilitation Benefit.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Maximum benefit sum payable</td><td>

For LTC benefits, depending on the plan that the insured chooses, he may claim, for example, between S$300 and S$5,000 per month, as long as he is unable to perform the specified number of ADLs, and meets the other policy conditions. Some insurers may limit the maximum benefit sum payable.
For policies packaged with hospital benefits, there is usually a maximum amount that can be claimed per day, subject to a maximum number of days per year of hospitalisation.
For those with Surgical Benefits, the insured, again depending on the plan that he has purchased, can claim only a maximum amount per surgery.

</td></tr>
<tr><td>Benefit payment term</td><td>While most insureds prefer the policy benefits to be payable as long as they live, the premiums for such plans may be too expensive for them to buy. Some insurers allow customers to choose the benefit payment term. This means that the benefits will be payable for the chosen period (e.g. 12 years of benefits). The premiums payable for a shorter benefit payment term will be cheaper and more affordable. During the benefit payment period, premiums payable are waived.</td></tr>
<tr><td>ElderShield and CareShield Life</td><td>
<table>
<tr><th></th><th>ElderShield300</th><th>ElderShield400</th><th>CareShield Life</th></tr>
<tr><td>Pay-out amount</td><td>$300</td><td>$400</td><td>Pay-outs start at $600 per month in 2020 and increase over time</td></tr>
<tr><td>Pay-out duration</td><td>60 months</td><td>72 months</td><td>For entire duration of disability</td></tr>
<tr><td>Government subsidies and incentives</td><td colspan="2">No</td><td>Yes, depending on circumstances</td></tr>
<tr><td>Payable by MediSave?</td><td colspan="3">Yes</td></tr>
<tr><td>Pay-out criteria</td><td colspan="3">Unable to perform 3 or more of the 6 activities for daily living</td></tr>
</table>
</td></tr>
</table>

CHAPTER 6
CRITICAL ILLNESS INSURANCE

CHAPTER OUTLINE

1. Introduction
2. Critical Illness (CI) Insurance
3. LIA Critical Illness Framework
4. Benefits Offered under Critical Illness Insurance
5. Variation of Illness Insurance
6. Underwriting
7. Factors To Consider In Determining Adequacy of Critical Illness Coverage
8. Exclusions
9. Termination of Cover
10. Claims
11. Group Critical Illness (CI) Insurance Policy

Appendix 6A – Standard Definitions for Severe Stage of 37 Critical Illnesses: Version 2019

Annex 1 - List of changes to the standard list of 37 critical illness under the Critical Illness Framework 2019

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- describe how a Critical Illness Insurance policy works
- understand the Critical Illness Framework proposed by the Life Insurance Association
- know the eligibility criteria for payment of the Critical Illness Insurance benefit
- state the features of Critical Illness Insurance
- outline and differentiate the two types of Critical Illness covers
- know the advantages of severity-based Critical Illness covers
- know the latest market developments in Critical Illness Plans and understand the various coverages
- understand the factors to consider in determining the adequacy of Critical Illness Insurance coverage
- list the common exclusions under a Critical Illness Insurance policy and know the circumstances under which it will be terminated
- list the documents that the insured has to submit when making a claim and know the claim procedures
- know how a Group Critical Illness Insurance policy works

Contents

CHAPTER OUTLINE 101
LEARNING OUTCOMES 101
1. INTRODUCTION 104
2. CRITICAL ILLNESS (CI) INSURANCE 104
3. LIA CRITICAL ILLNESS FRAMEWORK 2019 ("THE CI FRAMEWORK") 104
A. The benefits to policyholders arising from the new definitions under the CI Framework 2019. 107
B. Coverage for Covid-19 108
4. BENEFITS OFFERED UNDER CRITICAL ILLNESS INSURANCE 108
A. Eligibility Criteria For Payment Of Critical Illness Benefit 108
B. Features Of CI Insurance 111
C. Types Of CI Insurance Covers 112
C1. Acceleration Benefit Critical Illness (CI) Insurance Cover 112
C2. Additional Benefit Critical Illness (CI) Insurance Cover 114
5. VARIATIONS OF CRITICAL ILLNESS INSURANCE 117
A. Severity-Based Critical Illness (CI) Insurance Plan (Early Pay CI) 117
A1. The Advantages of Severity-Based Cover 118
A2. Premium and Other Considerations 119
B. Multiple Pay Critical Illness (CI) Insurance Plan 119
C. Critical Illness Plans Covering Mental Illnesses 120
D. Insurance Covering Diabetes 120
E. Combination of CI Cover 120
F. Insurance Covering Pregnancy Complications 120
6. UNDERWRITING 121
A. Underwriting Requirements 121
B. Underwriting Considerations 121
7. FACTORS TO CONSIDER IN DETERMINING ADEQUACY OF CRITICAL ILLNESS COVERAGE 122
A. Life Insurance Association's (LIA) Recommended Amount 122
B. Minimum Five Years Of Income, After Taking Into Account Debt 123
C. Recovery Expenses 123
D. Providing For Dependents 123
8. EXCLUSIONS 124
9. TERMINATION OF COVER 124
10. CLAIMS 125
11. GROUP CRITICAL ILLNESS (CI) INSURANCE POLICY 125

APPENDIX 6A 127
ANNEX 1 138

1. INTRODUCTION

1.1 The first Critical Illness Insurance was developed and launched in 1983 in South Africa. The initial product was known as dread disease insurance, covering four primary health conditions: Cancer, Stroke, Heart Attack and Coronary Artery Bypass. Since then, the coverage has been widely accepted worldwide as people become more aware of the financial implication of serious medical conditions and the need for protection in the event of an unforeseen diagnosis of the illness. Critical Illness Insurance has evolved over the last three decades. In this chapter, we will take a closer look at Critical Illness Insurance, including the recent developments of the product in the market.

2. CRITICAL ILLNESS (CI) INSURANCE

2.1 A Critical Illness (also known as Dread Disease) policy is an insurance product designed to provide a lump sum benefit to a policyholder in the event that the insured is diagnosed to be suffering from one of the critical illnesses or has undergone a surgical procedure covered under the policy. Each critical illness or surgery covered by the policy is precisely defined in the policy, and the benefits will be paid only if he suffers a condition that meets the standard definition as specified in the policy.

2.2 Critical-illness coverage is a hyper-specific benefit, meaning that a condition must be specified within the policy to be covered

2.3 Benefits received from a Critical Illness policy can be used to finance the cost of care and treatment, recuperation, medical aids, replacing any income loss or even funding a change in lifestyle.

2.4 Critical Illness (CI) Insurance policy can be sold as a stand-alone policy (individual or group basis), or as an optional rider to a Whole Life, Endowment, Term Insurance or Investment-Linked Policy (ILP), to provide either an additional sum assured or the advanced payment of a portion, or the entire sum assured payable on death.

3. LIA CRITICAL ILLNESS FRAMEWORK 2019 ("THE CI FRAMEWORK")

3.1 The CI Framework seeks to balance the interests of both the consumers and the insurance companies i.e. offering clear and consistent coverage on the core critical illness benefits will allow for easier product comparison by consumers as well as consistent outcomes in CI claims. It seeks to reduce ambiguity of the same CI claim being paid by one insurer but rejected by another.

3.2 The CI Framework was set up in consultation with the Monetary Authority of Singapore. Member companies of Life Insurance Association (LIA) and General Insurance Association (GIA) undertake to comply with the framework which governs the provision of CI coverage by insurers. Under the CI framework,

severe Critical Illness definitions is standardised for 37 medical conditions by way of common definitions.

3.3 Since 2003, the industry has standardised definitions for a list of 37 severe critical illnesses for insurers to adopt to provide consistency for policyholders. Subsequent reviews were done in 2014 and 2019 to update the standard definitions having considered advancements in medical technology, health trends, diagnosis as well as the experiences gathered by the industry to address any issues that arose due to lack of clarity on the definitions.

3.4 In the 2014 review, the previous maximum limit of 30 medical conditions per CI plan was abolished. Insurers could then offer any number of medical conditions under a CI plan including single-illness CI plans. For each insured medical condition, subject to the adoption of the common definitions, there were no restrictions on how many stages and what the stages of illness progression to be covered by the insurers. Definitions for additional critical illnesses not covered by the 37 standardised definitions were to be set by the individual insurers.

3.5 In the latest review of 2019, the standardised definitions were updated to enhance clarity. Critical Illness insurance products could incorporate either Version 2014 or Version 2019 definitions. On and after 26 August 2020, CI products using Version 2014 definitions were no longer sold in Singapore. For Individual Policies, the application of Version 2019 definitions was to be based on the Proposal Signed Date. For proposals that were signed by 25 August 2020, insurers were to ensure that the policies were issued by 25 November 2020. This gave insurers a grace period of three months to issue all such policies under Version 2014 definitions. Policyholders with existing Critical Illness policies were not impacted by the new definitions.

3.6 However, the above-mentioned timelines have been affected by the COVID-19 pandemic. On 29 June 2020, LIA issued a circular to members advising them of an extension of Grace Period. In view that COVID-19 has presented a practical difficulty for applications requiring medical examinations, LIA members were advised that the grace period for transition to Version 2019 Definitions would be extended from the original three months to six months, i.e. by 25 February 2021.

3.7 Insurers that were implementing Version 2019 Definitions before 26 August 2020 could, if they wish, align to the same cut-off date of 25 February 2021. For proposals that had been signed by 25 August 2020, insurers had to ensure that the policies were issued no later than 25 February 2021. This gave insurers a grace period of six months to issue all such policies under Version 2014 definitions.

3.8 In short, if the insured is purchasing critical illness insurance from 26 August 2020 onwards, the updated set of definitions for the standard list of 37 critical illnesses would apply as per the Life Insurance Association (LIA) Critical Illness Framework 2019 outlined above.

3.9 In order for financial advisors to better advise their clients, they need to know the CI definitions well as well as be able to highlight to their clients regarding the definitions. Conditions are covered under the policy only if they meet the definitions.

3.10 The list of changes to the standard list of 37 critical illness under the Critical Illness Framework 2019 are shown in Annex 1.

3.11 **Appendix 6A** shows the Standard Definitions for Severe Stage of 37 Critical Illnesses: Version 2019 extracted from the LIA Website at: www.lia.org.sg

3.12 In addition, insurers must adopt a **90-day waiting period** for the severe stage of five CIs to minimise anti-selection risk. Waiting period refers to the period of time stated in the policy which must pass, before some or all of the insured's Health Insurance coverage can begin. These five CIs are:

(a) Major Cancer

(b) Coronary Artery By-Pass Surgery

(c) Heart Attack of Specified Severity

(d) Angioplasty and Other Invasive Treatments for Coronary Artery

(e) Other Serious Coronary Artery Disease

3.13 Although each insurer is free to adopt its own wordings on the waiting period clause, the waiting period is to begin from the date that cover commences, or date of reinstatement and the "date of diagnosis" shall be used to apply to the waiting period. For conditions that pay a benefit on surgical procedure, this "date of diagnosis" is the date of diagnosis of the medical condition that leads to the surgical procedure but not to the date of surgical procedure itself.

3.14 The following are **within the scope of the CI Framework**:

(a) New individual policies or benefits

(b) New group policies or renewals, including any new CI cover during the policy year

(c) CI benefits issued as a standalone policy or a rider

(d) CI benefits issued on an individual basis or a group basis

(e) CI benefits issued as a rider to an H&S policy or a PA policy

(f) For cases of top-up to existing CI policies, insurers are given the discretion to decide to either apply the existing definitions to the top-up amount or apply the prevailing current definitions to the top-up amount. Where it is the latter, it is for the insurer to decide on the date of implementation of such a practice. Further, the insurer should disclose this practice to the policyholder in order to avoid any misunderstanding or difficulties in the future.

(g) Where an existing individual CI term policy (yearly renewable type) is auto-renewed or has to be cancelled and re-issued due to administrative

reasons, for example: change of payment mode or credit cards, the same approach applies as under (f) above.

(h) Where an existing CI benefit attached to a health policy (including Integrated Shield Plan) is auto-renewed, the same approach applies as under (f) above.

3.15 The following are out of scope of the CI Framework:

(a) CI products for Male or Female or Children which do not cover any of the CI conditions in its entire scope. Example, a Female CI product which covers only Female Organs Cancer does not need to apply the Major Cancer definition.

(b) Terminal Illness issued under the general benefits of a basic plan.

3.16 However, the above does not preclude insurers from customising their products by extending coverage for more medical conditions and stages of illness progression, beyond the standard list of 37 critical illnesses. Therefore, policyholders need to fully understand the benefits of any critical illness insurance they are purchasing.

3.17 For example, some plans offer coverage for 187 conditions that go beyond critical illnesses, including 150 multi-stage critical illnesses.

A. The benefits to policyholders arising from the new definitions under the CI Framework 2019.

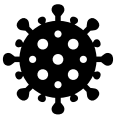
3.18 While the main objective of the changes made was to enhance the clarity of the definitions of coverage in respect of severe stages of CI, there are additional benefits for policyholders as detailed below:

3.19 Previously, those who suffer from Thalassaemia or Haemophillia could not claim under "HIV Due to Blood Transfusion and Occupationally Acquired HIV". This group can claim under this category now.

3.20 The legal definition of blindness of 6/60 has been adopted for "Blindness (Irreversible Lost of Sight)" condition as compared to the previous definition of 3/60.The latest critical illness definitions offer both pros and cons for policyholders. Policyholders and consumers should be advised to check with their insurer on coverage options available to them. Financial advisors should advise their clients on how much coverage they need before purchasing critical illness insurance. The policyholders can look to LIA's 2017 Protection Gap Study – Singapore[1] as a guide, which recommends having enough coverage to last for an assumed critical illness recovery period of five years. Certain insurers also avail to their policyholders critical illness calculators so that they can work out how much critical illness coverage they need today.

[1] https://www.lia.org.sg/media/1332/protection-gap-study-report-2017.pdf

B. Coverage for Covid-19



3.21 In Singapore, COVID-19 is not one of the critical illnesses under the insurers' list of critical illness conditions.

3.22 However, for any consequential complication arising after the diagnosis of COVID-19 leading to a critical illness, such as End Stage Lung Disease, the critical illness benefit covered under these plans will apply.

4. BENEFITS OFFERED UNDER CRITICAL ILLNESS INSURANCE

A. Eligibility Criteria For Payment Of Critical Illness Benefit

4.1 The common eligibility criteria are highlighted below:

(a) The policy must be in force.

(b) The life insured has not reached the expiry age of the CI Insurance cover (if applicable).

(c) Critical Illness Must Be One That Is Covered.

The critical illness suffered must be one of the diseases as specified in the policy contract, and it must be the first incidence of it for the life insured. This means that if the critical illness is a pre-existing illness or is excluded from the policy, it will not be covered.

(d) Meets The Definition Of Critical Illness.

(i) The definitions of the various critical illnesses as specified in the policy forms an extremely important part of the policy, as they will determine whether a claim is payable. For a severe Critical illness that is under the list of 37 conditions in the LIA CI framework, the definition shall follow the industry standard. For any illness not found in the list, it shall follow the respective definition which the insurer has adopted. It is important that you take some time to explain to your prospective client, and ensure that your prospective client understands that the benefits will be paid only if the illness qualifies and meets the definition as specified in the policy.

(ii) Let us look at one of the severe CI definitions (based on LIA CI Framework 2019), to illustrate how you should explain the "meeting the definition" criteria to your prospective clients.

"Major Cancer"
A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.

The term Major Cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.

Major Cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.

For the above definition, the following are excluded:

- All tumours which are histologically classified as any of the following:
  - Pre-malignant;
  - Non-invasive;
  - Carcinoma-in-situ (Tis) or Ta;
  - Having borderline malignancy;
  - Having any degree of malignant potential;
  - Having suspicious malignancy;
  - Neoplasm of uncertain or unknown behaviour; or
  - All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
- Any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All Prostate cancers histologically described as T1N0M0 (TNM Classification) or below; or Prostate cancers of another equivalent or lesser classification;
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- All Neuroendocrine tumours histologically classified as T1N0M0 (TNM Classification) or below;
- All tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification) or below;
- All Gastro-Intestinal Stromal tumours histologically classified as Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3;
- All bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
- All tumours in the presence of HIV infection."

(iii) As can be seen from the above specification, it does not mean that, so long as the life insured is diagnosed to be suffering from cancer, he can make a critical illness claim under his policy. Standard definitions allow consumers to compare the CI plans covering the severe stage of medical conditions of different insurers. The scope of coverage is clear and consistent across the industry, giving consumers assurance and confidence. These standard definitions have been refined to clearly reflect the intent of coverage.

(iv) As the definitions can be very technical, you may have difficulties explaining them to your prospective clients. In such a case, it is advisable that you approach your underwriter or claims manager, with the request for your company to provide you with adequate training in this technical area.

(e) Diagnosis Meets The Conditions Set Down By The Insurer.

(i) The diagnosis of the critical illness must be made by registered medical practitioners. It excludes physicians who are themselves the life insureds, their spouses and other lineal relatives[2] of theirs.

(ii) The diagnosis must be supported by medical evidence, such as radiological, clinical, histological or laboratory evidence acceptable to the insurer. In addition, some insurers require that the diagnosis must be supported by their own medical director who may base his opinion on the medical evidence submitted by the claimant and/or any additional evidence requested by him.

(iii) If there is any dispute on the appropriateness or correctness of the diagnosis, the insurer has the right to call for a medical examination of the life insured, or the evidence used in arriving at such a diagnosis by an acknowledged independent expert in the field of medicine concerned, as selected by the insurer. The expert's opinion will be binding on both the insurer and the life insured.

(f) Meets The Waiting Period Requirement.

(i) The critical illness must be diagnosed after the waiting period. Waiting period for CI plans can be up to 90 days starting from the date of issue, or the date of any reinstatement of the policy. For example, a CI Insurance policy was issued on 1 January 2020. The life insured could make a claim under his policy, if he was diagnosed to be suffering from one of the critical illnesses only on or after 1 April 2020.

(ii) The waiting period is imposed to prevent consumers from buying the policy only when they suspect that there is something wrong with their health; a practice known as anti-selection. If a person is found to be suffering from any of the critical illnesses before or during the waiting period, the insurer will void the policy and refund the premiums paid.

[2] Lineal relatives refer to people who are descendants from the same ancestor.

(g) Meets The Survival Period Requirement.

(i) The life insured must survive a period before the critical illness benefit becomes payable. This survival period is the period of time (which typically range from 7 to 30 days) starting from the date of occurrence of a critical illness. Note that this survival period is applicable only to the Additional Benefit type of Critical Illness cover.

(ii) In a nutshell,

The benefits under a CI Insurance policy are payable ONLY if the:

- policy is in force;
- life insured has not reached the expiry age of the CI Insurance cover;
- critical illness which the life insured is suffering from is one that is covered under the policy and meets the conditions as specified in the policy;
- critical illness is not a pre-existing illness;
- critical illness contracted meets the definition of the particular critical illness as specified in the policy;
- critical illness is diagnosed to have commenced after the waiting period; and
- life insured survives the survival period if there is one imposed on the policy.

B. Features Of CI Insurance

4.2 Although there are two types of CI Insurance covers, each of them shares common features as described below:

(a) It pays a lump sum amount upon diagnosis of an insured critical illness.

(b) Generally, one critical illness claim is allowed unless it is a Multiple Pay CI Insurance plan.

(c) It has a specific waiting period (usually ranging from 30 to 90 days).

(d) Some insurers may impose a limit on the total amount of sum assured (e.g. S$2,000,000) that a policy owner can buy. This is to minimise the risk of moral hazard.

(e) The premium is usually level and non-guaranteed.

(f) The premium is usually not fixed and is based on the age band basis (e.g. age of 35 to 39 years is one rate, age of 40 to 44 years is another rate) for policies that are renewable on a yearly basis.

(g) There is no restriction on how the CI Insurance benefit payable is to be used.

(h) It can be packaged or attached to an ILP, Term, Endowment or Whole Life Insurance policy.

(i) It can be issued on a stand-alone basis (such a policy pays the benefit only upon diagnosis of one of the covered critical illnesses. It does not pay upon the life insured's death or total and permanent disability).

(j) It can be attached as a supplementary benefit to a basic policy.

(k) The CI Insurance rider does not acquire any cash value.

(l) The CI Insurance rider is automatically terminated once the basic policy is surrendered or converted into an Extended Term Insurance policy.

(m) The packaged CI Insurance policy which accumulates cash value (e.g. Whole Life type of CI Insurance policy) also provides non-forfeiture options. However, the CI Insurance cover may be terminated once the policy owner exercises any of the non-forfeiture options (excluding the paid-up option).

(n) A stand-alone Term CI Insurance policy does not acquire cash value. Hence, it does not have any non-forfeiture option.

(o) It provides 24 hours a day, worldwide coverage, unless otherwise endorsed or amended in the policy.

(p) Assignment of the policy may or may not be allowed.

(q) There is a maximum (e.g. age of 60 years) and minimum (e.g. age of one year) entry age restriction. For young lives, it may be subject to lien[3].

(r) There is a minimum (e.g. S$10,000) and maximum (e.g. S$2,000,000) sum assured restriction.

(s) The cover may expire at a maximum age (e.g. 75 years) or a whole life cover may be provided.

C. Types Of CI Insurance Covers

4.3 There are two main types of CI Insurance covers offered in the insurance market. They either provide an:

- Acceleration Benefit; or
- Additional Benefit.

4.4 Some insurers have also introduced Severity-Based and Multiple Pay CI Insurance plans. Let us look at how each of them works.

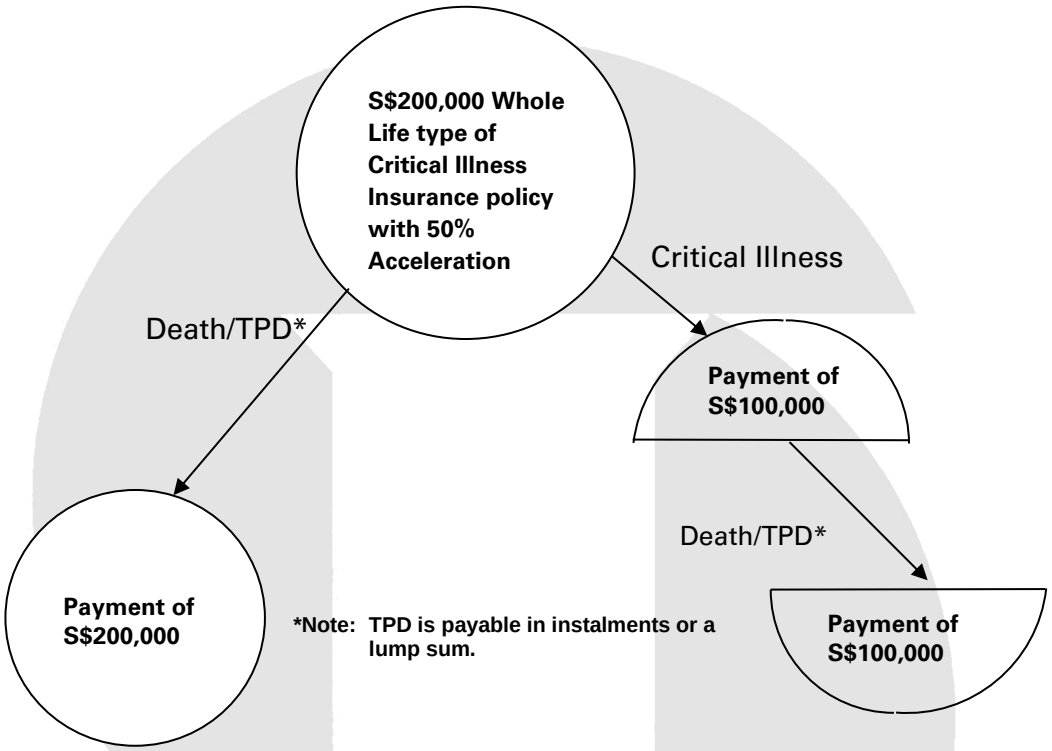
C1. Acceleration Benefit Critical Illness (CI) Insurance Cover

4.5 This type of CI Insurance cover can be issued as a packaged policy or rider. As the name implies, this type of cover provides for the pre-payment of a portion (e.g. 50%) or the full sum assured (i.e. 100%) of the basic policy to which it is packaged or attached. For example, if an individual buys a S$200,000 Whole Life type of CI Insurance policy with 50% acceleration, in the event that he is diagnosed to be suffering from one of the critical illnesses covered under his policy, the insurer will pay him S$100,000 (i.e. 50% x S$200,000) plus bonuses (if any). The balance of the sum assured plus bonuses (if any) will be paid, when he dies or suffers a Total and Permanent Disability (TPD). In the latter case, the payment may be paid in yearly instalments or in one lump sum. On the other

[3] A lien is a feature which restricts the sum assured payable on the happening of the insured event. Most insurers impose the lien on policies taken on children's lives for a specified number of years, e.g. three years. In such a case, if the insured child dies within the 1st year after the inception of the policy, the insurer will pay only 25% of the sum assured. This percentage increases on the 2nd and 3rd year to 50% and 75%, respectively. From the 4th year onwards, the full sum assured will be paid, whenever the insured event happens.

hand, if he dies or suffers a TPD without contracting any critical illness, the full S$200,000 plus bonuses (if any) will be paid to him. **Figure 6.1** illustrates how this policy works.

Figure 6.1: Illustration Of The Working Of A S$200,000 Whole Life Type Of Critical Illness (CI) Insurance Policy With 50% Acceleration



4.6 As you can see from **Figure 6.1**, the insured can make a critical illness claim only once[4]. If he contracts another critical illness, the policy will not pay him the remaining sum assured. The amount of benefit that he will get from this policy is always equal to the sum assured plus bonuses (if any). As the sum assured reduces, the future premiums may be reduced in the same proportion.

4.7 If the person has chosen a 100% (instead of 50%) Acceleration Benefit in the above example, the full basic sum assured plus bonuses (if any) will be paid, regardless of whether he contracts a critical illness, dies or suffers a TPD.

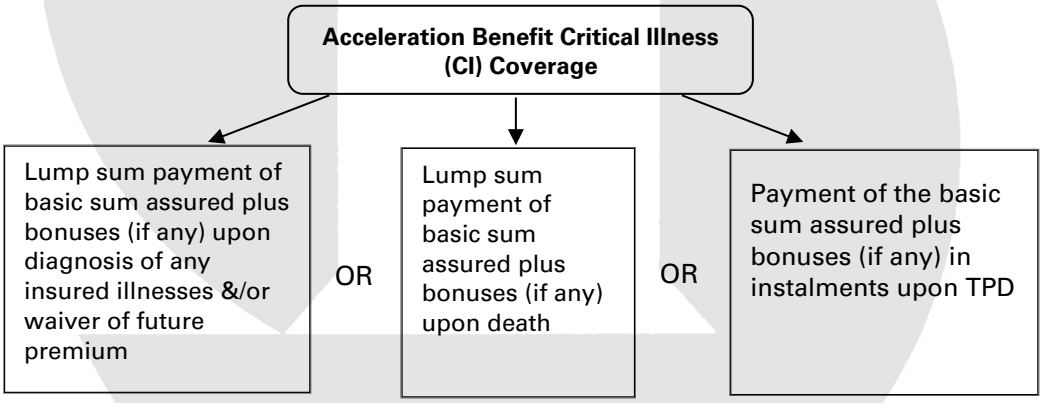
4.8 Some insurers allow the policy owner the flexibility of specifying the percentage of acceleration that he wants. Others give a number of options for the policy owner to choose from, e.g. 50%, 75% or 100%. For policy owners who opt for less than 100% acceleration, you should advise them to attach a CI Waiver of Premium rider to it, so that the future premiums on the balance sum assured will be waived. This is to ensure that the policy owner need not worry about not being able to service the premium for the remaining sum assured during the policy term.

[4] Although rare, there are now certain CI Insurance policies in the insurance market allowing for more than one critical illness claim.

4.9 The cover for this type of CI Insurance policy may be up to the age of 100 years, or for life, depending on the type of Life Insurance policy to which it is attached or packaged. This means to say that, if it is packaged or attached to an ILP or Endowment Insurance policy, then it will follow the same terms of these basic policies. On the other hand, if it is a Whole Life Insurance policy to which it is attached or packaged, then the cover is usually up to the age of 100 years, so long as the policy owner keeps the policy in force.

4.10 Another factor that affects the tenor of the CI Insurance cover is whether the attached policy will acquire a cash value. When attached to a Term Insurance policy which does not acquire a cash value, the cover will terminate if the Term Insurance ends. On the other hand, if the CI Insurance cover is attached to an Endowment Insurance or a Whole Life Insurance policy, it will acquire a cash value. Once such a policy has acquired a cash value, the insurer can make use of the automatic premium loan feature to keep the policy in force should the policy owner default in his premium payment after the grace period is over. Alternatively, the policy owner can exercise the paid-up option, in which case, the life insured will still enjoy the CI Insurance cover, but only for a reduced amount.

4.11 In a nutshell, an Acceleration Benefit CI Insurance policy or rider provides a life insured with the following coverage, depending on whichever event happens first:

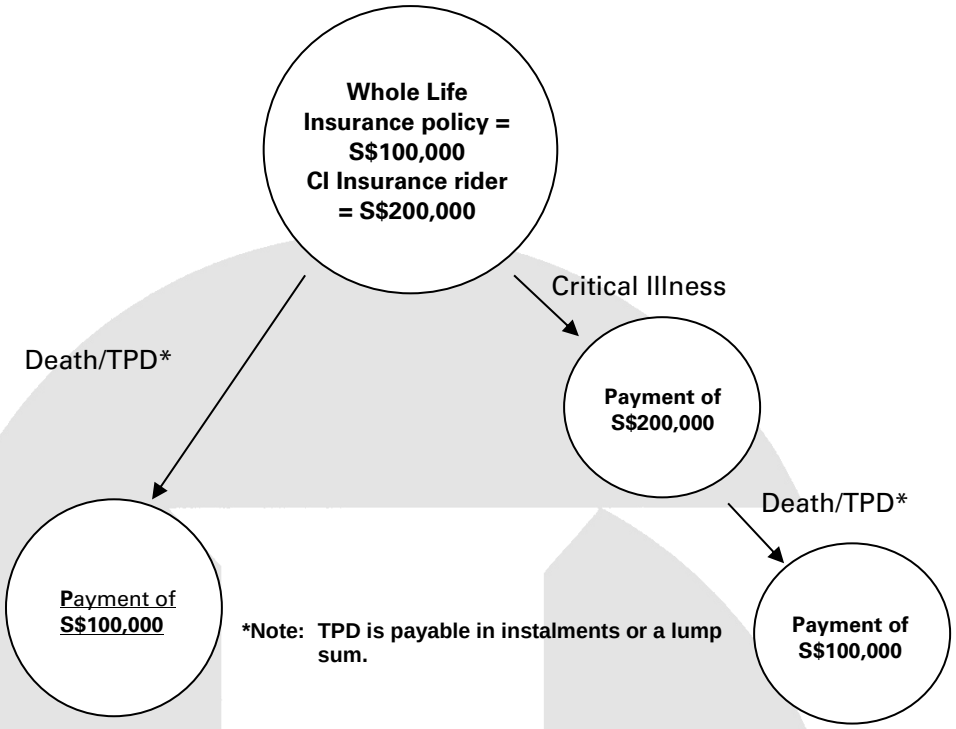


C2. Additional Benefit Critical Illness (CI) Insurance Cover

4.12 This type of cover is available on a stand-alone basis or as a rider.

- On a stand-alone basis, the sum assured will be paid upon the diagnosis of a covered critical illness, and the policy will be terminated.
- As a rider, it pays an amount in addition to the sum assured of the basic policy to which it is attached. For example, if a person purchases a S$100,000 Whole Life Insurance policy with a S$200,000 Additional Benefit CI Insurance rider, the insurer will pay him S$200,000 if he contracts one of the critical illnesses covered by his policy. The Whole Life Insurance sum assured of S$100,000 will be paid only upon his death or TPD. **Figure 6.2** illustrates the working of this type of CI Insurance rider.

Figure 6.2: Illustration Of The Working Of A S$100,000 Whole Life Policy With A S$200,000 Additional Benefit Critical Illness (CI) Insurance Rider



4.13 Note from **Figure 6.2**, the payment of the CI Insurance benefit does not affect that of the basic sum assured. This means that, if he contracts a critical illness followed by death, the total amount that the insurer will pay under this policy will be S$300,000. However, if he does not contract any critical illness, then the amount that the insurer needs to pay is only S$100,000 upon death or TPD.

4.14 Note that the term of this type of CI Insurance rider can be shorter, but not longer than that of the basic policy. Usually, this rider expires when the life insured reaches a specified age (usually the age of 65 years). The sum assured, on the other hand, can be higher than the sum assured of the basic policy, e.g. up to five times that of the basic sum assured.

4.15 Another point that you need to take note of is that, whenever you are proposing this type of CI Insurance cover to your client, you should also advise him to attach a CI Waiver of Premium rider, so that he need not worry about the premium payment for the basic policy to which the CI Insurance rider is attached.

4.16 **Table 6.1** gives a summary of the differences between the Acceleration and Additional Benefit types of CI Insurance covers.

Table 6.1: Summary Of Comparison Of Acceleration & Additional Benefit Types Of Critical Illness (CI) Insurance Covers

Acceleration Benefit	Additional Benefit	
(Packaged Policy Or Rider)	**Stand-alone Policy**	**Rider**
It must be packaged or attached to a basic policy, i.e. ILP, Term, Endowment or Whole Life Insurance policy.	It need not be attached to any basic policy.	It must be attached to a basic policy.
On diagnosis of a critical illness, a percentage of the basic sum assured as specified in the policy will be paid.	On diagnosis of a critical illness, the full sum assured of the policy will be paid.	On diagnosis of a critical illness, the full sum assured of the rider will be paid.
Payment of a CI Insurance claim will cause the policy to be terminated if it is a 100% Acceleration type of policy or rider.	Payment of a CI Insurance claim will cause the policy to be terminated.	Payment of a CI Insurance claim will not affect the basic policy which will continue to be in force.
Total amount paid under the policy is equal to the basic sum assured plus bonuses (if any).	Total amount paid under the policy is equal to the basic sum assured.	Total amount paid under the policy is equal to the sum assured of the CI Insurance rider, plus the sum assured of the basic policy, plus any bonuses payable under the basic policy, in the event of a person who contracts a critical illness dies, or becomes totally disabled subsequently.
CI Insurance rider sum assured must not exceed that of the basic policy.	Not applicable.	Sum assured can be up to a certain number of times of the basic sum assured, subject to the insurer's specified guidelines.
CI Insurance rider term usually follows that of the basic policy.	Not applicable.	The term must not exceed that of the basic policy and usually expires, when the life insured reaches a specified age.

5. VARIATIONS OF CRITICAL ILLNESS INSURANCE

5.1 It is important to note that under a regular Critical Illness plan, even if one is diagnosed with an illness covered by the policy, it does not mean that the policy automatically pays the claim. An insured would have to diagnosed with an illness that has reached a certain stage before the policy pays the claim.

5.2 For critical illness coverage, there are different products offered in the market. The coverage offered by such critical illness insurance products vary with the coverage, number of critical illnesses, types of critical illnesses and/or stages of critical illnesses covered. **The stages can be classified as early, intermediate or severe.**

5.3 Traditional CI policies would cover only severe (end) stage critical illnesses. In other words, the insured had to wait until the condition was severe enough to claim for pay-outs. For instance, the insured would receive the pay-out if he got diagnosed for stage 4 colon cancer, but not for stage 0 or 1. Newer types of CI covers such as Severity-Based Critical Illness plans, offer a pay-out when the insured gets diagnosed during the early or intermediate stages of a critical illness. Medical and technological advancements have now made it possible to detect critical illnesses during the early stages. Receiving the pay-out in the early stage of a CI is advantageous to the insured as the monies received can be used towards earlier medical intervention and better treatment outcomes. The insured also stands to have a financial peace of mind while undergoing treatments.[5]

5.4 Financial advisers advising on Critical Illness (CI) coverage should highlight /bring to attention of their clients the following:

- Type of Plan Purchased
- Scope of Cover and Exclusions
- Coverage of the CI -whether early, intermediate, end stage
- Claim conditions, including if the client is holding on to several CI policies covering the same CI condition and whether all the policies pay out if the claims conditions are met.
- Premium payments of the plan if it is a standalone or attached as a rider
- Waiver of Premium Rider

A. Severity-Based Critical Illness (CI) Insurance Plan (Early Pay CI)

5.5 Insurers have introduced CI Insurance that pays in an earlier stage of the illness. Commonly known as Early Pay CI, this type of severity-based CI Insurance plan pays claims during early stages and less severe critical illnesses. Benefits are claimable at various stages of the illness, from early to intermediate to severe.

[5] https://www.axa.com.sg/blog/insurance-guide/ultimate-guide-to-critical-illness-insurance-in-singapore

5.6 Depending on the stages and severity of the critical illness, the plan gives a percentage of the sum assured as a lump sum payment to the policy owner. The progressive lump sum payments, subject to a monetary cap of each severity level, amounts to the total sum assured which can be multiples of the original coverage.

5.7 Waiting Period and Survival Period are both applicable to Severity-based CI plans.

5.8 Severity-based CI plans may appeal to those who are concerned about financial support for early treatment of the critical illness. It can be purchased as a term plan or attached as a rider to an existing Life Insurance policy, to enhance and complement the life insured's CI Insurance coverage. The plan covers any individual person from the age of one up to 75 years. The premium is higher than that of the normal CI Insurance plan.

A1. The Advantages of Severity-Based Cover[6]

5.9 We can regard severity-based covers as a hybrid of the traditional critical illness cover.

5.10 Unlike the traditional covers where the insured gets all or nothing (when insured is diagnosed with the covered CI, he gets 100% of the sum assured), severity-based critical illness insurance will pay a certain percentage based on how severe the illness is. The insured receives lower pay-outs when he is diagnosed with a less severe CI.

5.11 The advantages of severity based critical illness insurance are:

a) Greater number of illnesses covered
The insured is covered for a greater number of covered illnesses. Less severe forms of cancer are covered. This would not be possible in a standard critical illness policy. For example, partial blindness can be claimed under a severity-based cover. However, for traditional critical illness covers, only totally blindness can be claimed. It addresses the pitfall of a traditional CI policy i.e. the insured may be severely ill but he cannot get the pay-out as the illness is not a covered illness.

b) Pay-outs received at an early stage of the illness
This enables the insured to have the funds to prevent the illness from deteriorating. The insured stands to receive a sum earlier that can be used for treatment. For example, if a polyp is detected in one's colon and is identified as an early-stage cancer, one can claim and have his colon operated on.

[6] https://www.criticalillness.org.uk/critical-illness-vs-severity-based-cover.html

c) The ability to claim more than once

The insured can only claim once under a traditional CI policy. The cover terminates once that claim is made. The severity-based policy allows the insured to claim for more than one illness even for unrelated conditions.

d) Continuity of coverage after a claim

The CI cover will still continue after the insured has claimed for a less severe critical illness.

A2. Premium and Other Considerations

5.12 An early pay CI plan is not cheap. For example, a 30-year old male who is a non-smoker and who wants to be insured for $100,000 till the age of 65 can expect to pay about $100 per month. Do note that premiums charged vary with each insurer.

5.13 Also, it is important to note while the severity-based policy allows the insured to claim for more than one illness, any claims made will be deducted against the sum assured. Therefore, the insured cannot claim an infinite amount of times against his policy. This is especially so if the insured is unfortunate enough to be diagnosed with multiple illnesses.

B. Multiple Pay Critical Illness (CI) Insurance Plan

5.14 A multi-pay critical illness plan pays the insured multiple times over each diagnosis of critical illness and recurrent or reoccurring critical illnesses. An insured may get a critical illness once. Some insureds may get critical illness again, and again. A normal critical illness plan would most likely terminate after paying the insured. It may not be viable for the insured to buy another critical plan as the costs would be very high. It would be also challenging as the insurer may be reluctant to offer cover as it considers the probability of a recurrence of the illness.

5.15 This type of CI Insurance plan allows for more than one critical illness claim on the policy. A second claim and subsequent ones are allowed if the medical condition deteriorates or if a different medical condition occurs.

5.16 Such multiple claims are not restricted to only severe stage CI. When such CI plan includes benefits for severity-based CI, insurers may allow for multi-claims on early stages of the CI subject to benefit limits.

5.17 Waiting Period and Survival Period are applicable for such plans.

5.18 Some insurers offer another boost of the coverage for Relapse/ Recurring condition of Major Cancer after a 2-year gap from the first Major Cancer claim.

5.19 Future premiums may be waived upon diagnosis of first claim on advanced stage CI.

5.20 It is critical therefore for financial advisors selling CI cover to advise their clients not only on the definitions of CI but also which stage of the CI is covered. Their clients need to know what is payable and what is not.

C. Critical Illness Plans Covering Mental Illnesses

5.21 The prevalence of mental illnesses has created yet another opportunity for product innovation in providing coverage for mental conditions, which has been traditionally excluded by insurers. Insurance plans that covers mental illness typically pay a lump sum (which is usually a reduced coverage of the original CI) upon diagnosis of one of the covered mental illnesses. The illnesses covered are typically the following five conditions:

(a) Major Depressive Disorders (MDD)

(b) Schizophrenia

(c) Bipolar Disorder

(d) Obsessive Compulsive Disorder (OCD)

(e) Tourette Syndrome

5.22 Pay-out for Mental Illness covers is limited to a maximum benefit per life. Waiting Period and Survival Period are applicable for such covers.

D. Insurance Covering Diabetes

5.23 Being diagnosed with diabetes and having to adjust to the new lifestyle can be a daunting experience. Insurers have designed coverage to help diabetic patients with the financial burden of treatment.

5.24 Insurance covering diabetes provides a lump sum on diagnosis of the chronic illness, diabetes complications or a diabetes-related critical illness. Coverage may extend to limb amputation(s) resulting from diabetes-related complications.

5.25 Waiting Period and Survival Period are applicable for such covers.

E. Combination of CI Cover

5.26 It is now quite common to find insurers offering a combination of advance stage, severity-stage, multi-pay CI covers with diabetes and mental illness covered in one CI Plan. Note that there may be caps imposed on the coverage for each of the respective categories.

F. Insurance Covering Pregnancy Complications

5.27 This is a term insurance, usually valid for three to six years, covering both the mother and the baby for pregnancy related complications and congenital illness.

5.28 The plan provides a fixed lump sum benefit in the event of pregnancy complications that may affect the mother or the diagnosis of congenital illness of

the child. Each insurer has its own list of conditions covered under pregnancy complications and congenital illnesses.

5.29 A hospital cash benefit may be paid when the mother or child is hospitalised due to the covered complications. Benefits may also be extended to cover developmental delay of the child or even death of the mother or the child.

5.30 The plan may cover up to four (4) babies in a single pregnancy. In return for a higher premium, some insurers may even cover if the pregnancy is through assisted reproduction such as In Vitro Fertilisation (IVF).

5.31 There is a minimum and maximum age applicable for such covers. Typically, an applicant has to be between the ages of 18 to 45 years and within 13 to 36 weeks of pregnancy at the time of application. Coverage can be standalone or a rider to a life, an endowment or IPL policy.

5.32 Note that this plan does not typically cover the usual costs of giving birth where the mother and/or the child do not suffer any complications arising from the pregnancy or the birth.

6. UNDERWRITING

A. Underwriting Requirements

6.1 The underwriting requirements are basically the same as those for Life Insurance policies, namely the completion of a proposal form (usually the same as that for Life Insurance) and the insured undergoing various medical tests. The only difference is that the non-medical limit for CI covers is lower. In other words, the life insured could be required to undergo medical tests for a sum assured whereas he would not be required to do so if he were to apply for a Life Insurance policy with the same sum assured.

B. Underwriting Considerations

6.2 The underwriting considerations are similar to those for Life Insurance policies and these will be discussed in greater detail in later chapter of this Study Guide.

6.3 Usually, only standard and sub-standard risks with up to a medium rating can be considered for CI Insurance. Risks with high extra mortality and those to be declined for Life Insurance are not regarded as acceptable for CI Insurance.

6.4 Generally, the terms of acceptance are the same as those discussed in later of this Study Guide, except that the insurer may specifically exclude the covered critical illnesses which the life insured is likely to contract in the future in view of his occupation, lifestyle, as well as medical and family history.

7. FACTORS TO CONSIDER IN DETERMINING ADEQUACY OF CRITICAL ILLNESS COVERAGE [7]

7.1 Critical Illness (CI) insurance provides a pay out when the insured is diagnosed with a critical illness. Policyholders should check the policy documents to see the exact list of illnesses covered. It is important to bear in mind that not all CI policies cover the same range of illnesses.

7.2 There are different ways in which the CI insurance policy pays out and they are largely based on the policy coverage.

7.3 Most CI policies provide a lump sum payment when the insured is diagnosed with a critical illness. They usually pay only if the illness is at a severe stage (e.g. stage IV cancer). However, other CI policies do pay out at earlier stages of the disease. In addition, policies that provide multiple pay outs are more common nowadays. These multiple pay out policies pay at different stages of the disease.

7.4 Therefore, having a CI policy should not be the main objective but selecting the one that provides the right degree of financial support is the key. In determining the adequacy of CI coverage, there are five factors to consider:

- Life Insurance Association's (LIA) recommended amount
- Minimum five years of income, after taking into account debt
- Recovery expenses
- Providing for dependents

A. Life Insurance Association's (LIA) Recommended Amount

7.5 Each CI plan should be customised to fit the insured's specific financial situation. It is best to avoid buying a generic plan that that does not fit one's own unique circumstances.

7.6 LIA recommends that the average Singaporean has CI coverage of around $316,000.

7.7 However, LIA's recommended sum should be viewed as a rough guideline rather than a goal. Each of us face different circumstances. For example, if the insured has dependents with special needs, or the insured has to provide for parents. In such circumstances, the amount of CI coverage would be higher.

7.8 On the other hand, the insured's children could be independent. In this case, the CI coverage could be smaller as there is no need to provide for them.

7.9 The insured is advised to seek the help of a qualified Financial Consultant in selecting a CI plan that best fits his financial situation.

[7] ttps://www.axa.com.sg/blog/insurance-guide/critical-illness-coverage-for-singaporeans

B. Minimum Five Years Of Income, After Taking Into Account Debt

7.10 A rule of thumb is to have coverage of at least five years of the insured's income. However, the age of the insured's dependents has to be considered. If the insured's children at a tender age, he would need more coverage.

7.11 The CI policy should provide enough funds equivalent to at least five years of the insured's income. This amount should be after considering all debts and other liabilities. The nett amount should be sufficient to support the insured's way of living for five years. Other practitioners may even recommend a minimum of seven years, depending on the insured's circumstances.

7.12 One thing worth noting is that one cannot just rely on life insurance as it is a death benefit cover. A living benefit cover as found in CI insurance is needed as the insured is still around during the extent of the critical illness. Life insurance (without any additional riders) would pay out upon the insured's death. Another challenge is that it is often difficult to achieve a very accurate estimation of remaining lifespan. The insured could have months, or years, left.

7.13 It is important not to just stick to the LIA recommended sum of $316,000 as a guideline. The minimum income approach serves to preserve the insured's family lifestyle. The LIA sum of $316,000, works out to be roughly $5,260 per month. This may not be adequate for some families. It also does not consider that the insured may want quality time with them.

C. Recovery Expenses

7.14 Following the contraction of a critical illness, the insured would need to incur costs such as engaging a nurse, hiring domestic help etc. These added costs must be taken into consideration.

7.15 Having a critical illness does not mean having no chances of recovery. With access to the best medical care in such circumstances, the insured could recover in the early stages. Having an early-stage CI plan would be most useful in this regard. With certain early-stage CI plans, the insured can get pay outs for different stages of critical illness. Moreover, obtaining coverage for recurring critical illness is also possible. These types of plans can pay out up to 600 per cent of the Sum Assured.

7.16 CI insurance complements the insured's existing hospital and surgical insurance coverage. For example, the pay outs can be used to cover treatments that are usually excluded under hospital and surgical insurance.

D. Providing For Dependents

7.17 As discussed, life insurance policies provide death benefits only. Living benefits are equally vital. When the insured is critically ill, he cannot work. He still needs to pay the bills. This is where CI insurance plays a vital role.

7.18 In view of the above, it is important to consider the needs of the insured's dependents. If his child is just 10 years old, for example, coverage should span eight years instead of five (this will last till the child is 18 where he or she could be expected to be more independent then).

7.19 On the other hand, the insured's dependents could be already financially independent. The insured may then be able to get by with less coverage. It is best for the insured to seek the advice of his Financial Consultant on such matters.

7.20 CI insurance is not just about providing the funds and pay-outs. It is about the insured being able to spend time with his loved ones, at a crucial – and perhaps the final – stage in his life.

8. EXCLUSIONS

8.1 The common exclusions seen in a CI Insurance policy are:

(a) pre-existing illnesses;

(b) self-inflicted injury or illness, while sane or insane;

(c) wilful misuse of drugs and/or alcohol;

(d) congenital anomalies or inherited disorders;

(e) Acquired Immune Deficiency Syndrome (AIDS) or infection by any human immunodeficiency virus (HIV);

(f) bodily injury sustained as a result of travel in or on any type of aircraft, except as a fare-paying passenger or as a crew member of an international airline operating on a regularly scheduled passenger flight of a licensed commercial aircraft; and

(g) war or warlike operation, nuclear, strike, riot and civil commotion risks.

8.2 If the life insured suffers from one of the critical illnesses covered under the CI Insurance policy as a result of any of the above causes, the insurer is not required to pay the claim. Note that the exclusions vary from insurer to insurer. Hence, you should find out the precise exclusions imposed by your insurer and highlight them to your clients accordingly.

9. TERMINATION OF COVER

9.1 The CI Insurance cover will terminate on the happening of any one of the following events:

(a) a valid critical illness claim has been made (usually the case, unless the policy contract states otherwise);

(b) the maximum coverage allowed under the policy is paid out;

(c) the basic Life Insurance policy to which it is attached or packaged matures or expires;

(d) the policy lapses owing to non-payment of premiums after the grace period;

(e) the policy is surrendered for its cash value or converted into an Extended Term Insurance policy;

(f) the life insured dies; or

(g) the life insured reaches the expiry age of the CI Insurance rider.

10. CLAIMS

10.1 In the event of a claim, the claimant must submit the following supporting documents:

(a) claimant's statement to be completed by the policy owner and the life insured if they are not the same person;

(b) Attending Physician's Report; and

(c) proof of the critical illness, such as biopsy report, histology report, imaging/scan report, laboratory report, and others as mentioned earlier, or as requested by the insurer, furnished at the expense of the claimant.

10.2 These are the basic requirements. However, the insurer reserves the right to call for any other relevant supporting information and documents as it deems fit.

10.3 Usually, the insurer will require:

(a) written notice of the claim to be submitted within a specified period (usually 60 days) of the diagnosis of the critical illness or the performance of a surgery as covered under the policy;

(b) submission of the claim form within a specified period (e.g. 15 days) from the date that the insurer sent it out; and

(c) all proofs of the critical illness must be submitted within a specified period (usually 60 days) from the date of diagnosis of the critical illness or surgery.

10.4 As it can be seen, the sooner the policy owner or life insured informs and submits all proofs of evidence to the insurer, the better it is for him.

11. GROUP CRITICAL ILLNESS (CI) INSURANCE POLICY

11.1 Group CI Insurance cover can be issued as a packaged policy or as a rider. The coverage of a Group CI Insurance cover is similar to that of the Individual CI Insurance cover, and it can be in the form of either the Acceleration or the Additional Benefit CI type of cover. However, there will always be an expiry age (e.g. 75 years) specified in the CI Insurance cover, regardless of whether it is an Acceleration or Additional Benefit type of CI Insurance cover.

11.2 In the earlier part of this chapter, we discussed the Version 2019 definitions in respect of medical conditions at the "severe" stage. For Group Policies:

(a) The application of Version 2019 definitions will be based on the CI Policy Effective Date. (This is unlike Individual Policies, where we earlier learnt that the application of Version 2019 definitions will be based on the Proposal Signed Date)

(b) Any group policy that was newly effected or renewed on or after 26 August 2020 had to carry the Version 2019 definitions.

(c) Insurers could adopt Version 2019 definitions before 26 August 2020.

APPENDIX 6A

LIA CRITICAL ILLNESS (CI) FRAMEWORK 2019
STANDARD DEFINITIONS FOR SEVERE STAGE OF 37 CRITICAL ILLNESSES: VERSION 2019

Industry list of all 37 critical illnesses:

1 Major Cancer
2 Heart Attack of Specified Severity
3 Stroke with Permanent Neurological Deficit
4 Coronary Artery By-pass Surgery
5 End Stage Kidney Failure
6 Irreversible Aplastic Anaemia
7 End Stage Lung Disease
8 End Stage Liver Failure
9 Coma
10 Deafness (Irreversible Loss of Hearing)
11 Open Chest Heart Valve Surgery
12 Irreversible Loss of Speech
13 Major Burns
14 Major Organ / Bone Marrow Transplantation
15 Multiple Sclerosis
16 Muscular Dystrophy
17 Idiopathic Parkinson's Disease
18 Open Chest Surgery to Aorta
19 Alzheimer's Disease / Severe Dementia
20 Fulminant Hepatitis
21 Motor Neurone Disease
22 Primary Pulmonary Hypertension
23 HIV Due to Blood Transfusion and Occupationally Acquired HIV
24 Benign Brain Tumour
25 Severe Encephalitis
26 Severe Bacterial Meningitis
27 Angioplasty & Other Invasive Treatment for Coronary Artery
28 Blindness (Irreversible Loss of Sight)
29 Major Head Trauma
30 Paralysis (Irreversible Loss of Use of Limbs)
31 Terminal Illness
32 Progressive Scleroderma
33 Persistent Vegetative State (Apallic Syndrome)
34 Systemic Lupus Erythematosus with Lupus Nephritis
35 Other Serious Coronary Artery Disease
36 Poliomyelitis
37 Loss of Independent Existence

Source : LIA Website: LIA Critical Illness (CI) Framework 2019
Standard Definitions For Severe Stage Of 37 Critical Illnesses: Version 2019

1 Major Cancer

A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells with invasion and destruction of normal tissue.

The term Major Cancer includes, but is not limited to, leukemia, lymphoma and sarcoma.

Major Cancer diagnosed on the basis of finding tumour cells and/or tumour-associated molecules in blood, saliva, faeces, urine or any other bodily fluid in the absence of further definitive and clinically verifiable evidence does not meet the above definition.

For the above definition, the following are excluded:

- All tumours which are histologically classified as any of the following:
  Pre-malignant;
  Non-invasive;
  Carcinoma-in-situ (Tis) or Ta; Having borderline malignancy;
  Having any degree of malignant potential; Having suspicious malignancy;
  Neoplasm of uncertain or unknown behaviour; or
  All grades of dysplasia, squamous intraepithelial lesions (HSIL and LSIL) and intra epithelial neoplasia;
- Any non-melanoma skin carcinoma, skin confined primary cutaneous lymphoma and dermatofibrosarcoma protuberans unless there is evidence of metastases to lymph nodes or beyond;
- Malignant melanoma that has not caused invasion beyond the epidermis;
- All Prostate cancers histologically described as T1N0M0 (TNM Classification) or below; or Prostate cancers of another equivalent or lesser classification;
- All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;
- All Neuroendocrine tumours histologically classified as T1N0M0 (TNM Classification) or below;
- All tumours of the Urinary Bladder histologically classified as T1N0M0 (TNM Classification) or below;
- All Gastro-Intestinal Stromal tumours histologically classified as Stage I or IA according to the latest edition of the AJCC Cancer Staging Manual, or below;
- Chronic Lymphocytic Leukaemia less than RAI Stage 3;
- All bone marrow malignancies which do not require recurrent blood transfusions, chemotherapy, targeted cancer therapies, bone marrow transplant, haematopoietic stem cell transplant or other major interventionist treatment; and
- All tumours in the presence of HIV infection.

2 Heart Attack of Specified Severity

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 Cardiologist specified by the Company.

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

3 Stroke with Permanent Neurological Deficit

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 Attacks;
- Brain damage due to an accident or injury, infection, vasculitis, and inflammatory disease;
- Vascular disease affecting the eye or optic nerve;
- Ischaemic disorders of the vestibular system; and
- Secondary haemorrhage within a pre-existing cerebral lesion.

4 Coronary Artery By-pass Surgery

The actual undergoing of open-chest surgery or Minimally Invasive Direct Coronary Artery Bypass surgery to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. This diagnosis must be supported by angiographic evidence of significant coronary artery obstruction and the procedure must be considered medically necessary by a consultant cardiologist.

Angioplasty and all other intra-arterial, catheter-based techniques, 'keyhole' or laser procedures are excluded.

5 End Stage Kidney Failure

Chronic irreversible failure of both kidneys requiring either permanent renal dialysis or kidney transplantation.

6 Irreversible Aplastic Anaemia

Chronic persistent and irreversible bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring treatment with at least one of the following:

- Blood product transfusion;
- Bone marrow stimulating agents;
- Immunosuppressive agents; or
- Bone marrow or haematopoietic stem cell transplantation.

The diagnosis must be confirmed by a haematologist.

7 End Stage Lung Disease

End stage lung disease, causing chronic respiratory failure. This diagnosis must be supported by evidence of all of the following:

- FEV1 test results which are consistently less than 1 litre;
- Permanent supplementary oxygen therapy for hypoxemia;
- Arterial blood gas analyses with partial oxygen pressures of 55mmHg or less ($PaO2 \leq 55mmHg$);
  and
- Dyspnea at rest.

The diagnosis must be confirmed by a respiratory physician.

8 End Stage Liver Failure

End stage liver failure as evidenced by all of the following:

- Permanent jaundice;
- Ascites; and
- Hepatic encephalopathy.

Liver disease secondary to alcohol or drug abuse is excluded.

9 Coma

A coma that persists for at least 96 hours. This diagnosis must be supported by evidence of all of the following:

- No response to external stimuli for at least 96 hours;
- Life support measures are necessary to sustain life; and
- Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

For the above definition, medically induced coma and coma resulting directly from alcohol or drug abuse are excluded.

10 Deafness (Irreversible Loss of Hearing)

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by audiometric and sound-threshold tests provided and certified by an Ear, Nose, Throat (ENT) specialist.

Total means "the loss of at least 80 decibels in all frequencies of hearing".

Irreversible means "cannot be reasonably restored to at least 40 decibels by medical treatment, hearing aid and/or surgical procedures consistent with the current standard

of the medical services available in Singapore after a period of 6 months from the date of intervention."

11 Open Chest Heart Valve Surgery

The actual undergoing of open-heart surgery to replace or repair heart valve abnormalities. The diagnosis of heart valve abnormality must be supported by cardiac catheterization or echocardiogram and the procedure must be considered medically necessary by a consultant cardiologist.

12 Irreversible Loss of Speech

Total and irreversible loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose, Throat (ENT) specialist.

All psychiatric related causes are excluded.

13 Major Burns

Third degree (full thickness of the skin) burns covering at least 20% of the surface of the Life Assured's body.

14 Major Organ / Bone Marrow Transplantation

The receipt of a transplant of:

- Human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or
- One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end stage failure of the relevant organ.

Other stem cell transplants are excluded.

15 Multiple Sclerosis

The definite diagnosis of Multiple Sclerosis, and must be supported by all of the following:

- Investigations which unequivocally confirm the diagnosis to be Multiple Sclerosis; and
- Multiple neurological deficits which occurred over a continuous period of at least 6 months. Other causes of neurological damage such as SLE and HIV are excluded.

16 Muscular Dystrophy

The unequivocal diagnosis of muscular dystrophy must be made by a consultant neurologist. The condition must result in the inability of the Life Assured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

17 Idiopathic Parkinson's Disease

The unequivocal diagnosis of idiopathic Parkinson's Disease by a consultant neurologist. This diagnosis must be supported by all of the following conditions:

- The disease cannot be controlled with medication; and
- Inability of the Life Assured to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living" for a continuous period of at least 6 months.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

18 Open Chest Surgery to Aorta

The actual undergoing of major surgery to repair or correct an aneurysm, narrowing, obstruction or dissection of the aorta through surgical opening of the chest or abdomen. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches.

Surgery performed using only minimally invasive or intra-arterial techniques are excluded.

19 Alzheimer's Disease / Severe Dementia

Deterioration or loss of cognitive function as confirmed by clinical evaluation and imaging tests, arising from Alzheimer's disease or irreversible organic disorders, resulting in significant reduction in mental and social functioning requiring the continuous supervision of the life assured. This diagnosis must be supported by the clinical confirmation of an appropriate consultant and supported by the Company's appointed doctor.

The following are excluded:
- Non-organic diseases such as neurosis and psychiatric illnesses; and
- Alcohol related brain damage.

20 Fulminant Hepatitis

A submassive to massive necrosis of the liver by the Hepatitis virus, leading precipitously to liver failure. This diagnosis must be supported by all of the following:

- Rapid decreasing of liver size as confirmed by abdominal ultrasound;
- Necrosis involving entire lobules, leaving only a collapsed reticular framework;
- Rapid deterioration of liver function tests;
- Deepening jaundice; and
- Hepatic encephalopathy.

21 Motor Neurone Disease

Motor neurone disease characterised by progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurones which include spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis and primary lateral sclerosis. This diagnosis must be confirmed by a neurologist as progressive and resulting in permanent neurological deficit.

22 Primary Pulmonary Hypertension

Primary Pulmonary Hypertension with substantial right ventricular enlargement confirmed by investigations including cardiac catheterisation, resulting in permanent physical impairment of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

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.

23 HIV Due to Blood Transfusion and Occupationally Acquired HIV

A. Infection with the Human Immunodeficiency Virus (HIV) through a blood transfusion, provided that all of the following conditions are met:

- The blood transfusion was medically necessary or given as part of a medical treatment;
- The blood transfusion was received in Singapore after the Issue Date, Date of endorsement or Date of reinstatement of this Supplementary Contract, whichever is the later; and
- The source of the infection is established to be from the Institution that provided the blood transfusion and the Institution is able to trace the origin of the HIV tainted blood.

B. Infection with the Human Immunodeficiency Virus (HIV) which resulted from an accident occurring after the Issue Date, date of endorsement or date of reinstatement of this Supplementary Contract, whichever is the later whilst the Insured was carrying out the normal professional duties of his or her occupation in Singapore, provided that all of the following are proven to the Company's satisfaction:

- Proof that the accident involved a definite source of the HIV infected fluids;
- Proof of sero-conversion from HIV negative to HIV positive occurring during the 180 days after the documented accident. This proof must include a negative HIV antibody test conducted within 5 days of the accident; and
- HIV infection resulting from any other means including sexual activity and the use of intravenous drugs is excluded.

This benefit is only payable when the occupation of the insured is a medical practitioner, housemen, medical student, state registered nurse, medical laboratory technician, dentist (surgeon and nurse) or paramedical worker, working in medical centre or clinic (in Singapore).

This benefit will not apply under either section A or B where a cure has become available prior to the infection. "Cure" means any treatment that renders the HIV inactive or non-infectious.

24 Benign Brain Tumor

Benign brain tumour means a non-malignant tumour located in the cranial vault and limited to the brain, meninges or cranial nerves where all of the following conditions are met:

- It has undergone surgical removal or, if inoperable, has caused a permanent neurological deficit; and
- Its presence must be confirmed by a neurologist or neurosurgeon and supported by findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques.

The following are excluded:
- Cysts;
- Abscess;
- Angioma;
- Granulomas;
- Vascular Malformations;
- Haematomas; and
- Tumours of the pituitary gland, spinal cord and skull base.

25 Severe Encephalitis

Severe inflammation of brain substance (cerebral hemisphere, brainstem or cerebellum) and resulting in permanent neurological deficit which must be documented for at least 6 weeks. This diagnosis must be certified by a consultant neurologist, and supported by any confirmatory diagnostic tests.

Encephalitis caused by HIV infection is excluded.

26 Severe Bacterial Meningitis

Bacterial infection resulting in severe inflammation of the membranes of the brain or spinal cord resulting in significant, irreversible and permanent neurological deficit. The neurological deficit must persist for at least 6 weeks. 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.

27 Angioplasty & Other Invasive Treatment for Coronary Artery

The actual undergoing of balloon angioplasty or similar intra-arterial catheter procedure to correct a narrowing of minimum 60% stenosis, of one or more major coronary arteries as shown by angiographic evidence. The revascularisation must be considered medically necessary by a consultant cardiologist.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery.

Payment under this condition is limited to 10% of the Sum Assured under this policy subject to a S$25,000 maximum sum payable. This benefit is payable once only and

shall be deducted from the amount of this Contract, thereby reducing the amount of the Sum Assured which may be payable herein.

Diagnostic angiography is excluded.

28 Blindness (Irreversible Loss of Sight)

Permanent and irreversible loss of sight in both eyes as a result of illness or accident to the extent that even when tested with the use of visual aids, vision is measured at 6/60 or worse in both eyes using a Snellen eye chart or equivalent test, or visual field of 20 degrees or less in both eyes. The blindness must be confirmed by an ophthalmologist.

The blindness must not be correctable by surgical procedures, implants or any other means.

29 Major Head Trauma

Accidental head injury resulting in permanent neurological deficit to be assessed no sooner than 6 weeks from the date of the accident. This diagnosis must be confirmed by a consultant neurologist and supported by relevant findings on Magnetic Resonance Imaging, Computerised Tomography, or other reliable imaging techniques. "Accident" means an event of violent, unexpected, external, involuntary and visible nature which is independent of any other cause and is the sole cause of the head Injury.

The following are excluded:
- Spinal cord injury; and
- Head injury due to any other causes.

30 Paralysis (Irreversible Loss of Use of Limbs)

Total and irreversible loss of use of at least 2 entire limbs due to injury or disease persisting for a period of at least 6 weeks and with no foreseeable possibility of recovery. This condition must be confirmed by a consultant neurologist.

Self-inflicted injuries are excluded.

31 Terminal Illness

The conclusive diagnosis of an illness that is expected to result in the death of the Life Assured within 12 months. This diagnosis must be supported by a specialist and confirmed by the Company's appointed doctor.

Terminal illness in the presence of HIV infection is excluded.

32 Progressive Scleroderma

A systemic collagen-vascular disease causing progressive diffuse fibrosis in the skin, blood vessels and visceral organs. This diagnosis must be unequivocally confirmed by a consultant rheumatologist and supported by biopsy or equivalent confirmatory test, and serological evidence, and the disorder must have reached systemic proportions to involve the heart, lungs or kidneys.

The following are excluded:

- Localised scleroderma (linear scleroderma or morphea);
- Eosinophilic fascitis; and
- CREST syndrome.

33 Persistent Vegetative State (Apallic Syndrome)

Universal necrosis of the brain cortex with the brainstem intact. This diagnosis must be definitely confirmed by a consultant neurologist holding such an appointment at an approved hospital. This condition has to be medically documented for at least one month.

34 Systemic Lupus Erythematosus with Lupus Nephritis

The unequivocal diagnosis of Systemic Lupus Erythematosus (SLE) based on recognised diagnostic criteria and supported with clinical and laboratory evidence. In respect of this contract, systemic lupus erythematosus will be restricted to those forms of systemic lupus erythematosus which involve the kidneys (Class III to Class VI Lupus Nephritis, established by renal biopsy, and in accordance with the RPS/ISN classification system). The final diagnosis must be confirmed by a certified doctor specialising in Rheumatology and Immunology.

The RPS/ISN classification of lupus nephritis:

Class I	Minimal mesangial lupus nephritis
Class II	Mesangial proliferative lupus nephritis
Class III	Focal lupus nephritis (active and chronic; proliferative and sclerosing)
Class IV	Diffuse lupus nephritis (active and chronic; proliferative and sclerosing; segmental and global)
Class V	Membranous lupus nephritis
Class VI	Advanced sclerosis lupus nephritis

35 Other Serious Coronary Artery Disease

The narrowing of the lumen of at least one coronary artery by a minimum of 75% and of two others by a minimum of 60%, as proven by invasive coronary angiography, regardless of whether or not any form of coronary artery surgery has been performed.

Diagnosis by Imaging or non-invasive diagnostic procedures such as CT scan or MRI does not meet the confirmatory status required by the definition.

Coronary arteries herein refer to left main stem, left anterior descending, circumflex and right coronary artery. The branches of the above coronary arteries are excluded.

36 Poliomyelitis

The occurrence of Poliomyelitis where the following conditions are met:

- Poliovirus is identified as the cause,
- Paralysis of the limb muscles or respiratory muscles must be present and persist for at least 3 months.

The diagnosis must be confirmed by a consultant neurologist or specialist in the relevant medical field.

37 Loss of Independent Existence

A condition as a result of a disease, illness or injury whereby the Life Assured is unable to perform (whether aided or unaided) at least 3 of the 6 "Activities of Daily Living", for a continuous period of 6 months. This condition must be confirmed by the company's approved doctor.

Non-organic diseases such as neurosis and psychiatric illnesses are excluded.

For the purpose of this definition, "aided" shall mean with the aid of special equipment, device and/or apparatus and not pertaining to human aid.

Others

The following two terms can be found in some of the above definitions, and their meanings are as follows:

1. Permanent Neurological Deficit

Permanent means expected to last throughout the lifetime of the Life Assured.

Permanent neurological deficit means symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Life Assured. Symptoms that are covered include numbness, paralysis, localized weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium and coma.

2. Activities of Daily Living (ADLs)

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

End

ANNEX 1

List of changes to the standard list of 37 critical illness under the Critical Illness Framework 2019

No.	Critical Illnesses	Name changed?	Definitions changed?
1	Major Cancer	Yes	Yes
2	Heart Attacks of Specified Severity	No change	Yes
3	Stroke with Permanent Neurological Deficit	Yes	Yes
4	Coronary Artery By-pass Surgery	No change	No change
5	End Stage Kidney Failure	Yes	No change
6	Irreversible Aplastic Anaemia	Yes	Yes
7	End Stage Lung Disease	No change	No change
8	End Stage Liver Disease	No change	No change
9	Coma	No change	Yes
10	Deafness (Irreversible Loss of Hearing)	Yes	Yes
11	Open Chest Heart Valve Surgery	Yes	No change
12	Irreversible Loss of Speech	Yes	Yes
13	Major Burns	No change	No change
14	Major Organ/Bone Marrow Transplantation	No change	No change
15	Multiple Sclerosis	No change	Yes
16	Muscular Dystrophy	No change	Yes
17	Idiopathic Parkinson's Disease	Yes	Yes
18	Open Chest Surgery to Aorta	Yes	No change
19	Alzheimer's Disease / Severe Dementia	No change	Yes
20	Fulminant Hepatitis	No change	No change
21	Motor Neurone Disease	No change	Yes
22	Primary Pulmonary Hypertension	No change	No change
23	HIV Due to Blood Transfusion and Occupationally Acquired HIV	No change	Yes
24	Benign Brain Tumor	No change	Yes
25	Severe Encephalitis	Yes	Yes

26	Severe Bacterial Meningitis	Yes	No change
27	Angioplasty & Other Invasive Treatment for Coronary Artery	No change	No change
28	Blindness (Irreversible Loss of Sight)	Yes	Yes
29	Major Head Trauma	No change	Yes
30	Paralysis (Irreversible Loss of Use of Limbs)	Yes	No change
31	Terminal Illness	No change	No change
32	Progressive Scleroderma	No change	Yes
33	Persistent Vegetative State (Apallic Syndrome)	Yes	No change
34	Systemic Lupus Erythematosus with Lupus Nephritis	No change	Yes
35	Other Serious Coronary Artery Diesease	No change	Yes
36	Poliomyelitis	No change	Yes
37	Loss of Independent Existence	Yes	No change

CHAPTER
06

CRITICAL ILLNESS INSURANCE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
How a Critical Illness Insurance policy works?	A Critical Illness (also known as Dread Disease) policy is an insurance product designed to provide a lump sum benefit to a policyholder in the event that the insured is diagnosed to be suffering from one of the critical illnesses or has undergone a surgical procedure covered under the policy. Each critical illness or surgery covered by the policy is precisely defined in the policy, and the benefits will be paid only if he suffers a condition that meets the standard definition as specified in the policy.
Critical Illness Framework proposed by the Life Insurance Association	The CI Framework seeks to balance the interests of both the consumers and the insurance companies i.e. offering clear and consistent coverage on the core critical illness benefits will allow for easier product comparison by consumers as well as consistent outcomes in CI claims. It seeks to reduce ambiguity of the same CI claim being paid by one insurer but rejected by another. Please refer to LIA Website at: www.lia.org.sg for the latest definitions.
Eligibility criteria for payment of the Critical Illness Insurance benefit	• Policy must be in force. • Life insured has not reached the expiry age of the CI Insurance cover (if applicable). • Critical Illness Must Be One That Is Covered. • Meets The Definition Of Critical Illness. • Diagnosis Meets The Conditions Set Down By The Insurer. • Meets The Waiting Period Requirement. • Meets The Survival Period Requirement.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Features of Critical Illness Insurance	• Pays a lump sum amount upon diagnosis of an insured critical illness. • Generally, one critical illness claim is allowed unless it is a Multiple Pay CI Insurance plan. • A specific waiting period (usually ranging from 30 to 90 days). • Some insurers may impose a limit on the total amount of sum assured (e.g. S$2,000,000) that a policy owner can buy. This is to minimise the risk of moral hazard. • Premium is usually level and non-guaranteed. • Premium is usually not fixed and is based on the age band basis (e.g. age of 35 to 39 years is one rate, age of 40 to 44 years is another rate) for policies that are renewable on a yearly basis. • No restriction on how the CI Insurance benefit payable is to be used. • Can be packaged or attached to an ILP, Term, Endowment or Whole Life Insurance policy. • Can be issued on a stand-alone basis (such a policy pays the benefit only upon diagnosis of one of the covered critical illnesses. It does not pay upon the life insured's death or total and permanent disability). • Can be attached as a supplementary benefit to a basic policy. • CI Insurance rider does not acquire any cash value. • CI Insurance rider is automatically terminated once the basic policy is surrendered or converted into an Extended Term Insurance policy. • Packaged CI Insurance policy which accumulates cash value (e.g. Whole Life type of CI Insurance policy) also provides non-forfeiture options. However, the CI Insurance cover may be terminated once the policy owner exercises any of the non-forfeiture options (excluding the paid-up option). • A stand-alone Term CI Insurance policy does not acquire cash value. Hence, it does not have any non-forfeiture option. • Provides 24 hours a day, worldwide coverage, unless otherwise endorsed or amended in the policy. • Assignment of the policy may or may not be allowed. • A maximum (e.g. age of 60 years) and minimum (e.g. age of one year) entry age restriction. For young lives, it may be subject to lien. • A minimum (e.g. S$10,000) and maximum (e.g. S$2,000,000) sum assured restriction. • Cover may expire at a maximum age (e.g. 75 years) or a whole life cover may be provided.
Two main types of Critical Illness covers	• Acceleration Benefit. • Additional Benefit. Some insurers have also introduced Severity-Based and Multiple Pay CI Insurance plans.
Example on Acceleration Benefit Critical Illness (CI) Insurance Cover	If an individual buys a S$200,000 Whole Life type of CI Insurance policy with 50% acceleration, in the event that he is diagnosed to be suffering from one of the critical illnesses covered under his policy, the insurer will pay him S$100,000 (i.e. 50% x S$200,000) plus bonuses (if any). The balance of the sum assured plus bonuses (if any) will be paid, when he dies or suffers a Total and Permanent Disability (TPD).
Example on Additional Benefit Critical Illness (CI) Insurance Cover	If a person purchases a S$100,000 Whole Life Insurance policy with a S$200,000 Additional Benefit CI Insurance rider, the insurer will pay him S$200,000 if he contracts one of the critical illnesses covered by his policy. The Whole Life Insurance sum assured of S$100,000 will be paid only upon his death or TPD.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS

Comparison Of Acceleration & Additional Benefit Types Of Critical Illness (CI) Insurance Covers

Acceleration Benefit	Additional Benefit	
(Packaged Policy Or Rider)	Stand-alone Policy	Rider
It must be packaged or attached to a basic policy, i.e. ILP, Term, Endowment or Whole Life Insurance policy.	It need not be attached to any basic policy.	It must be attached to a basic policy.
On diagnosis of a critical illness, a percentage of the basic sum assured as specified in the policy will be paid.	On diagnosis of a critical illness, the full sum assured of the policy will be paid.	On diagnosis of a critical illness, the full sum assured of the rider will be paid.
Payment of a CI Insurance claim will cause the policy to be terminated if it is a 100% Acceleration type of policy or rider.	Payment of a CI Insurance claim will cause the policy to be terminated.	Payment of a CI Insurance claim will not affect the basic policy which will continue to be in force.
Total amount paid under the policy is equal to the basic sum assured plus bonuses (if any).	Total amount paid under the policy is equal to the basic sum assured.	Total amount paid under the policy is equal to the sum assured of the CI Insurance rider, plus the sum assured of the basic policy, plus any bonuses payable under the basic policy, in the event of a person who contracts a critical illness dies, or becomes totally disabled subsequently.
CI Insurance rider sum assured must not exceed that of the basic policy.	Not applicable.	Sum assured can be up to a certain number of times of the basic sum assured, subject to the insurer's specified guidelines.
CI Insurance rider term usually follows that of the basic policy.	Not applicable.	The term must not exceed that of the basic policy and usually expires, when the life insured reaches a specified age.

Variations of Critical Illness Insurance

- Severity-Based Critical Illness (CI) Insurance Plan (Early Pay CI).
- Multiple Pay Critical Illness (CI) Insurance Plan.
- Critical Illness Plans Covering Mental Illnesses.
- Insurance Covering Diabetes.
- Combination of CI Cover.
- Insurance Covering Pregnancy Complications.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Underwriting requirements	• Basically, the same as those for Life Insurance policies, namely the completion of a proposal form (usually the same as that for Life Insurance) and the insured undergoing various medical tests. • Difference is that the non-medical limit for CI covers is lower. In other words, the life insured could be required to undergo medical tests for a sum assured whereas he would not be required to do so if he were to apply for a Life Insurance policy with the same sum assured.
Factors to consider in determining adequacy of Critical illness Coverage	Having a CI policy should not be the main objective but selecting the one that provides the right degree of financial support is the key. In determining the adequacy of CI coverage, there are five factors to consider: • Life Insurance Association's (LIA) recommended amount • Minimum five years of income, after taking into account debt • Recovery expenses • Providing for dependents
Common exclusions under a Critical Illness Insurance policy	• Pre-existing illnesses; • Self-inflicted injury or illness, while sane or insane; • Wilful misuse of drugs and/or alcohol; • Congenital anomalies or inherited disorders; • Acquired Immune Deficiency Syndrome (AIDS) or infection by any human immunodeficiency virus (HIV); • Bodily injury sustained as a result of travel in or on any type of aircraft, except as a fare-paying passenger or as a crew member of an international airline operating on a regularly scheduled passenger flight of a licensed commercial aircraft; and • War or warlike operation, nuclear, strike, riot and civil commotion risks. Note that the exclusions vary from insurer to insurer.
Circumstances under which Critical Illness Insurance policy will be terminated	• A valid critical illness claim has been made (usually the case, unless the policy contract states otherwise); • Maximum coverage allowed under the policy is paid out; • Basic Life Insurance policy to which it is attached or packaged matures or expires; • Policy lapses owing to non-payment of premiums after the grace period; • Policy is surrendered for its cash value or converted into an Extended Term Insurance policy; • Life insured dies; or • Life insured reaches the expiry age of the CI Insurance rider.
Documents that the insured has to submit when making a claim	• Claimant's statement to be completed by the policy owner and the life insured if they are not the same person; • Attending Physician's Report; and • Proof of the critical illness, such as biopsy report, histology report, imaging/scan report, laboratory report, and others as mentioned earlier, or as requested by the insurer, furnished at the expense of the claimant.
Claim procedures	• Written notice of the claim to be submitted within a specified period (usually 60 days) of the diagnosis of the critical illness or the performance of a surgery as covered under the policy; • Submission of the claim form within a specified period (e.g. 15 days) from the date that the insurer sent it out; and • All proofs of the critical illness must be submitted within a specified period (usually 60 days) from the date of diagnosis of the critical illness or surgery. Note that it may vary from insurer to insurer.
How a Group Critical Illness Insurance policy works?	• Coverage of a Group CI Insurance cover is similar to that of the Individual CI Insurance cover • Can be in the form of either the Acceleration or the Additional Benefit CI type of cover. • However, there will always be an expiry age (e.g. 75 years) specified in the CI Insurance cover, regardless of whether it is an Acceleration or Additional Benefit type of CI Insurance cover.

CHAPTER 7
OTHER TYPES OF HEALTH INSURANCE

CHAPTER OUTLINE

1. Introduction
2. Hospital Cash (Income) Insurance
3. Medical Expense Benefits Under Travel Insurance
4. Group Dental Care Insurance

Appendix 7A – Sample Schedule Of Allowances Under Group Dental Insurance

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- understand how a Hospital Cash (Income) Insurance policy works (whether as a stand-alone policy or as a rider)
- briefly explain the conditions to be met before a claim can be admitted under a Hospital Cash Insurance policy
- state the features and types of a Hospital Cash Insurance policy
- list the common exclusions under a Hospital Cash Insurance policy/rider and know the circumstances under which it will be terminated
- list the documents that need to be submitted in the event of a claim under a Hospital Cash Insurance policy
- know the common medical benefits provided by a Travel Insurance policy
- state the common exclusions for the medical expense benefits under a typical Travel Insurance policy
- know how the benefits are paid under Group Dental Insurance and whether there are any limits to the benefits that one is entitled to claim
- state the common exclusions under a Group Dental Insurance policy and understand how the limitation clause of a Group Dental Insurance policy works
- know the circumstances under which a Group Dental Insurance policy will be terminated
- know the claim procedures, including the types of documents that need to be submitted for a Group Dental Care Insurance claim

Contents

CHAPTER OUTLINE 140
LEARNING OUTCOMES 140
1. INTRODUCTION 142
2. HOSPITAL CASH (INCOME) INSURANCE 142
A. Conditions To Be Met Before A Claim Can Be Admitted 143
A1. Waiting Period 143
A2. Hospital Confinement 143
B. Features Of Hospital Cash Insurance 144
C. Types Of Hospital Cash Insurance 144
C1. Stand-alone Hospital Cash Insurance 145
C2. Hospital Cash Insurance Riders 145
D. Underwriting 145
E. Exclusions 146
F. Termination Of Cover 146
G. Claims 147
3. MEDICAL EXPENSE BENEFITS UNDER TRAVEL INSURANCE 147
A. Medical Expenses & Other Related Benefits 147
B. Hospital Confinement Allowance 148
C. Emergency Medical Evacuation 148
D. Repatriation 149
F. Exclusions 149
4. GROUP DENTAL CARE INSURANCE 150
A. Benefits Offered 150
B. Flexibility 151
C. Exclusions 151
D. Limitation Clause 151
E. Termination Of Cover 152
F. Claims 152
APPENDIX 7A 153

1. INTRODUCTION

1.1 In this chapter, we will introduce you to three more types of Health Insurance products: Hospital Cash Insurance, Medical Expenses Benefits covered in Travel Insurance, as well as Group Dental Care Insurance.

2. HOSPITAL CASH (INCOME) INSURANCE

2.1 Hospital Cash (also known as Hospital Income) Insurance pays a daily cash benefit to the insured if he is hospitalised as a result of an injury or illness. The daily benefit is a fixed dollar amount (e.g. S$100) chosen by the insured at the inception of the policy. The amount has no direct correlation to the actual amount of medical fees incurred. The total amount paid under this policy may be more or less than the actual medical expenses incurred. The payment of the benefit is limited to a specified number of days (e.g. 180 days) per hospitalisation. Some insurers may impose a lifetime limit on the number of days (e.g. 1,000 days) that a person may claim.

2.2 Let us look at **Example 7.1** to illustrate the working of this benefit.

Example 7.1: Illustration Of The Working Of A Hospital Cash Insurance Policy

Illustration of the claims history of Harry who purchased a Hospital Cash Insurance that paid a daily benefit of S$100 up to a period of 180 days per hospitalisation and 1,000 days per lifetime:

2008 - hospitalised for 150 days for car accident injury
2010 - hospitalised for 210 days for complicated heart by-pass surgery
2012 - hospitalised for 170 days for severe osteoporosis
2015 - hospitalised for 190 days for hip replacement
2017 - hospitalised for 200 days for broken thigh bone treatment
2019 - hospitalised for 160 days for varicose vein treatment

The total amount that the insurer paid to him to-date worked out to be as follows:
2008 - 150 days
2010 - 180 days
2012 - 170 days
2015 - 180 days
2017 - 180 days
2019 - 140 days (i.e. 1,000 – 860)

Total - 1,000 days X S$100 per day = **S$100,000**

2.3 Note that, although Harry had stayed in the hospital for more than 180 days in 2010, 2015 and 2017, the insurer paid him only up to 180 days being the maximum period per hospitalisation. In year 2019, though his stay was 160 days, because the balance of his lifetime limit was 140 days, the insurer paid him for the hospital stay of only 140 days.

2.4 Since he had claimed for the maximum number of hospitalisation days allowed per lifetime, his policy was terminated after he had received the last payment from the insurer.

2.5 Hospital Cash Insurance can be issued as a stand-alone policy or as a rider. Most of the time, it is either sold as a rider or included or bundled into other types of insurance, such as Personal Accident Insurance, Travel Insurance, Critical Illness Insurance or Medical Expense Insurance policies, to make the cover more attractive to the buyers. The amount payable under Hospital Cash Insurance is usually in addition to all other Health Insurance policies, plans or schemes (including MediShield Life, Integrated Shield Plan and any Group Hospital & Surgical Insurance Scheme) for which the individual is covered.

2.6 This benefit can be issued to cover hospitalisation resulting from:

- injury only; or
- both injury and illness.

A. Conditions To Be Met Before A Claim Can Be Admitted

2.7 Usually for a claim under a Hospital Cash Insurance policy to be considered valid, it must meet the criteria as described below:

A1. Waiting Period

(a) For Injury

If the insured is hospitalised as a result of injury, the injury must be caused by an accident[1] directly and independently of any other cause. Usually, there is no waiting period for such a case.

(b) For Illness

If the insured is hospitalised because of an illness or disease, it must be contracted or commenced after the policy has taken effect, as well as after a specified period of time (e.g. 30 days) has lapsed from the date of issue or reinstatement of the policy. In addition, it must not be an illness that is specifically excluded from the coverage of the policy.

A2. Hospital Confinement

2.8 The insured must be confined to a hospital for a specified minimum period of time. Note that the minimum duration required for hospital confinement varies from insurer to insurer, and that it ranges from six to 24 hours.

(a) Per Lifetime Limit

The insured's total number of hospitalisation days claimed has not exceeded the per lifetime limit (as illustrated in **Example 7.1** of this chapter).

[1] Accident normally means any event caused by violent, accidental, external and visible means.

(b) Expiry Age
The insured has not reached the expiry age as stated in the policy.

(c) Cause
The cause of the injury or illness must not fall under one of the exclusions as discussed in a later section of this chapter.

B. Features Of Hospital Cash Insurance

2.9 Although Hospital Cash Insurance can be issued as a stand-alone policy or as a rider, it shares the common features as described below:

(a) There is a per day hospitalisation benefit.

(b) There is a cap to the maximum amount payable on a single life usually expressed as a maximum number of days.

(c) The benefit is a fixed amount throughout the policy term as specified at the inception of the policy.

(d) There is no waiting period if the cause of hospitalisation is due to an injury. A waiting period is usually imposed from the date of issue or reinstatement of the policy if the cause of hospitalisation is due to an illness.

(e) The benefit payment is not affected by the payments from other Health Insurance policies, plans or schemes (including Medishield Life, Integrated Shield Plan and any Group Hospital & Surgical Insurance Scheme), i.e. it is paid on top of the benefits received from all other medical insurance covers.

(f) The cover expires at a specified age (e.g. 65, 70 or 75 years).

(g) The premiums may be level or increased once the insured reaches a higher age-band.

(h) It is yearly renewable.

(i) It usually provides 24-hour, worldwide coverage, although some insurers limit the cover to certain geographical areas.

(j) It usually has no cash value.

(k) No assignment of the policy is allowed.

(l) For a policy that is in force for a consecutive period of insurance and free of any claim, a premium discount is usually given at renewal. This is usually called a "No Claim Discount". A certain percentage (e.g. 25%) will be deducted from the next renewal premium, subject to conditions as imposed by the insurer.

C. Types Of Hospital Cash Insurance

2.10 As already mentioned, Hospital Cash Insurance can be issued as a stand-alone policy or as a rider. Let us look at how each of them works.

C1. Stand-alone Hospital Cash Insurance

2.11 Usually, when Hospital Cash Insurance is being issued as a stand-alone policy, the daily benefits offered are more attractive. It may also include:

(a) payment of 150% of the daily benefit if the insured stays in a High Dependency Unit (HDU) or Coronary Care Unit (CCU) of a hospital;

(b) double or triple payment if the insured stays in the Intensive Care Unit (ICU) of a hospital;

(c) triple payment if hospitalisation is due to accident, or if the insured is hospitalised overseas;

(d) get-well benefit;

(e) rehabilitation income;

(f) free accidental death benefit; and

(g) involuntary loss of employment benefit (in excess of 30 days) - waiver of premium (up to six months).

2.12 The premium for a stand-alone policy usually increases when the insured crosses into the next age-band upon the renewal of the policy. For example, from the ages of 21 to 40 years, the insured may need to pay S$21.50 per month for S$100 per day benefit. From the ages of 41 to 50 years, he may need to pay S$33.50 per month, and so on. In other words, the premium increases with age.

2.13 The insured can have a choice of different plans providing varying amounts of benefits, and may include his spouse and children under the cover. The policy is usually automatically renewable on an annual basis up to a specified age (e.g. 65, 70 or 75 years). Normally, the coverage is 24-hour, worldwide basis.

C2. Hospital Cash Insurance Riders

2.14 Hospital Cash Insurance can also be issued as a rider attached to a basic policy, such as a Life Insurance policy (e.g. Whole Life Insurance, Endowment Insurance or Critical Illness Insurance policy). The rider usually expires when the insured reaches a specified age (e.g. 65, 70 or 75 years) or on the maturity of the policy, whichever is the earlier. Thus, the term of this rider cannot be longer than that of the basic policy, since the rider cannot stand on its own.

D. Underwriting

2.15 Owing to its small premiums, Hospital Cash Insurance policy is usually not underwritten. Pre-existing medical conditions are permanently excluded under the policy.

E. Exclusions

2.16 The common exclusions of a Hospital Cash Insurance policy include:

(a) pre-existing medical condition that the insured knew existed or has received treatment and/or medical advice;

(b) pre-existing physical defect or infirmity, unless declared to and accepted by the insurer;

(c) self-inflicted injuries or suicide, while sane or insane;

(d) Human immunodeficiency virus (HIV) or any HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or any illness arising from it;

(e) sexually transmitted disease;

(f) mental/nervous disorder, drug addiction, intoxication, alcoholism, obesity, weight reduction/improvement, bulimia, anorexia nervosa, preventive treatment, such as vaccination or acupuncture;

(g) illegal or unlawful act of the insured;

(h) pregnancy, miscarriage, childbirth, abortion, birth control or infertility;

(i) routine physical or any other medical examination not relating to any health impairment;

(j) cosmetic or plastic surgery, circumcision, congenital condition, dental work or myopic treatment;

(k) war and related operations;

(l) nuclear weapons material, ionising or radiation;

(m) strike, riot and civil commotion; and

(n) participation in hazardous sports like skiing or sky-diving, aerial activities other than air travel as a fare-paying passenger of a licensed aircraft, driving or riding in any kind of race, motor-cycling or pillion riding.

2.17 These are just some of the common exclusions, and they vary from insurer to insurer.

F. Termination Of Cover

2.18 A Hospital Cash Insurance cover will terminate when one of the following events occurs:

(a) the premium is not paid at the end of the grace period;

(b) the insured reaches the expiry age as stated in the policy;

(c) the per lifetime limit is reached;

(d) the basic policy lapses or matures; or

(e) the insured dies.

G. Claims

2.19 In the event of a claim, the insurer will require submission of the following supporting documents:

(a) claim form; and

(b) hospital discharge summary and bills.

2.20 These are the usual documents that the insured is required to submit. Note that the insurer reserves the right to call for additional documentary evidence, such as the Attending Physician's Report and any other relevant supporting documents.

3. MEDICAL EXPENSE BENEFITS UNDER TRAVEL INSURANCE

3.1 Travel Insurance can be issued on an individual or group basis to cover any losses, liabilities, medical expenses and other travel inconveniences suffered by an individual while travelling outside Singapore. In this section, we will focus our discussion on the medical and related benefits offered only under a Travel Insurance policy. The other benefits are discussed in detail in "Personal General Insurance (PGI)" Study Guide published by the Singapore College of Insurance Limited.

3.2 The medical benefits offered by a Travel Insurance policy usually include:

- medical expenses and other related benefits;
- hospital confinement allowance;
- emergency medical evacuation; and
- repatriation.

A. Medical Expenses & Other Related Benefits

3.3 Travel Insurance will reimburse most of the non-elective overseas medical and treatment expenses necessarily and reasonably incurred by the insured person for sustaining injury or sickness (as defined in the policy) as follows:

- medical expenses, such as clinical, hospital, surgical, nursing, ambulance and medical supply charges, and emergency accidental dental and miscarriage expenses, including any follow-up medical expenses in Singapore incurred within a certain specified period (usually 30 days) after the insured person returns from his trip; and
- expenses incurred for treatment by Traditional Chinese Medicine physician, including acupuncturist, bonesetter, chiropractor, herbalist or physiotherapist, up to a limit (e.g. S$750) as specified by some insurers;

subject to an overall limit of indemnity (e.g. as much as S$2,000,000).

3.4 Because there is typically no age limit to apply for travel insurance policy, insurer sets lower benefit limits for children (below age 18) and elderly person (usually above the age of 70 years) if insured under such a policy.

3.5 Traditionally excluded from travel policies, some insurers are now extending coverage for pre-existing medical conditions to travel policies with either a higher premium and/or simple health questions.

3.6 Reimbursement is also made for the following:

- reasonable additional accommodation and travelling expenses necessarily incurred by the insured person (and a travel companion if required) to remain in the overseas country of visit for medical treatment on the written advice of a medical practitioner, up to a limit (e.g. S$25,000); and
- hospital visit – reasonable travel and accommodation expenses necessarily incurred by one relative or friend of the insured person who has been hospitalised overseas for more than five days for example, to visit and stay with him until he is medically fit to return home, up to a limit (e.g. S$10,000).

B. Hospital Confinement Allowance

3.7 The insured person is entitled to an amount of daily cash payment (e.g. S$200 per day) that he is hospitalised abroad up to a certain period (e.g. 100 days) or up to a certain amount (e.g. S$20,000), in addition to any medical expenses which he has claimed. The benefits are payable upon his return to Singapore, when he submits a claim with all relevant supporting documents of evidence to the insurer.

3.8 For hospitalisation in Singapore where treatment is sought within a certain period (e.g. seven days) upon return, the limits are generally lower (e.g. S$100 per day payable up to 10 days).

3.9 Some insurers provide double benefit for overseas hospitalisation in an Intensive Care Unit resulting from an accident up to a certain period (e.g. 10 days).

C. Emergency Medical Evacuation

3.10 This covers the cost of any emergency medical evacuation. Emergency medical evacuation means that, in the event of a critical situation in which the insured person suffers a serious illness or injury abroad, and has to be evacuated to another place to seek emergency medical treatment, because the local medical services are inadequate or unavailable.

3.11 The insurer contracts a specialist company to provide emergency medical evacuation. It is a requirement in the policy that the insured person must contact such specialist company which shall then decide whether or not the insured person will require emergency medical evacuation. For this purpose, a 24-hour multilingual helpline or hotline phone number of such a specialist company is specified in the policy, as well as a handy card, which a policyholder can bring along for his trip.

3.12 There is usually a maximum benefit limit (e.g. S$500,000) payable for the lower coverage plan. However, for the higher coverage plan, the coverage amount is usually unlimited.

3.13 An important aspect of having emergency assistance cover is that it gives further peace of mind to the insured person if he suffers a serious illness or injury in an unfamiliar environment, knowing that help will be on the way with just a phone call away.

D. Repatriation

3.14 Travel Insurance covers the expenses incurred in emergency medical repatriation and repatriation of body remains.

3.15 Emergency medical repatriation occurs when, as a result of an unfortunate illness or accident abroad, the insured has to be repatriated to his country of origin (e.g. return to Singapore). The decision as to whether or not he should be repatriated would strictly rest with the attending medical doctor or the insurer's contracted specialist company.

3.16 Repatriation of remains means the transportation of and return of the deceased insured's mortal remains to his country of origin.

3.17 There is a maximum benefit limit (e.g. S$30,000) payable for the lower coverage plan. However, for the higher coverage plan, the coverage amount is usually unlimited.

F. Exclusions

3.18 Travel Insurance usually does not cover any claims directly or indirectly arising from or in connection with:

(a) war, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection or military or usurped power;

(b) ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;

(c) participation in civil defence, police, military, naval or air force service or operation, or national service in accordance with the Enlistment Act 1970;

(d) self-inflicted injury, suicide or attempted suicide, while sane or insane, mental or physical defect or infirmity, insanity or nervous disorder, intoxication or use of non-prescription drugs;

(e) routine health check-up, or cosmetic (aesthetic) or plastic surgery;

(f) sexually transmitted disease, AIDS and HIV conditions or AIDS related infections;

(g) pregnancy or childbirth or any sickness associated with pregnancy or childbirth;

(h) any pre-existing condition (except for some policies, subject to Section 4.5 above) for which the insured person received medical treatment, diagnosis,

consultation or prescribed drugs within the 12 (or six) months' period before the commencement date of the policy period of insurance;

(i) driving or riding in any kind of race, engaging in any professional sport, ice or winter sport, mountaineering requiring the use of guides and ropes, or underwater activity involving the use of underwater breathing apparatus;

(j) aerial activity other than air travel as a fare-paying passenger in a licensed passenger-carrying aircraft;

(k) direct participation in criminal, unlawful or terrorist act, or strike, riot or civil commotion;

(l) any event including strike, riot, civil commotion, health threatening situation, natural disaster published by the mass media or through advisory of the authority, unless the policy already issued or the trip already commenced before the date of publication or advisory; or

(m) travel booked or undertaken against medical advice, or for the purpose of obtaining or seeking any medical care or treatment abroad.

3.19 Note that the exclusions, restrictions and limitations vary from insurer to insurer.

4. GROUP DENTAL CARE INSURANCE

4.1 Dental Care Insurance is usually offered on a group basis and without underwriting. Most insurers issue it as a rider attached to a Group Hospital and Surgical Insurance policy. Like all group policies, only employees who are actively at work can be covered under this policy, and it is usually on a non-contributory basis. Coverage is 24-hour, worldwide basis. The policy is usually issued for a period of two years and thereafter, renewable every one or two years, depending on the insurer.

A. Benefits Offered

4.2 The benefits provided are very comprehensive and include dental procedures ranging from simple scaling and polishing to root canal treatment and wisdom tooth extraction. **Appendix 7A** is a sample of the Schedule of Allowances specifying the benefits/procedures covered.

4.3 The Schedule of Allowances in **Appendix 7A** also shows one of the ways in which the insurer reimburses the insured for dental expenses incurred. The basis of reimbursement is based on the limits as specified in the Schedule of Allowances. There is no annual claim limit and also no restriction on the number of visits per policy year. For example, an employee can go to the insurer's panel of dentists for cleaning and polishing twice a year. The cost of each treatment is S$40 for example, but he will not be required to pay a single cent, as the amount will be borne by the insurer.

4.4 Instead of setting benefit limits for each treatment/procedure, some insurers set an overall limit (e.g. S$200) that each insured employee may claim during each policy year. Once this limit is reached, the insured employee will have to pay from his own pocket for any treatment/procedure received.

4.5 Note also that pre-existing dental conditions are usually covered as well.

B. Flexibility

4.6 Most insurers that issue Group Dental Care Insurance policies do not have their own panel of dentists. As such, the insured employees can visit their own dentists for treatments. Insurers who have their own panel of dentists also allow the insured employees to go to their own dentists, but will usually reimburse them up to the maximum limit as stated in the Schedule of Allowances. The employee will have to pay the difference from his own pocket.

4.7 Most insurers also allow the coverage to be extended to cover the insured employee's family members, namely spouse and children.

C. Exclusions

4.8 Like all other insurance covers, Group Dental Care Insurance policies also impose certain exclusions on the cover provided. Some common exclusions include:

(a) dental procedures that are not specified in the Schedule of Allowances;
(b) hospital charges;
(c) injuries arising directly or indirectly from war (declared or undeclared), revolution, or any warlike operation;
(d) medicine given;
(e) treatment which is purely cosmetic in nature;
(f) treatment resulting from self-inflicted injury, while sane or insane; and
(g) replacement of broken, lost or stolen dentures.

4.9 These are the general exclusions. You need to find out the specific exclusions under your insurer's policies, as the exclusions vary among the insurers.

D. Limitation Clause

4.10 All Group Dental Care Insurance policies include this Limitation Clause, to bring to the attention of the insured persons (employees) that the reimbursements under their policies will be reduced by benefits claimable under:

(a) the Work Injury Compensation Insurance policy;

(b) any government or public programme of dental or medical benefits; or

(c) any other group or individual Health or Dental Care Insurance policy.

E. Termination Of Cover

4.11 Cover for each individual insured employee under a Group Dental Care Insurance policy will automatically terminate on the earliest of the following dates:

(a) the date of termination of the insured employee's active full-time employment with the policy owner (employer);

(b) the date of termination of the policy;

(c) the date of expiration of the period for which the last premium payment is made in respect of the insured employee's cover;

(d) the date on which the insured employee enters full-time military, naval, air or police service, except during peacetime National Service reservist duty or training in accordance with the Enlistment Act 1970; or

(e) the date of expiration of the period within which the insured employee reaches a specified age (e.g. 65 years).

F. Claims

4.12 For any insurer that has a panel of dentists, the insurer will issue a membership card or certificate to every individual insured employee who will need to produce it, whenever he visits the dental clinic for treatment. In such a case, the dental clinic will bill the insurer directly, and the employee need not pay a single cent nor file any claim with the insurer.

4.13 On the other hand, if the insurer does not have a panel of doctors, or the employee decides to use his own dentist, he will have to make the payment to the clinic first, and then file a claim with the insurer to seek reimbursement in accordance with the policy. Normally, the insurer will require the following documents to be produced:

- completed claim form; and
- original receipts and itemised bills.

4.14 The insurer requires the employer to submit these documents within a specific period (e.g. 21 days from the date of treatment).

APPENDIX 7A

ABC Insurance Company (Singapore) Ltd

21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

GROUP DENTAL INSURANCE

SCHEDULE OF ALLOWANCES

Benefits/Procedures	Non-Panel Dentist Claim Limit S$	Panel Dentist Claim Limit S$
Examination		
Initial	15.00	As charged
X-Ray		
Intraoral	12.00	As charged
Bitewing	12.00	As charged
Panorex	32.00	As charged
Test & Laboratory		
Biopsy & examination of tissue	48.00	As charged
Prophylaxis (cleaning, polishing, scaling and fluoride treatment)		
Routine	40.00	As charged
Complex	60.00	As charged
Fluoride Treatment		
Fluoride Application	22.50	As charged
Fillings (Silver) – For Posterior Teeth Only		
Amalgam – one surface	16.00	As charged
Amalgam – two surfaces	24.00	As charged
Amalgam – three or more surfaces	32.00	As charged
Reinforced Pin	9.00	As charged
Fillings (Tooth-Coloured Material) – For Anterior Teeth Only		
One surface	30.00	As charged
Two surfaces	40.00	As charged
Three or more surfaces	50.00	As charged
Gold Inlay Restorations		
Inlay, gold – one surface	120.00	As charged
Inlay, gold – two surfaces	160.00	As charged
Inlay, gold – three or more surfaces	200.00	As charged
Pulpotomy		
Pulpotomy	40.00	As charged
Pulp cap	20.00	As charged
Root Canal Treatment		
Single root canal filling	150.00	As charged
Double root canal filling	220.00	As charged
Three or more canals	350.00	As charged
Extractions		
Routine (simple) – each tooth	30.00	As charged

SCHEDULE OF ALLOWANCES

Benefits/Procedures	Non-Panel Dentist Claim Limit S$	Panel Dentist Claim Limit S$
Surgical Extractions		
Erupted tooth or root	120.00	As charged
Soft tissue impaction	160.00	As charged
Part bony impaction	250.00	As charged
Completely bony impaction	320.00	As charged
Oral antral root recovery	144.00	As charged
Closure of oral antral fistula	64.00	As charged
Removal of labial frenum	40.00	As charged
Alveoplasty		
Per quadrant, in connection with extractions	30.00	As charged
Per quadrant, not in connection with extractions	42.00	As charged
Complete alveoplasty involving more than one quadrant	160.00	As charged
Excision Of Tumour		
Excision of tumour	76.00	As charged
Fracture Of Jaw		
Simple	500.00	As charged
Compound	600.00	As charged
Repair Of Prosthetic Appliance		
Repair of broken complete or partial denture	20.00	As charged
Repair denture & replace broken tooth	40.00	As charged
Adding tooth to partial denture to replace extracted tooth	27.00	As charged
Adding tooth to partial denture plus clasp	54.00	As charged
Space Maintainers		
Fixed band type (uni or bilateral)	135.00	As charged
Removal in acrylic (uni or bilateral)	67.00	As charged
Periodontal Treatment		
Root planning per tooth	24.00	As charged
Root planning per quadrant	72.00	As charged
Miscellaneous		
Tooth replantation (of patient's own natural tooth)	144.00	As charged
Tooth replantation (of patient's own natural tooth, metal implant not covered)	144.00	As charged

Note: No amount is chargeable if the insured employee visits a dentist within the panel of approved dentists. For any insured employee who visits a dentist outside of the panel of approved dentists, the claim limits are as specified in this Schedule of Allowance.

CHAPTER 07

OTHER TYPES OF HEALTH INSURANCE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
How a Hospital Cash (Income) Insurance policy works?	• Also known as Hospital Income. • Insurance pays a daily cash benefit to the insured if he is hospitalised as a result of an injury or illness. • Fixed dollar amount (e.g. S$100) chosen by the insured at the inception of the policy. • Amount has no direct correlation to the actual amount of medical fees incurred. • Total amount paid under this policy may be more or less than the actual medical expenses incurred. • Payment of the benefit is limited to a specified number of days (e.g. 180 days) per hospitalisation. Some insurers may impose a lifetime limit on the number of days (e.g. 1,000 days) that a person may claim. • Can be issued as a stand-alone policy or as a rider.
Conditions to be met before a claim can be admitted under a Hospital Cash Insurance policy	• Waiting period » For injury. » For illness. • Hospital confinement » Per lifetime limit. » Expiry age. » Cause.
Features of a Hospital Cash Insurance policy	• Per day hospitalisation benefit. • A cap to the maximum amount payable on a single life usually expressed as a maximum number of days. • Benefit is a fixed amount throughout the policy term as specified at the inception of the policy. • No waiting period if the cause of hospitalisation is due to an injury. A waiting period is usually imposed from the date of issue or reinstatement of the policy if the cause of hospitalisation is due to an illness. • Benefit payment is not affected by the payments from other Health Insurance policies, plans or schemes (including Medishield Life, Integrated Shield Plan and any Group Hospital & Surgical Insurance Scheme), i.e. it is paid on top of the benefits received from all other medical insurance covers. • Cover expires at a specified age (e.g. 65, 70 or 75 years). • Premiums may be level or increased once the insured reaches a higher age-band. • Yearly renewable. • Usually provides 24-hour, worldwide coverage, although some insurers limit the cover to certain geographical areas. • Usually has no cash value. • No assignment of the policy is allowed. • For a policy that is in force for a consecutive period of insurance and free of any claim, a premium discount is usually given at renewal. This is usually called a "No Claim Discount". A certain percentage (e.g. 25%) will be deducted from the next renewal premium, subject to conditions as imposed by the insurer.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Types of a Hospital Cash Insurance policy	• Stand-alone Hospital Cash Insurance • Hospital Cash Insurance Riders
Common exclusions under a Hospital Cash Insurance policy/rider	• Pre-existing medical condition that the insured knew existed or has received treatment and/or medical advice; • Pre-existing physical defect or infirmity, unless declared to and accepted by the insurer; • Self-inflicted injuries or suicide, while sane or insane; • Human immunodeficiency virus (HIV) or any HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or any illness arising from it; • Sexually transmitted disease; • Mental/nervous disorder, drug addiction, intoxication, alcoholism, obesity, weight reduction/improvement, bulimia, anorexia nervosa, preventive treatment, such as vaccination or acupuncture; • Illegal or unlawful act of the insured; • Pregnancy, miscarriage, childbirth, abortion, birth control or infertility; • Routine physical or any other medical examination not relating to any health impairment; • Cosmetic or plastic surgery, circumcision, congenital condition, dental work or myopic treatment; • War and related operations; • Nuclear weapons material, ionising or radiation; • Strike, riot and civil commotion; and • Participation in hazardous sports like skiing or sky-diving, aerial activities other than air travel as a fare-paying passenger of a licensed aircraft, driving or riding in any kind of race, motor-cycling or pillion riding.
Circumstances under which a Hospital Cash Insurance policy/rider will be terminated.	• Premium is not paid at the end of the grace period; • Insured reaches the expiry age as stated in the policy; • Per lifetime limit is reached; • Basic policy lapses or matures; or • Insured dies
Documents that need to be submitted in the event of a claim under a Hospital Cash Insurance policy	• Claim form. • Hospital discharge summary and bills. Note that the insurer reserves the right to call for additional documentary evidence.
Common medical benefits provided by a Travel Insurance policy	• Medical expenses and other related benefits; • Hospital confinement allowance; • Emergency medical evacuation; and • Repatriation.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Common exclusions for the medical expense benefits under a typical Travel Insurance policy	• War, invasion, act of foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, rebellion, revolution, insurrection or military or usurped power; • Ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel; • Participation in civil defence, police, military, naval or air force service or operation, or national service in accordance with the Enlistment Act 1970; • Self-inflicted injury, suicide or attempted suicide, while sane or insane, mental or physical defect or infirmity, insanity or nervous disorder, intoxication or use of non-prescription drugs; • Routine health check-up, or cosmetic (aesthetic) or plastic surgery; • Sexually transmitted disease, AIDS and HIV conditions or AIDS related infections; • Pregnancy or childbirth or any sickness associated with pregnancy or childbirth; • Any pre-existing condition (except for some policies, subject to Section 4.5 above) for which the insured person received medical treatment, diagnosis, consultation or prescribed drugs within the 12 (or six) months' period before the commencement date of the policy period of insurance; • Driving or riding in any kind of race, engaging in any professional sport, ice or winter sport, mountaineering requiring the use of guides and ropes, or underwater activity involving the use of underwater breathing apparatus; • Aerial activity other than air travel as a fare-paying passenger in a licensed passenger-carrying aircraft; • Direct participation in criminal, unlawful or terrorist act, or strike, riot or civil commotion; • Any event including strike, riot, civil commotion, health threatening situation, natural disaster published by the mass media or through advisory of the authority, unless the policy already issued or the trip already commenced before the date of publication or advisory; or • Travel booked or undertaken against medical advice, or for the purpose of obtaining or seeking any medical care or treatment abroad. Note that the exclusions, restrictions and limitations vary from insurer to insurer.
How the benefits are paid under Group Dental Insurance?	• Based on a Schedule of Allowances » One of the ways in which the insurer reimburses the insured for dental expenses incurred. • Basis of reimbursement is based on the limits as specified in the Schedule of Allowances.
Limits to the benefits that one is entitled to claim under Group Dental Insurance.	• Some insurers set an overall limit (e.g. S$200) that each insured employee may claim during each policy year.
Common exclusions under a Group Dental Insurance policy	• Dental procedures that are not specified in the Schedule of Allowances; • Hospital charges; • Injuries arising directly or indirectly from war (declared or undeclared), revolution, or any warlike operation; • Medicine given; • Treatment which is purely cosmetic in nature; • Treatment resulting from self-inflicted injury, while sane or insane; and • Replacement of broken, lost or stolen dentures. Note that it may vary from insurer to insurer.
How the limitation clause of a Group Dental Insurance policy works?	Reimbursements under their policies will be reduced by benefits claimable under: • Work Injury Compensation Insurance policy; • Any government or public programme of dental or medical benefits; or • Any other group or individual Health or Dental Care Insurance policy.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Circumstances under which a Group Dental Insurance policy will be terminated	• Date of termination of the insured employee's active full-time employment with the policy owner (employer); • Date of termination of the policy; • Date of expiration of the period for which the last premium payment is made in respect of the insured employee's cover; • Date on which the insured employee enters full-time military, naval, air or police service, except during peacetime National Service reservist duty or training in accordance with the Enlistment Act 1970; or • Date of expiration of the period within which the insured employee reaches a specified age (e.g. 65 years). Earliest of the above dates.
Claim procedures for a Group Dental Care Insurance claim	For any insurer that has a panel of dentists: • Insurer will issue a membership card or certificate to every individual insured employee who will need to produce it, whenever he visits the dental clinic for treatment. • Dental clinic will bill the insurer directly, and the employee need not pay a single cent nor file any claim with the insurer. If the insurer does not have a panel of doctors or the employee decides to use his own dentist: • Make the payment to the clinic first, and then file a claim with the insurer to seek reimbursement in accordance with the policy. Insurer requires the employer to submit these documents within a specific period (e.g. 21 days from the date of treatment)
Types of documents that need to be submitted for a Group Dental Care Insurance claim	• Completed claim form; and • Original receipts and itemised bills.

CHAPTER 8
MANAGED HEALTHCARE

CHAPTER OUTLINE

1. Introduction
2. What Is Managed Healthcare (MHC)?
3. How Does MHC Work?
4. What Are The Common Types Of MHC Plans?
5. Choice Of Providers Versus Cost Control
6. Managed Healthcare (MHC) Insurance
7. MHC Model In Singapore

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- know what MHC is
- describe how MHC works
- list the four common payment methods used by Managed Healthcare Organisations (MHCOs) and understand how they work:
  - capitation
  - discounted-fee-for-service
  - salary
  - fee schedule
- list the three common types of MHC plans and describe how each of them works
- describe how the four basic types of Health Maintenance Organisations (HMOs) differ from each other:
  - Staff Model HMO
  - Group Model HMO
  - Network Model HMO
  - Independent Practitioners Association (IPA) HMO
- rank in ascending or descending order the degree of control the Insurers/MHOs have over cost and the choice of providers
- list some of the benefits provided under a MHC Insurance policy
- know the elements of co-insurance and deductible for MHC Insurance
- list the common exclusions under a typical MHC Insurance policy
- know the underwriting requirements for MHC Insurance
- state the procedures for claims under a MHC Insurance policy
- have a view of the MHC scheme available locally

Contents

CHAPTER OUTLINE 155
LEARNING OUTCOMES 155
1. INTRODUCTION 157
2. WHAT IS MANAGED HEALTHCARE (MHC)? 157
3. HOW DOES MHC WORK? 157
A. Accessibility 157
B. Cost 158
C. Quality Of Care 159
4. WHAT ARE THE COMMON TYPES OF MHC PLANS? 159
A. Health Maintenance Organisation (HMO) 159
A1. Staff Model HMO 160
A2. Group Model HMO 160
A3. Network Model HMO 161
A4. Independent Practitioners Association (IPA) Model HMO 162
A5. Mixed Model HMOs 162
B. Preferred Provider Organisations (PPOs) 162
C. Point-of-Service (POS) Plan 163
5. CHOICE OF PROVIDERS VERSUS COST CONTROL 163
6. MANAGED HEALTHCARE (MHC) INSURANCE 164
A. Benefits Offered 164
B. Elements Of Co-insurance & Deductible 164
C. Exclusions 164
D. Underwriting 165
E. Claims 165
7. MHC MODEL IN SINGAPORE 166

1. INTRODUCTION

1.1 Managed Healthcare (MHC) schemes have evolved in the market as a response to increasing medical costs. MHC plans are usually managed or run by insurers as insurance-backed plans. Locally, only group MHC insurance is available. Such policies are often purchased by employers as part of their Employee Benefit package, and as an alternative to traditional Group Health Insurance plans. In this chapter, we will first look at the concept and various models of MHC, before we discuss briefly the MHC insurance covers that are available in the market.

2. WHAT IS MANAGED HEALTHCARE (MHC)?

2.1 MHC refers to an overall strategy for containing medical care costs, while assuring that people receive appropriate medical care. It will pay for most of the medical bills, when an individual sees a General Practitioner (GP), specialist or receives treatment in a hospital. Such strategies make use of a number of MHC techniques related to how medical care is accessed, provided and paid for.

3. HOW DOES MHC WORK?

3.1 MHC providers set up a healthcare network to manage the accessibility, cost and quality of care of its members. They negotiate and contract with doctors, hospitals, clinics, and other health care providers, such as pharmacies, laboratories, X-ray centres, and medical equipment vendors, in exchange for more patients directed to them.

3.2 MHC works through carefully managing the following three components, in order to contain and control healthcare expenditure:

- accessibility;
- cost; and
- quality of care.

A. Accessibility

3.3 In a MHC plan, members are referred to a carefully selected network of healthcare providers. In some MHC plans, a member may be required to receive all his healthcare services from a particular provider within the network. This doctor will be his Primary Care Physician (PCP). In other managed care plans, he may be able to receive care from providers who are not part of the network, but will have to pay a larger share of the cost to receive those services.

3.4 As the emphasis of MHC is on primary and preventive care to avoid serious health problems, PCPs are the backbone of many MHC plans. PCPs are valued because of their ability to diagnose and treat a broad range of medical conditions. Additionally, as they are familiar with the health conditions and circumstances of their patients, PCPs are often better able to ascertain the type of specialty care that members may need.

3.5 PCP is usually a general practitioner who serves as the member's "personal physician" and acts as the first contact with the MHC. If additional care is needed, the PCP will refer the member to a specialist within the network. Under most MHC plans, a member must obtain a referral from the PCP before seeing a specialist. As such, PCPs are often called "gatekeepers". As gatekeepers, PCPs co-ordinate and manage all aspects of the members' care. Members are allowed to change their PCPs.

B. Cost

3.6 A Managed Healthcare Organisation (MHCO) uses various methods to control increasing medical care costs. One of which is negotiated provider fees.

3.7 By limiting the number of physicians or hospitals in a provider network, the MHCO can negotiate the physicians' or hospitals' fees and reduce the cost for providing medical services to its members. The MHCO is able to achieve this, because physicians, hospitals and other medical service providers are generally willing to reduce their fees, in exchange for the increase in patient volume that a MHC network can provide them.

3.8 The four common payment methods used by MHCO are as follows:

- capitation;
- discounted-fee-for-service;
- salary; and
- fee schedule.

(a) Capitation

Under this method, the MHCO pre-pays its providers a fixed amount for each member's medical care usually on a monthly basis. The provider is paid the same amount each month, regardless of how often the member receives medical attention or the cost of that medical attention. The fixed fee may not be the same for all the MHCO members.

(b) Discounted-Fee-For-Service

MHCO pays its physicians a certain percentage of their normal fees (e.g. 90% of the normal fee), thereby achieving a discount of 10% on the physicians' fees.

(c) Salary

This method is used in the Staff Model HMO (Health Maintenance Organisation). Under this method, the HMO compensates the physicians with a fixed salary. These salaries are based on the average earnings of local physicians in the same field or specialty. The HMO also pays the physicians performance-based bonuses or gives incentive payments.

(d) Fee Schedule

Under this method, the MHCO places caps or limits on the dollar amounts that will be reimbursed for covered medical procedures and services. When using this fee schedule payment structure, the MHCO will pay no

more than the specified maximum fee allowed for each procedure. As this fee structure will result in a smaller reimbursement of fees for physicians who charge higher-than-average fees, it may encourage the provision of unnecessary medical services (e.g. physicians asking patients to go for more tests than necessary or return for follow-up checks).

3.9 Other methods used by the MHCO to control medical care costs include Utilisation Management and risk sharing agreements.

C. Quality Of Care

3.10 To ensure that the quality of care is not compromised with the cost-containment effort, members can be assured that the MHCO contracts with only those healthcare providers that possess the requisite skills, training and licences to provide the necessary services to them. These providers must provide the medically necessary services under prevailing professional standards of care. The MHCO also develops quality assurance programmes usually in co-operation with the providers to guarantee availability, accessibility and continuity of care to its members. In fact, the MHCO is just as much concerned about the quality of care delivered, as cost control for a good reputation is what attracts new members and keeps existing members.

4. WHAT ARE THE COMMON TYPES OF MHC PLANS?

4.1 The three common types are:

- Health Maintenance Organisation (HMO);
- Preferred Provider Organisation (PPO); and
- Point-of-Service (POS) plan.

4.2 Let us look at each of them in turn.

A. Health Maintenance Organisation (HMO)

4.3 A member enrolled in a Health Maintenance Organisation (HMO) will need to receive most or all of his health care from a network provider. HMOs require that the member chooses a primary care physician (PCP who is most often a family doctor, or paediatrician for children) who is responsible for managing and coordinating all of his health care.

4.4 If the member needs care from a physician specialist in the network or a diagnostic service such as a laboratory test or X-ray, the PCP will have to provide a referral. If the member does not have a referral or chooses to go to a doctor outside of his health plan's network, he will most likely have to pay all or most of the costs for that care, unless it was pre-authorised by the HMO, or deemed as an emergency.

4.5 The HMO is the most restrictive type of health plan, because the member has the least choice in selecting his healthcare provider.

4.6 There are four basic types of HMO as follows:

- Staff Model HMO;
- Group Model HMO;
- Network Model HMO; and
- Independent Practitioners Association (IPA) Model HMO.

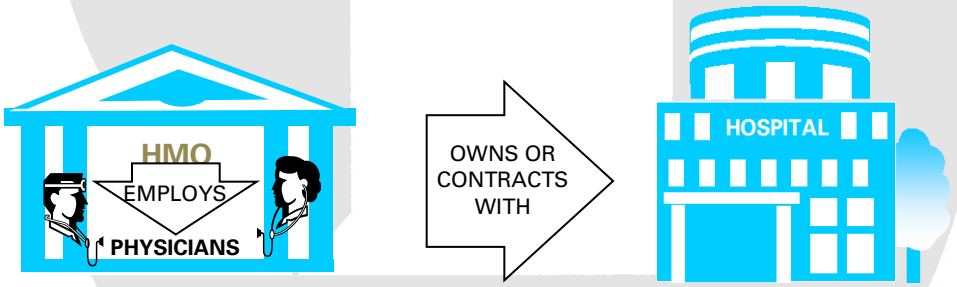
A1. Staff Model HMO

4.7 In a Staff Model HMO, the HMO employs the healthcare providers who usually work together in a centre. The doctors treat only patients who are members of the HMO. The usual way to provide specialist care is to refer their patients to certain contracted specialists.

4.8 A Staff Model HMO can be very effective at managing costs, as it has control over the physicians whom it employs. The treatment provided or recommended by the physicians can be monitored very closely for adherence to the HMO's guidelines. Moreover, as the physicians are paid regular salaries, regardless of the number of services that they provide, they have no financial incentive to over-treat the patients.

4.9 **Figure 8.1** is an illustration of the Staff Model HMO.

Figure 8.1: Staff Model HMO



A2. Group Model HMO

4.10 In a Group Model HMO, the doctors and healthcare providers are not hired directly. It contracts with a large group medical practice to provide medical care services to its members and pays the group in bulk. The physicians decide within the group how the money is distributed.

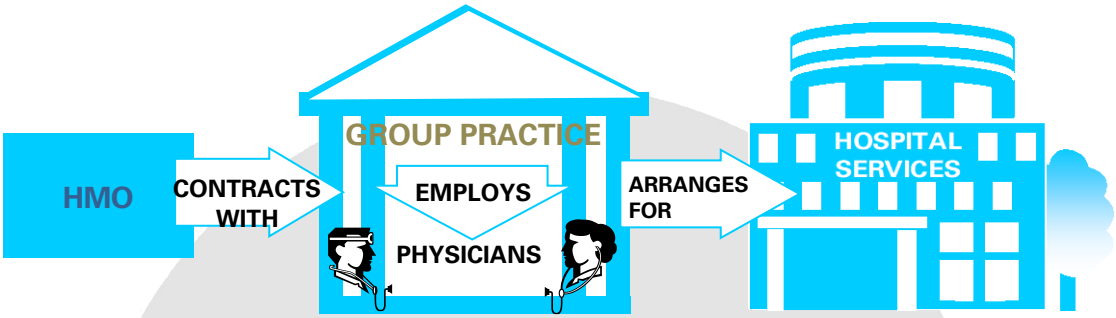
4.11 The group practice in turn is responsible for:

- obtaining the physicians necessary to provide the contracted services;
- compensating its physicians;
- providing facilities in which its physicians will perform the contracted services; and
- arranging to provide hospital services.

4.12 As with the Staff Model HMO, the physicians only see patients that signed up for the HMO that contracted them and has the same effectiveness at managing cost.

4.13 **Figure 8.2** is a graphical illustration of the organisation of the Group Model HMO.

Figure 8.2: Group Model HMO

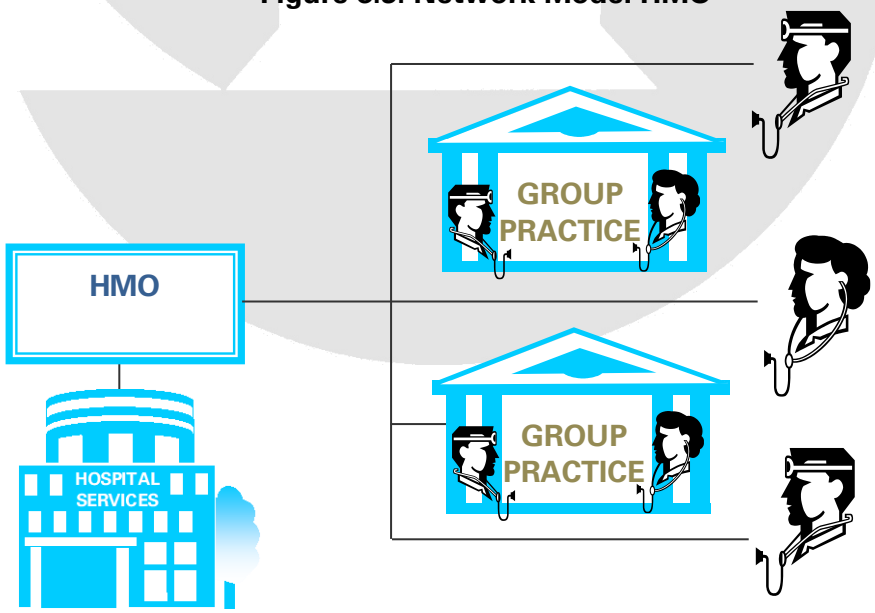


A3. Network Model HMO

4.14 The Network Model HMO is similar to the Group Model HMO in that it contracts for medical care services, instead of employing the physicians. Instead of contracting with one or just a few large multi-speciality group practices, it contracts with a relatively large number of group practices, some of which may have a single speciality. Some Network Model HMOs may even contract with individual physicians, so that they can offer a comprehensive range of medical care services to their members. The Network Model HMO also arranges for the provision of hospital services to its members.

4.15 **Figure 8.3** is a graphical illustration of the organisation of the Network Model HMO.

Figure 8.3: Network Model HMO



4.16 Physicians operate out of their own offices or the facilities provided to them by their group practice. The Network Model HMO physicians do not necessarily obtain all their patients from a particular HMO. Some network physicians may contract to provide services to more than one HMO. They may also belong to one or more PPO networks or may treat other walk-in private patients. For this reason, and because the HMO arranges for hospital services, rather than the physicians, the Network Model HMO does not have as tight a control over Utilisation Management[1] as the two models discussed earlier.

A4. Independent Practitioners Association (IPA) Model HMO

4.17 Here, the HMO contracts an independent practice association that works similarly to a multi-speciality physician group practice, except its members are allowed to treat non-HMO patients. Under this model, the primary care physicians are allowed to refer employees to medical services outside the network. However, the HMO might not provide as much coverage as it would for the employees who had stayed within the network.

A5. Mixed Model HMOs

4.18 The four HMO models as described so far are the traditional HMOs. An increasing number of HMOs are now operating as mixed-model plans, which means that the organisation of the plan is a combination of two or more of the four types of plans which we have already discussed.

4.19 For example, a plan may have been established as a Staff Model HMO, but at a later time, it may decide to expand its capacity by adding physicians under an IPA arrangement. Mixed Model HMOs are common nowadays, because they offer broader consumer choice of physicians and clinical settings.

B. Preferred Provider Organisations (PPOs)

4.20 A Preferred Provider Organisation (PPO) has negotiated contracts with a network of preferred providers from which a member can choose. A member does not need to select a PCP and does not need referrals to see other providers in the network. However, to encourage the use of network providers and/or get a referral for a specialist, PPO offers "richer" benefits to members as financial incentives. These include lower or no deductible, lower or no co-payment, and higher benefits. For example, if a member sees a network provider, he will not need to pay for the medical cost. However, if he sees a non-network provider, he may have to pay as much as 50% of the total bill.

4.21 PPOs are less restrictive than HMOs in the choice of healthcare providers. However, they tend to require greater "out-of-pocket" payments from the members.

[1] Utilisation Management is a programme designed to manage the use of medical services to ensure that a patient receives necessary, appropriate and high-quality care in a cost-effective manner.

C. Point-of-Service (POS) Plan

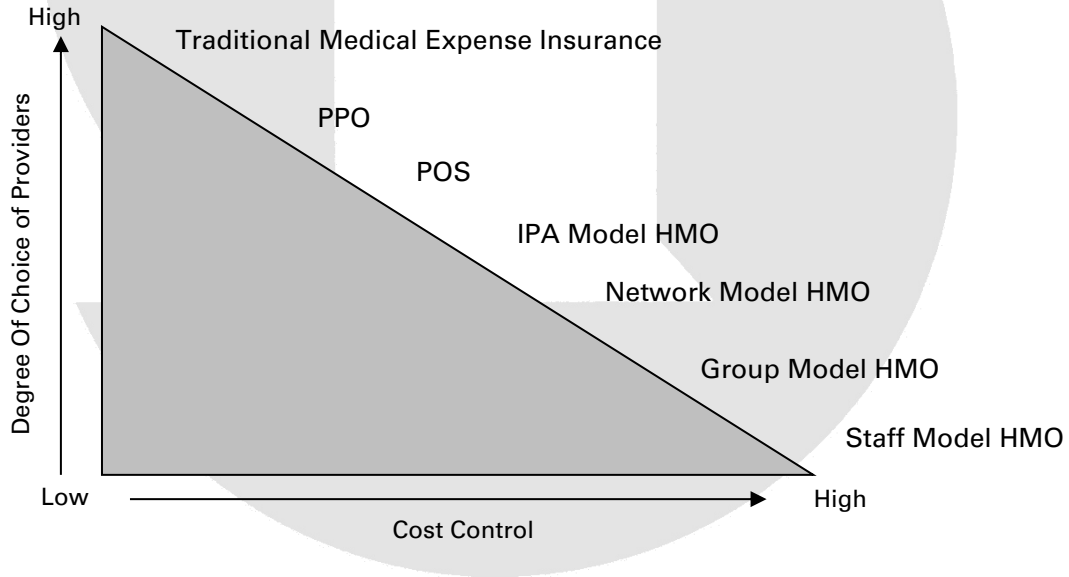
4.22 A POS plan is a combination of a HMO and a PPO. Typically, a POS plan has a contracted provider network that functions like a HMO. A POS plan encourages, but does not require, a member to choose a PCP. A POS plan also allows a member to use a provider who is not in the network. However, if he chooses to go out of the network for his care, he will pay higher co-payments and/or deductibles than any member who uses a PCP.

4.23 The plan is known as point-of-service, because each time a member needs healthcare service (the time or "point" of service), he can decide to stay in the network to allow his PCP to manage his care service, or to go outside the network on his own, without a referral from his PCP.

5. CHOICE OF PROVIDERS VERSUS COST CONTROL

5.1 As mentioned, MHCOs help to contain the cost of healthcare by managing the access to providers, cost of providing healthcare, as well as the quality of care. **Figure 8.4** illustrates the relationship between the degree of control over the cost and access, and their effects on the purchaser.

Figure 8.4: Degree Of Choice Of Providers Versus Degree Of Cost Control



5.2 Note from **Figure 8.4** that the Staff Model HMO has the greatest cost control, but its members have the lowest degree of choice of providers. The cost saved is passed on to the purchasers who are charged a lower price for participating in the plan. At the other extreme, there is no control over the access to healthcare providers under a traditional Medical Expense Insurance, and no cost control too. As a result, the premium for a traditional Medical Expense Insurance policy is higher as compared to the MHC plan.

5.3 At present, no MHC plan can offer high level of benefits, unlimited access to providers and low cost, all at the same time. The best that any plan can expect to accomplish is two of the three features. Some plans will focus on costs and access, while others will focus on benefits and costs, or access and benefits.

6. MANAGED HEALTHCARE (MHC) INSURANCE

6.1 Having seen how the different types of MHC plans work, let us look at how a typical insurer's MHC insurance policy in Singapore works.

A. Benefits Offered

6.2 For fixed annual premiums, insurers offering MHC plans may provide their policy owners with some or all of the coverage as described below:

- Primary Care – provided by a wide network of general physicians in clinics all over Singapore. It includes consultation, medication, procedures and tests deemed medically necessary.
- Specialist Care - provided by a wide network of specialists from different medical specialties. It includes consultation, medication, tests and surgery upon referral from a PCP.
- Hospital Care – provided for confinement in private, public or community hospitals. Reimbursement for the hospital and surgical expenses will be subject to limits under the insured plan.
- Emergency Care – provides 24-hour cover for accident and emergency.
- Preventive Care – provides educational programmes, such as talks, seminars and workshops on nutritional counselling, etc., designed to keep members free from diseases.

6.3 The benefits offered by the MHCOs may differ, as some may provide only outpatient care, while others may provide the full spectrum of benefits. These benefits can also be extended to dependants. As you will see in later chapter of this Study Guide, CPF members may use their Medisave to purchase MHC plans which are approved by the CPF Board.

6.4 Like other Health Insurance policies, there is a minimum, as well as a maximum entry age for MHC plans, but it usually varies among insurers.

B. Elements Of Co-insurance & Deductible

6.5 Like other types of traditional Health Insurance, the elements of co-insurance and deductible may be found in MHC Insurance.

C. Exclusions

6.6 The common exclusions under a MHC Insurance policy include:

- pre-existing conditions;
- congenital anomaly, hereditary condition and disorder;
- mental illness and personality disorder;

- infertility, sub-fertility, assisted conception treatment;
- treatment of sexually transmitted disease;
- Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex or infection by human immunodeficiency virus (HIV);
- self-inflicted injuries;
- drug addiction or alcoholism;
- purchase of eyewear or related eye care items;
- purchase of kidney dialysis machine, iron-lung, prosthesis and other special appliances;
- private nursing charges;
- injuries arising from direct participation in strike, riot or civil commotion;
- injuries arising directly or indirectly from nuclear fallout, war (whether declared or not declared) and related risks;
- childbirth and abortion or routine ante-natal and post-natal visits;
- cosmetic surgery (except for treatment necessitated by an accident);
- general exclusions imposed on Medical Expense Insurance policies are also applicable to MHC Insurance plans;
- optional items which are outside the scope of treatment; and
- reimbursements for Work Injury Compensation Insurance and other forms of insurance coverage.

6.7 Note that the exclusions vary from insurer to insurer. Hence, you need to find out what the exclusions of your insurer are and highlight them to your clients.

D. Underwriting

6.8 The underwriting requirements for MHC are discussed in later chapter of this Study Guide. They are similar to those for Medical Expense Insurance cover.

E. Claims

6.9 The procedure for MHC claims is mainly between the MHCO and the providers. Members who use the in-network care are not required to file any claims with the insurer. It is only those who use out-of-network providers will need to file claims with the MHCO. The relevant supporting documents to be submitted for such a case include:

- the claimant's statement; and
- original itemised medical bill.

7. MHC MODEL IN SINGAPORE

7.1 The MHC arrangements described above are not common in Singapore. Locally, employers either engage MHCO or insurance company to offer cashless medical services to employees. Such services include cashless outpatient general practitioner (GP) and specialist consultation visits. To ensure the specialist cost is covered, employee needs to obtain a GP's referral to see a specialist. The GP acts as a gatekeeper to minimise unnecessary specialist visit.

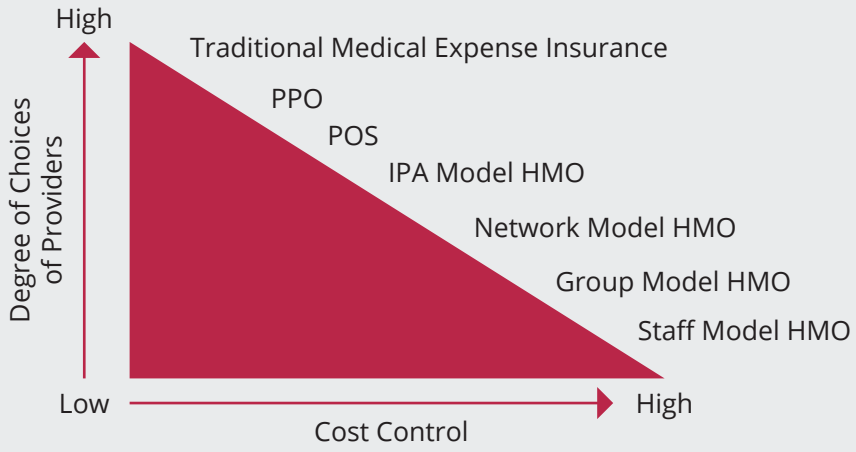
7.2 Employees have to go to the selected panel to enjoy cashless facilities and the cost and quality of care are managed by MHCO or the insurer. If an employee chooses to visit a non-panel clinic, the cost is either not covered or partially covered subject to co-payments and/or benefit limits.

7.3 If the arrangement is under an insured scheme, insurer will also provide an added hospitalisation cover (Group Hospital & Surgical) which may be cashless with the provision of letter of guarantee to the hospital.

CHAPTER 08

MANAGED HEALTHCARE

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Managed Healthcare (MHC)	MHC refers to an overall strategy for containing medical care costs, while assuring that people receive appropriate medical care. It will pay for most of the medical bills, when an individual sees a General Practitioner (GP), specialist or receives treatment in a hospital.
How MHC works?	MHC providers set up a healthcare network to manage the accessibility, cost and quality of care of its members. They negotiate and contract with doctors, hospitals, clinics, and other health care providers, such as pharmacies, laboratories, X-ray centres, and medical equipment vendors, in exchange for more patients directed to them.
Payment methods used by Managed Healthcare Organisations (MHCOs) • **Capitation**	MHCO pre-pays its providers a fixed amount for each member's medical care usually on a monthly basis. The provider is paid the same amount each month, regardless of how often the member receives medical attention or the cost of that medical attention. The fixed fee may not be the same for all the MHCO members.
Payment methods used by Managed Healthcare Organisations (MHCOs) • **Discounted-fee-for-service**	MHCO pays its physicians a certain percentage of their normal fees (e.g. 90% of the normal fee), thereby achieving a discount of 10% on the physicians' fees.
Payment methods used by Managed Healthcare Organisations (MHCOs) • **Salary**	This method is used in the Staff Model HMO (Health Maintenance Organisation). Under this method, the HMO compensates the physicians with a fixed salary. These salaries are based on the average earnings of local physicians in the same field or specialty. The HMO also pays the physicians performance-based bonuses or gives incentive payments.
Payment methods used by Managed Healthcare Organisations (MHCOs) • **Fee schedule**	MHCO places caps or limits on the dollar amounts that will be reimbursed for covered medical procedures and services. When using this fee schedule payment structure, the MHCO will pay no more than the specified maximum fee allowed for each procedure.
Common types of MHC plans	• Health Maintenance Organisation (HMO); • Preferred Provider Organisation (PPO); and • Point-of-Service (POS) plan.
Four basic types of Health Maintenance Organisations (HMOs): • **Staff Model HMO**	• Employs the healthcare providers who usually work together in a centre. • Doctors treat only patients who are members of the HMO. • Usual way to provide specialist care is to refer their patients to certain contracted specialists.
Four basic types of Health Maintenance Organisations (HMOs): • **Group Model HMO**	• Doctors and healthcare providers are not hired directly. • Contracts with a large group medical practice to provide medical care services to its members and pays the group in bulk. • Physicians decide within the group how the money is distributed.
Four basic types of Health Maintenance Organisations (HMOs): • **Network Model HMO**	• Similar to the Group Model HMO. • Contracts for medical care services, instead of employing the physicians. • Contracts with a relatively large number of group practices, some of which may have a single speciality.
Four basic types of Health Maintenance Organisations (HMOs): • **Independent Practitioners Association (IPA) HMO**	• HMO contracts an independent practice association that works similarly to a multi-speciality physician group practice, except its members are allowed to treat non-HMO patients. • Allowed to refer employees to medical services outside the network. • HMO might not provide as much coverage as it would for the employees who had stayed within the network.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Degree of control the Insurers/MHOs have over cost and the choice of providers	
Some benefits provided under a MHC Insurance policy	• Primary Care. • Specialist Care. • Hospital Care. • Emergency Care. • Preventive Care.
Elements of co-insurance and deductible for MHC Insurance	Like other types of traditional Health Insurance, the elements of co-insurance and deductible may be found in MHC Insurance.
Common exclusions under a typical MHC Insurance policy	• Pre-existing conditions; • Congenital anomaly, hereditary condition and disorder; • Mental illness and personality disorder; • Infertility, sub-fertility, assisted conception treatment; • Treatment of sexually transmitted disease; • Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex or infection by human immunodeficiency virus (HIV); • Self-inflicted injuries; • Drug addiction or alcoholism; • Purchase of eyewear or related eye care items; • Purchase of kidney dialysis machine, iron-lung, prosthesis and other special appliances; • Private nursing charges; • Injuries arising from direct participation in strike, riot or civil commotion; • Injuries arising directly or indirectly from nuclear fallout, war (whether declared or not declared) and related risks; • Childbirth and abortion or routine ante-natal and post-natal visits; • Cosmetic surgery (except for treatment necessitated by an accident); • General exclusions imposed on Medical Expense Insurance policies are also applicable to MHC Insurance plans; • Optional items which are outside the scope of treatment; and • Reimbursements for Work Injury Compensation Insurance and other forms of insurance coverage. Note that the exclusions vary from insurer to insurer.
Underwriting requirements for MHC Insurance	Similar to those for Medical Expense Insurance cover.
Procedures for claims under a MHC Insurance policy	• Mainly between the MHCO and the providers. • If using out-of-network providers will need to file claims with the MHCO. The relevant supporting documents to be submitted for such a case include: » Claimant's statement; and » Original itemised medical bill.
MHC scheme available in Singapore	• Not common in Singapore. • Employers either engage MHCO or insurance company to offer cashless medical services to employees.

CHAPTER 9
PART I HEALTHCARE FINANCING

CHAPTER OUTLINE

1. Introduction
2. Healthcare Subsidies
3. MediSave
4. MediShield Life
5. Integrated Shield Plans (IPs)

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- understand Singapore's healthcare financing philosophy
- describe the Singapore Government subsidies available
- describe the following healthcare financing schemes:
  - Community Health Assist Scheme (CHAS)
  - MediSave
  - MediShield Life
  - Integrated Shield Plans
  - ElderShield & ElderShield Supplements
  - CareShield Life & CareShield Life Supplements
- outline how MediSave can be used to meet a CPF member's healthcare needs and buy approved Medical Expense Insurance
- explain the shift from MediShield to MediShield Life
- describe the enhanced benefits under MediShield Life
- describe how MediShield Life premiums are kept affordable
- explain how MediShield Life interacts with Integrated Shield Plans
- know the claims process of MediShield Life, Integrated Shield Plans, Medical Expense Insurance and MediSave

Contents

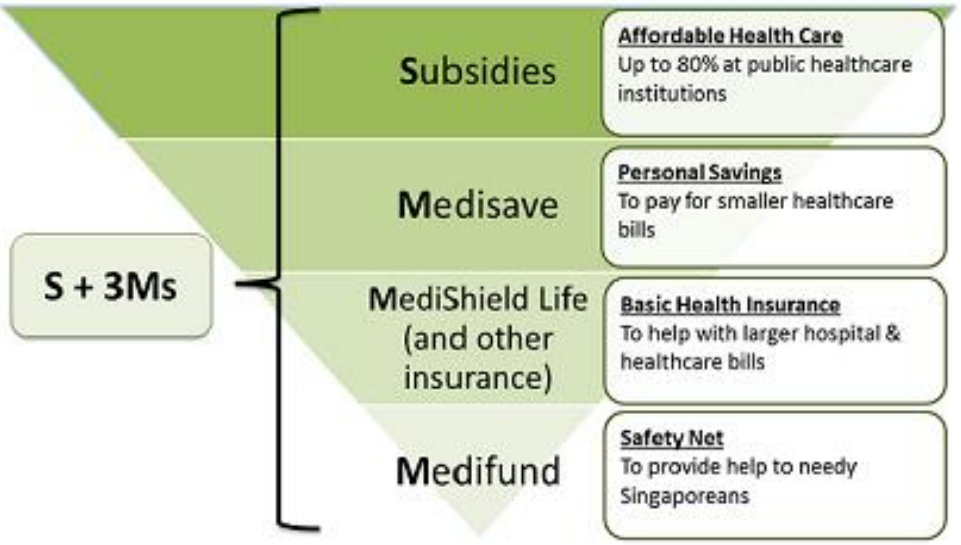
CHAPTER OUTLINE 167
LEARNING OUTCOMES 167
1. INTRODUCTION 169
2. HEALTHCARE SUBSIDIES 169
A. Public Hospitals 170
B. Other Healthcare Services 171
3. MEDISAVE 172
A. Basic Healthcare Sum 173
B. Uses Of MediSave 173
C. How Much Medisave Can Be Used? 177
4. MEDISHIELD LIFE 179
A. MediShield Life Premiums 179
B. MediShield Life Subsidies 180
C. MediShield Life Benefits 181
D. How Are MediShield Life Claim Payouts Computed? 182
E. MediShield Life Fund 185
5. INTEGRATED SHIELD PLANS (IPs) 185
A. Integrated Structure Of IPs 187
B. Standard IP 189
C. MediSave Use For IP Premiums 189
D. Riders 190
E. Terminating or Switching IP/Switching Insurer 191
F. Risk-Loading By Private Insurers 192
G. Pre-Authorisation for IP, Claim Process For MediShield Life/IP, Other Private Insurance & MediSave 192
APPENDIX 9A 195
APPENDIX 9B 198
APPENDIX 9C 200

1. INTRODUCTION

1.1 In this chapter, we will review the various subsidies and healthcare financing schemes that the Singapore Government has put in place to help Singaporeans meet the costs of healthcare.

1.2 Through a mixed financing system (see **Figure 9.1** below), Singapore has secured good healthcare outcomes for its population. For example, life expectancy at birth has increased from 80.3 in 2006 to 83.93 in 2022[1], while infant mortality rate improved from 2.6 per thousand live births to 1.8 per thousand live births[2] as at 2020. The Government has done so with a national healthcare expenditure of about 2.1% of the country's Gross Domestic Product (GDP) in 2018, which is low among developed countries (although this is expected to grow with an ageing population over the years).

Figure 9.1: Main Components in Singapore's Healthcare Financing System



Source: Managing the Cost of Health Insurance in Singapore, Health Insurance Task Force, Singapore

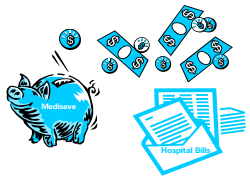
2. HEALTHCARE SUBSIDIES

2.1 The Government provides funding to public healthcare institutions (e.g. public hospitals, national specialty centres and polyclinics), as well as selected private clinics and voluntary welfare organisations (VWOs) which offer a range of community and home-based care. This enables Singaporeans to have access to subsidised care.

2.2 In many healthcare settings, a means-test is used to target subsidies, so that needy patients can receive more help; lower-income patients receive more subsidies than higher-income patients. These targets limited resources at those who need them more and ensures that the Government subsidies are sustainable.

[1] https://www.macrotrends.net/countries/SGP/singapore/life-expectancy
[2] https://www.statista.com/statistics/624889/singapore-infant-mortality-rate/

A. Public Hospitals



A1. Inpatient

2.3 Patients can choose different ward classes if they need to be admitted into a hospital. These ward classes differ only in the type of physical amenities and level of comfort and range from one bedded rooms (Class A wards) to rooms with multiple beds (Class B/C wards). The standard of medical care is the same regardless of the ward class.

2.4 The subsidies provided by the government will differ according to the ward class. The wards with basic amenities (e.g. Class C wards) are heavily subsidised. Those who desire more amenities can choose a higher ward class but will receive less subsidy. Class B2 and C ward admissions (81% of public hospital beds) are heavily subsidised. Class B1 admissions are subsidised 20% while there is no subsidy for Class A ward admissions.[3] However, patients will be able to receive up to 80% in subsidies regardless of whether they are admitted to B2 or C class wards from 1 November 2022[4].

2.5 In January 2009, means testing in public hospitals was introduced to better target the heavy subsidies for Class B2 and Class C wards at the lower-income group. The subsidy received depended on the monthly income of the patient.

2.6 Patients requiring any follow-up at the specialist outpatient clinics (SOCs) after their Class B2 or Class C hospitalisation will continue to receive subsidies at the SOCs. (Patients in Class A and Class B1 wards will continue their treatments at the private SOCs at the public hospitals, if needed).

A2. Specialist Outpatient Clinics (SOCs)

2.7 For SOC services, lower- to middle-income SOC patients are subsidised 70% and 60% respectively, while the rest receive 50% subsidy[5]. Additionally, two new subsidy tiers will be introduced in 1 January 2023[6]: patients with a per capita household income above $3,300 and not more than $6,500 (for a family of four, this means a total income of $13,200) will receive a subsidy of 40% while those above $6,500 have a subsidy of 30%. Permanent Residents will continue to receive 25% subsidy.

2.8 For standard drugs at SOCs, all lower-to middle-income subsidised patients receive a 75% subsidy for standard drugs, while the rest of the subsidised SOC patients receive a 50% subsidy. Patients who opt to be admitted to A or B1 wards at public hospitals will be eligible for subsidies in SOC should they require follow-up visits at these clinics.

---

[3] https://www.moh.gov.sg/home/our-healthcare-system/healthcare-services-and-facilities/hospital-services
[4] https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/subsidies-for-acute-inpatient-care-at-public-healthcare-institutions
[5] https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/subsidies-for-services-and-drugs-at-public-healthcare-settings
[6] https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/subsidies-for-specialist-outpatient-care-at-public-healthcare-institutions

2.9 The eligibility for higher subsidy is based on the household monthly income per person, or annual value of residence (for any household with no income).

A3. Other Services

2.10 Other services such as day surgery and Accident & Emergency (A&E) services are subsidised up to 65% and 50% respectively. Similar to the Inpatient Subsidy Framework, day surgeries will also be subsidised up to 80% for Singapore Citizens and up to 50% for Permanent Residents with effect from 1 November 2022.

B. Other Healthcare Services

2.11 The services provided at Government polyclinics are subsidised at about 50% (75% if the patient is a child or an elderly person). All lower- to middle-income patients at the polyclinics will enjoy a 75% subsidy for all standard drugs.

B1. Community Health Assist Scheme (CHAS)

2.12 The Community Health Assist Scheme (CHAS) enables all Singapore Citizens, including Merdeka Generation (MG) and Pioneer Generation (PG) cardholders, to receive subsidies for medical and/or dental care* at participating General Practitioner (GP) and dental clinics. This scheme has been expanded beyond the lower- and middle-income group to include all Singapore Citizens. Using CHAS, one can also enjoy $2 to $5 fixed fee for recommended health screenings under Screen for Life.

*Only for CHAS Blue, CHAS Orange, MG and PG cardholders

2.13 Besides subsidies for care at CHAS clinics, CHAS, MG and PG cardholders enjoy subsidised referrals to public Specialist Outpatient Clinics (SOCs), as well as subsidised referrals to the National Dental Centre Singapore and National University Centre for Oral Health Singapore, if required.

2.14 For patients with chronic conditions, CHAS complements the Chronic Disease Management Programme (CDMP), which allows for MediSave to be used for outpatient treatment (for the same set of chronic conditions) covered under CHAS. Besides enjoying CHAS subsidies for the treatment of their chronic conditions, patients can also tap on their MediSave to defray part of the cost of these treatments.

2.15 Patients who seek treatment for their chronic conditions at CHAS GP clinics can also receive subsidised rates for healthcare services such as Diabetic Foot Screening (DFS), Diabetic Retinal Photography (DRP) and nurse counselling at Community Health Centres (CHCs) and Primary Care Network (PCN) clinics.

2.16 The colour of the CHAS card indicates the subsidy tier that cardholders are entitled to, namely the CHAS Blue, Orange or Green tier. All Pioneer Generation (PG) and Merdeka Generation (MG) seniors also receive special subsidies at CHAS clinics.

2.17 The amount that cardholders pay will be based on the fees charged by the clinic, minus the CHAS subsidies. The fees will vary according to each patient's condition and clinic's charges.

2.18 Subsidies are also given to long-term care providers which provide healthcare services, such as renal dialysis, mental rehabilitation and nursing home care. MOH provides subsidies of up to 80% depending on the type of intermediate long-term care service required.

3. MEDISAVE

3.1 MediSave is a mandatory national individual health savings scheme in Singapore under the Central Provident Fund (CPF) umbrella. Between 8% and 10.5% of each CPF member's monthly salary (depending on his age) is set aside in his personal MediSave Account (MA). This amount consists of contributions from him and his employer.[7] In the case of self-employed persons, they must make compulsory contributions to their MediSave Accounts after receiving a Notice of Computation (NOC) of CPF contributions from IRAS. The MediSave contribution is computed based on the self-employed person's age and Net Trade Income (NTI). The Government also provides MediSave top-ups for Singaporeans, especially lower-income workers and elderly persons.

3.2 Amounts in the MA earn an attractive annual interest income, with additional interest accruing to older CPF members to protect their savings against inflation. Since its introduction on 1 April 1984, MediSave has helped many Singaporeans to save for their medical needs. Saving for future medical expenses is important, since the need for medical care and hospitalisation increases significantly as one grows older.

3.3 Starting 1 January 2022, the maximum amount members can top up to MediSave will be the difference between their Basic Healthcare Sum (BHS) and their current MediSave balances. Members were previously only able to contribute the lower of the CPF Annual Limit and the difference between the BHS and their current MediSave balance. With the simplification, there is no longer a need to consider the CPF Annual Limit, which is typically made known only at the end of each year.

3.4 Furthermore, with effect from 1 January 2022, members can enjoy annual tax relief of:

- up to $8,000 (previously $7,000) when the member tops up to his/her own Special/Retirement Account and/or MediSave Account; and
- an additional tax relief of up to $8,000 (previously $7,000) when the member tops up his/her loved ones' Special/Retirement Account and/or MediSave Account

[7] Self-employed persons are also required to make contributions of between 4% and 10.5% of yearly income. These rates only apply the first $6,000/month of each CPF Member's monthly wage; in other words, the maximum contribution per month is 10.5% of $6,000, which is $650.

Note that the changes related to top-ups to MediSave accounts do not apply to self-employed persons.

3.5 With the Medisave Grant for Newborns, each Singaporean baby is now a CPF member at birth. The grant ensures that newborns have enough to pay for their MeidiShield Life premiums from birth till age 21.

A. Basic Healthcare Sum

3.6 Contributions to the MA are subject to a maximum amount, known as the Basic Healthcare Sum (BHS). The BHS is designed to be enough for a CPF member's basic, subsidised healthcare needs in his old age. Hence, amounts in the MA up to the BHS cannot be withdrawn as cash.

3.7 Amounts above the BHS will flow to the CPF member's Special or Retirement Accounts to boost his monthly payouts. If the CPF member has already met his Full Retirement Sum, the amounts will flow to his Ordinary Account, and can be withdrawn as cash from the age of 55 years.

3.8 For CPF members aged below 65 in 2022, the prevailing BHS is $66,000, and will be adjusted yearly. For CPF members who turn 65 in 2022, the cohort BHS is $66,000 and it will remain fixed for the rest of their lives. As life expectancy and healthcare costs rise, successive cohorts of CPF members will need more MediSave savings for their healthcare expenses in their old age. Therefore, the BHS is adjusted yearly in January, to keep pace with the growth in MediSave use by the elderly. Refer to the following link at the CPF Website for the current BHS:*https://www.cpf.gov.sg/member/faq/healthcare-financing/basic-healthcare-sum/what-is-the-basic-healthcare-sum*

3.9 The yearly BHS adjustment will apply only to CPF members aged 65 years and below in that year. When a CPF member reaches the age of 65 years, the BHS for him will be fixed at the prevailing BHS, and the amount will not change for the rest of his life[8].

B. Uses Of MediSave

3.10 MediSave can be used to pay for:

(a) the CPF member's medical expenses at all accredited institutions, in both the public and private sector; and
(b) medical expenses of the CPF member's approved dependents, namely his spouse, children, parents, siblings, and grandparents. If paying for a sibling or grandparent, the patient must be a Singapore Citizen or Singapore Permanent Resident (SPR).

3.11 Let us now look at these uses of MediSave in greater detail.

[8] All cohorts aged 65 years and above in 2016 will have the same BHS of S$49,800 for the rest of their lives.

B1. Outpatient Treatments

3.12 MediSave can be used to pay for selected outpatient services, including chronic disease treatments and preventative care at GPs, polyclinics and Specialist Outpatient Clinics (SOCs).

(a) Outpatient Treatment For Approved Chronic Diseases Under The Chronic Disease Management Programme

(i) MediSave can be used to pay for outpatient treatment for 23 approved chronic conditions under the Chronic Disease Management Programme (CDMP) – metabolic conditions, mental health conditions, respiratory conditions and other conditions such as Parkinson's disease, dementia, epilepsy and osteoporosis. The full list of approved chronic conditions under the CDMP is available on the MOH Website at the following link: https://www.moh.gov.sg/policies-and-legislation/chronic-disease-management-programme-(cdmp)

(ii) These are chronic conditions which can:

- result in serious complications like heart disease, kidney failure and leg amputations, when not well managed; and
- have high cost of treating the condition over the long term if poorly controlled.

(iii) The aim of allowing MediSave use under the CDMP is to:

- lower long-term healthcare costs; and
- improve care for patients with chronic conditions, resulting in better health outcomes.

(iv) A CPF member can use up to $500 for non-complex chronic conditions, or $700 for complex chronic conditions per patient per year, under the MediSave500/700 scheme. To ensure prudent use of MediSave and to avoid overconsumption of medical services, patients must make a 15% cash co-payment for all CDMP claims.

(b) Outpatient Treatment for Vaccinations

MediSave500/700 can be used to pay for vaccinations under the National Childhood Immunisation Schedule (NCIS) and National Adult Immunisation Schedule (NAIS). For the list of vaccinations which are payable by MediSave, please visit the CPF website at https://www.cpf.gov.sg/member/healthcare-financing/using-your-medisave-savings/using-medisave-for-outpatient-treatments

(c) Outpatient Treatment for Health Screenings

The MediSave500/700 scheme can also be used to pay for recommended health screenings. MediSave-eligible health screenings include:

- Mammogram screenings (for women aged 50 and above)
- Selected screening tests for newborns

(d) Flexi-MediSave for the Elderly

Under the Flexi-MediSave scheme, patients aged 60 and above can use up to $300 per patient per year from their own or their spouse's MediSave Account for outpatient medical treatment, as well as approved vaccinations and screenings. Both should be aged 60 and above for the patient to tap on the spouse's MediSave Account.

Flexi-MediSave can be used at:

- Specialist Outpatient Clinics in the public hospitals and national specialty centres;
- Polyclinics; and
- Participating Community Health Assist Scheme (CHAS) Medical GP clinics.

Flexi-MediSave can be used together with other outpatient MediSave limits, such as the MediSave500/700 limit.

B2. Inpatient Treatments

3.13 There are several types of hospitalisation and day surgery expenses that can be paid with MediSave.

3.14 The inpatient daily hospital limit applies if the patient is admitted to the hospital for at least 8 hours, while the day surgery limit applies if a patient undergoes a surgical operation listed under the Table of Surgical Procedures (TOSP) and is admitted and discharged within the same day. Visit the website: https://www.cpf.gov.sg/member/healthcare-financing/using-your-medisave-savings/using-medisave-for-hospitalisation to view the TOSP for the full list of surgeries and their MediSave withdrawal limits.

3.15 Let us look at some of these items:

(a) Inpatient Episodes

The CPF member can use up to $550 per day for the first two days and $400 per day thereafter under the daily hospital limit, which includes daily ward charges, daily treatment fees, investigations, and medicines.

MediSave can also be used to pay for surgical procedures required during the inpatient stay. The withdrawal limit depends on the complexity of the surgery, and ranges from S$250 to S$7,550 (refer to the MOH and the CPF Board websites for details).

For a CPF member who passes away during his hospitalisation, the patient's own MediSave can be used to pay for the last inpatient hospital bill in full, without being subject to existing MediSave withdrawal limits. This is because the need to save for future healthcare needs is no longer relevant following his death.

(b) Inpatient Psychiatric Episodes

Up to $150 per day can be used from the MediSave account for daily hospital charges, subject to a maximum of $5,000 a year.

(c) Day Surgery Episodes

The CPF member can use up to $300 per day for hospital charges, which include daily ward charges, daily treatment fees, investigations, and medicines.

MediSave can also be used to pay for the day surgical procedure. The withdrawal limit depends on the complexity of the surgery, and ranges from S$250 to S$7,550 (refer to the MOH and the CPF Board websites for details).

(d) Assisted Conception Procedures

MediSave may be used for Assisted Conception Procedure cycles regardless of whether treatment is received in inpatient or outpatient setting. Only the patient's and her spouse's MediSave accounts may be used.

B3. Long-Term Care

(a) Rehabilitation

MediSave can be used to cover the costs of rehabilitative care, if the patient is:

- An inpatient at an approved community hospital (for $250 per day, up to $5,000 per annum)
- An inpatient at an approved convalescent hospital (for $50 per day, up to $3,000 per annum)
- An outpatient at a day rehabilitation centre (for $25 per day, up to $1,500 per annum)
- An outpatient at an approved day hospital (for $150 per day, up to $3,000 per annum)

(b) Palliative Care

MediSave can be used to pay for palliative care, subject to the following withdrawal limits:

- Approved inpatient hospice palliative care services (up to $250 per day for general palliative care, and up to $350 per day for specialised palliative care)
- Home palliative and day hospice care (up to $2,500 per lifetime). If the patient has terminal cancer, end-stage organ failure or advanced dementia, there will not be any withdrawal limit if the bill is paid using the patient's own MediSave.

(c) Disability Care

Under MediSave Care, severely disabled Singapore Residents aged 30 and above will be able to withdraw up to $200 per month in cash from their or their spouse's MediSave account for their long-term care needs. The withdrawal quantum depends on the MediSave balance at the point of monthly withdrawal (see **Appendix 9A**).

B4. Insurance Premiums

3.16 Besides using MediSave to pay for medical expenses, a CPF member can use his MediSave to pay for his own health insurance premiums, or those of his approved dependents. MediShield Life and ElderShield or CareShield Life premiums can be paid fully with MediSave whereas Integrated Shield Plans (IPs) and ElderShield or CareShield Life supplement premiums are subject to withdrawal limits which are periodically reviewed by MOH.

3.17 **Table 9.1** summarises the uses of the MediSave Account.

Table 9.1 The Uses of MediSave Account

Uses of Medisave	Items that can be paid using MediSave
Outpatient Treatments	Selected outpatient treatments such as: ▪ Approved chronic conditions under the CDMP ▪ Vaccinations ▪ Health screenings
Inpatient Treatments	Inpatient care such as: ▪ Inpatient episodes ▪ Inpatient psychiatric episodes ▪ Day surgery episodes ▪ Assisted Conception Procedures
Long-Term Care	Long-Term Care treatments which include: ▪ Rehabilitative care ▪ Palliative care ▪ Disability care
Insurance Premiums	Premium payments of: ▪ MediShield Life ▪ ElderShield/CareShield Life which can be fully paid with MediSave ▪ Integrated Shield Plans and ElderShield/CareShield Life supplements which are subject to withdrawal limits periodically reviewed by MOH

C. How Much Medisave Can Be Used?

3.18 The use of MediSave is subject to withdrawal limits and other conditions. The types of limits include:

(i) **Withdrawal Limit** – the maximum amount that the CPF member can withdraw from his/her MediSave Account for his or her medical expenses. For the different categories and amount of withdrawal limits which apply to a member's CPF account, please refer to **Appendix 9A**.

(ii) **Additional Withdrawal Limit (AWL)** – the maximum amount of MediSave that can be used to pay for additional private insurance coverage. The excess premiums above AWLs are payable in cash. Please refer to

Appendix 9A for the AWL for Integrated Shield Plans (IP) and ElderShield/CareShield Life supplements.

C1. Where Can MediSave Be Used?

3.19 Payments via MediSave are allowed in all public healthcare institutions, as well as approved private hospitals and medical institutions. For an updated list of medical institutions participating in MediSave, refer to the CPF Board Website.

C2. Whose MediSave Can Be Used?

3.20 All CPF members are allowed to pay for their approved dependents' medical expenses; and there may be more than one payer per bill, e.g. two children can pay for their mother's hospitalisation bill. Each CPF member should specify to the institution the amount of MediSave that he would like to use to pay for the hospitalisation bill.

3.21 If the immediate family members' MediSave are not sufficient to pay for the hospitalisation bill, then the patient's family members can make an appeal to the hospital to have the bill settled by non-immediate family members via MediSave, e.g. children-in-law. However, this option is available only if the patient meets certain conditions, such as having stayed in the Class B2 or Class C ward of a public hospital.

C3. Prudent Use of MediSave

3.22 MediSave use is subject to withdrawal limits, which are generally sufficient for subsidised treatments in public healthcare institutions. This ensures that there continues to be sufficient savings for future healthcare needs. Those seeking treatments in Class B1 and Class A wards of public hospitals or private hospitals will usually have some cash out-of-pocket payments.

C4. Distribution Of MediSave Upon Demise

3.23 If a patient was hospitalised just before death and had authorised the use of his MediSave to pay for his medical bill, his MediSave balance would be used in full, without being subject to the existing MediSave withdrawal limits, to pay for his last inpatient medical bill.

3.24 If the patient had not authorised the use of his MediSave before his demise, his immediate family member (spouse, parent, or child who is aged 21 years and above), or donee or deputy can also do so for the last inpatient medical bill, provided that it has not been paid out to the patient's nominated beneficiaries. In the event that the patient does not have any immediate family member, or donee or deputy to authorise the use of the patient's MediSave, a relative who has been taking care of the patient may also write to MOH through the hospital to seek approval for the relative to authorise the withdrawal of patient's MediSave, to pay for the last inpatient medical bill.

3.25 The remaining MediSave balance, after the payment of the last medical bill, would be distributed to the nominated beneficiaries of the patient's CPF account if a nomination was made before his death. If there was no nomination made, the balance in the deceased patient's MA would be distributed by the Public Trustee to his family members under the intestacy laws for non-Muslims, or the Muslim inheritance law for Muslims.

4. MEDISHIELD LIFE

4.1 Unlike MediSave which is a savings scheme, MediShield Life is a basic health insurance scheme that protects all Singapore Citizens (SCs) and Permanent Residents (PRs) against large medical bills for life, regardless of age or health conditions. The claim limits are sized to cover subsidised bills incurred for hospitalisation in class B2/C wards, day surgery, and selected costly outpatient treatments (e.g., dialysis and chemotherapy) in the public hospitals.

4.2 There is no need to apply for MediShield Life. All SCs and PRs are automatically covered under MediShield Life from 1 Nov 2015. New SCs are covered from birth or from the day they attain citizenship. PRs are covered from the day they attain permanent residency.

4.3 By risk-pooling across the entire population, MediShield Life provides universal coverage for all Residents for life. MediShield Life premiums may be fully paid from MediSave.

4.4 MOH regularly reviews and enhances MediShield Life to ensure coverage adequacy and premium affordability. No one will lose MediShield Life coverage due to an inability to pay premiums.

4.5 MediShield Life provides coverage for all ward classes including private hospitals. However, MediShield Life benefits are designed based on Class B2/C bills, so as to keep premiums affordable. Those who would like additional coverage in Class A/B1 wards or private hospitals may consider buying Integrated Shield Plans (IP). As IPs premiums are higher than MediShield Life premiums and increase with age, one should consider the affordability of premiums over the longer-term prior to purchase.

A. MediShield Life Premiums

4.6 MediShield Life premiums are actuarially priced based on the health risks and expected healthcare utilisation of each age group so that each age group's payouts are broadly supported by their own premiums. This ensures that MediShield Life remains sustainable even as our population ages. Any applicable subsidies are automatically applied to the premium before premium payment.

4.7 Those with pre-existing medical conditions can enjoy coverage for their conditions. Only those with serious pre-existing medical conditions listed in the MOH website need to pay a nominal Additional Premium of 30% for the first 10

years, in addition to the standard MediShield Life premiums.

4.8 MediShield Life premiums can be fully paid by Medisave. One can pay premiums from own MediSave, or family members may pay one's premium using their MediSave. Parents may also tap on the MediSave Grant for newborns to pay for their child's MediShield Life premiums.

B. MediShield Life Subsidies

4.9 The Government provides various premium subsidies and support measures to help SCs and PRs with their MediShield Life premiums, including those who need to pay Additional Premiums:

(a) Premium Subsidies for the lower- to middle- income;

(b) Pioneer and Merdeka Generation Subsidies for Pioneer and Merdeka Generation seniors;

(c) COVID-19 Subsidies for SCs; and

(d) Additional Premium Support for those who are unable to afford their premiums even after subsidies, MediSave use and have limited family support.

B1. Premium Subsidies for the lower- to middle- income

4.10 This is a permanent feature, available to lower- to middle- income families with household monthly income per person of S$2,800 and below, and living in homes with an Annual Value (AV) of S$21,000 and below. The S$21,000 AV threshold covers all HDB flats and a small number of private properties. Those who own more than one property will not be eligible for this subsidy.

4.11 Those eligible can receive subsidies of up to 50% of their premiums. PRs will receive half the subsidy applicable to SCs.

B2. Pioneer Generation Subsidies and MediSave top-ups

4.12 Pioneers refer to Singapore Citizens born on or before 31 December 1949 and obtained citizenship on or before 31 December 1986.

4.13 Pioneers receive special Pioneer Generation Subsidies of between 40-60% depending on age. This is regardless of their household monthly income or the Annual Value of their home.

4.14 Pioneers also receive $250 - $900 a year in MediSave top-ups (depending on year of birth) for life, which can be used to pay for their MediShield Life premiums.

4.15 Older Pioneer Generation Seniors who have serious pre-existing conditions also receive additional MediSave top-ups of $50 - $200 annually from 2021 to 2025, which can be used to pay for their MediShield Life premiums.

B3. Merdeka Generation Subsidies and MediSave top-ups

4.16 Merdeka Generation seniors refer to:

(i) living Singapore Citizens who were born from 1 January 1950 to 31 December 1959 and had obtained citizenship on or before 31 December 1996; and

(ii) those who were born on or before 31 December 1949, had obtained citizenship on or before 31 December 1996 and do not receive the Pioneer Generation Package.

4.17 From 1 July 2019, Merdeka Generation seniors receive additional Merdeka Generation Subsidies of 5% of their annual MediShield Life premiums, increasing to 10% after they turn 75 years old, regardless of their household monthly income or the Annual Value of their home. This is on top of the above Premium Subsidies that the seniors may receive.

4.18 Merdeka Generation members will also receive $200 a year in MediSave top-ups for five years from 2019 to 2023. These top-ups can be used to pay for their MediShield Life premiums.

B4. COVID-19 Subsidies

4.19 COVID-19 Subsidies are provided to all Singapore Citizens for two years after the increase in MediShield Life premiums on 1 Mar 2021.

4.20 It is applied on the net premium increase over MediShield Life premiums before 1 Mar 2021, after Premium Subsidies, Pioneer Generation Subsidies or Merdeka Generation Subsidies, where applicable. It covers 70% of the net premium increase in the first year, followed by 30% of the net premium increase in the second year.

B5. Additional Premium Support

4.21 Individuals who are unable to afford MediShield Life premiums after Government subsidies, MediSave use and have limited family support will be invited by the Government to apply for Additional Premium Support (APS). If approved, APS will cover the outstanding MediShield Life premiums (if any) as well as the premiums for the next two years.

C. MediShield Life Benefits

4.22 MediShield Life benefits are reviewed regularly to keep pace with the evolving healthcare landscape and cost inflation so that it remains sustainable and relevant to the needs of Singaporeans. **Appendix 9B** shows the MediShield Life benefits applicable for admissions or treatments received on or after 1 March 2021.

D. How Are MediShield Life Claim Payouts Computed?

4.23 The MediShield Life Scheme pays on a reimbursement basis, subject to the claim limits imposed on the covered medical expenses, as well as deductible, co-insurance and pro-ration factors.

4.24 The deductible is the fixed amount payable by the insured each policy year (the year following his policy renewal month), before the MediShield Life payout starts. The deductible is payable only once every policy year. It helps to sieve out smaller, more affordable bills, which can be paid using MediSave and/or cash, and helps to keep the premiums affordable by focusing MediShield Life payouts on larger bills where support is more critical.

4.25 Co-insurance is the patient's share of the claimable amount which the insured will have to pay, along with the deductible. It decreases from 10% to 3% as the bill size increases. Co-insurance helps to prevent over-consumption of medical services and over-servicing by healthcare providers.

4.26 As private hospital bills and Class A/B1 bills in public hospitals are generally higher than the Class B2/C bills that MediShield Life is designed for, they are pro-rated to the equivalent level of a Class B2/C bill before MediShield Life payouts are computed. This ensures comparable payouts for subsidised and private patients.

4.27 **Table 9.2** shows an example of how the reimbursement under MediShield Life is arrived at.

Table 9.2: Claim Computation Of MediShield Life For Singapore Citizen Hospitalised In Class A Ward

Claim computation for a Singapore Citizen aged 60 who stays in a Class A ward
Length of Stay: 18 Days
Procedure Performed: Hip Replacement
Pro-ration Factor based on ward class 35%

	Hospital Bill	35% of Hospital Bill[9] (Refer to Table H)	MediShield Life Claim Computation
Daily Ward & Treatment Charges (18 days normal ward)	$12,000	$4,200 ($12,000 x 35%)	$4,200[10]
Surgical Procedure (Table 5C)	$8,500	$2,975 ($8,500 x 35%)	$2,180[11]
Implant	$4,000	$1,400 ($4,000 x 35%)	$1,400[12]
Total	$24,500	$8,575	$7,780
Less Deductible[13]	-	-	($2,000)
Claimable Amount (less Deductible)	-	-	$5,780
Less Co-insurance	-	-	($439)[14]
Medishield Life pays	-	-	**$5,341**
MediSave and/or Cash	-	-	$19,159

4.28 Note from **Table 9.2** that MediShield Life does not cover the majority of the Class A ward hospital bills. The insured's hospital bill was pro-rated to the equivalent Class B2/C bill, before being subject to the claim limits. He may use his MediSave (subject to the MediSave limits, based on the number of days stayed in hospital and the surgical table relating to his surgical procedure) and/or cash to pay the remaining portion of his bill (S$19,159).

4.29 Therefore, it is important for the insured to consider his insurance coverage carefully, before he chooses the hospital or ward to which he wishes to be admitted. If he wishes to have coverage for Class A/B1 ward and private hospital stays, he may apply to any of the approved insurers for an IP.

[9] As the insured member stayed in Class A ward, the MediShield Life claim is computed based on 35% of the bill
[10] Lower of the claim limit in Table A for Daily Ward & Treatment Charges, ($700 x 18 days) = $12,600, on 35% of charges incurred of $12,000 = $4,200. Therefore, the claimable amount is $4,200.
[11] Lower of the claim limit in Table A for surgical procedure, $2,180 (Table 5C), or 35% of charges incurred of $8,500 = $2,975. Therefore, the claimable amount is $2,180.
[12] Lower of the claim limit in Table A for Daily Ward & Treatment Charges, ($1000 x 2 + $800 x 16 days) = $14,800, on 35% of charges incurred of $12,000 = $4,200. Therefore, the claimable amount is $4,200.
[13] The insured member is below 80 years old, subject to deductible of $2,000 for Class A ward.
[14] Co-insurance = ($3,000 x 10%) + ($2,780 x 5%) = $439.

4.30 Exclusions are imposed on certain medical treatments and expenses. For such expenses incurred, the insured will not be able to claim under his MediShield Life.

4.31 The following treatment items, procedures, conditions, activities are not covered by MediShield Life and cannot be claimed (Applicable for admissions or treatments received on or after 1 March 2021):

- Treatment for any contraceptive operation or procedure, infertility, sub-fertility, or assisted conception or sex re-assignment surgery
- Surgical interventions for the following conditions: Trisomy 13, Bilateral Renal Agenesis, Bart's Hydrops and Anecephaly
- Cosmetic surgery
- Dental work or dental treatment, except approved dental treatment
- Outright purchase of kidney dialysis machines, iron-lung and other special appliances
- Optional items such as television, telephone, special requested meals and other items which are not necessary for the treatment of any illness, condition or any injury or disability
- Private nursing charges
- Ambulance services
- Vaccination
- Treatment for injuries and disablement resulting from deliberate exposure by the insured to exception danger (except in an attempt to save human life)
- Treatment for injuries and disablement resulting from insured person's own criminal act
- Treatment of injuries arising directly or indirectly from nuclear fallout, war and related risk
- Treatment of injuries arising from direct participation in civil commotion, riot or strike
- Expenses incurred after the 7th calendar day from being certified to be medically fit for discharge from inpatient treatment and assessed to have a feasible discharge option by a medical practitioner
- Overseas medical treatment
- Treatment which has received reimbursement from Workmen's Compensation and other forms of insurance coverage
- Treatment for pregnancy, childbirth (including Caesarean operations) or abortions, except treatments for serious complications related to pregnancy and childbirth

E. MediShield Life Fund

4.32 The MediShield Life Scheme is a not-for-profit scheme. All premiums collected are placed in the MediShield Life Fund and are used solely for the benefit of policyholders and in the administration of the scheme. The financial accounts for the Fund are audited by an external auditor and submitted to Parliament every year.

5. INTEGRATED SHIELD PLANS (IPs)

5.1 Integrated Shield Plans (IPs) are MediSave-approved hospitalisation insurance plans made up of two parts. The first is the MediShield Life component administered by the CPF Board. The second is an additional private insurance coverage component administered by approved private insurers, typically to cover Class A/B1 wards of public hospitals or private hospitals. Following the implementation of MediShield Life on 1 November 2015, MediShield Life automatically replaced the MediShield component of IPs. Thus, those who have IPs are already covered by MediShield Life, and there is no duplication of coverage between IPs and MediShield Life.

5.2 The following plans are IPs (as at 1 Apr 2021): AIA HealthShield Gold Max, Singlife with Aviva MyShield, AXA Shield, Great Eastern SupremeHealth, Income Insurance Limited's IncomeShield, Prudential's PRUshield and RHI Raffles Shield. To aid your understanding of the different IPs offered, you are advised to refer to the updated comparison tables of IPs across insurers, categorised by ward class, at the MOH Website[15].

5.3 The figure below illustrates the components of Integrated Shield Plans (IPs) as outlined above.

[15] https://www.moh.gov.sg/cost-financing/healthcare-schemes-subsidies/medishield-life/comparison-of-integrated-shield-plans

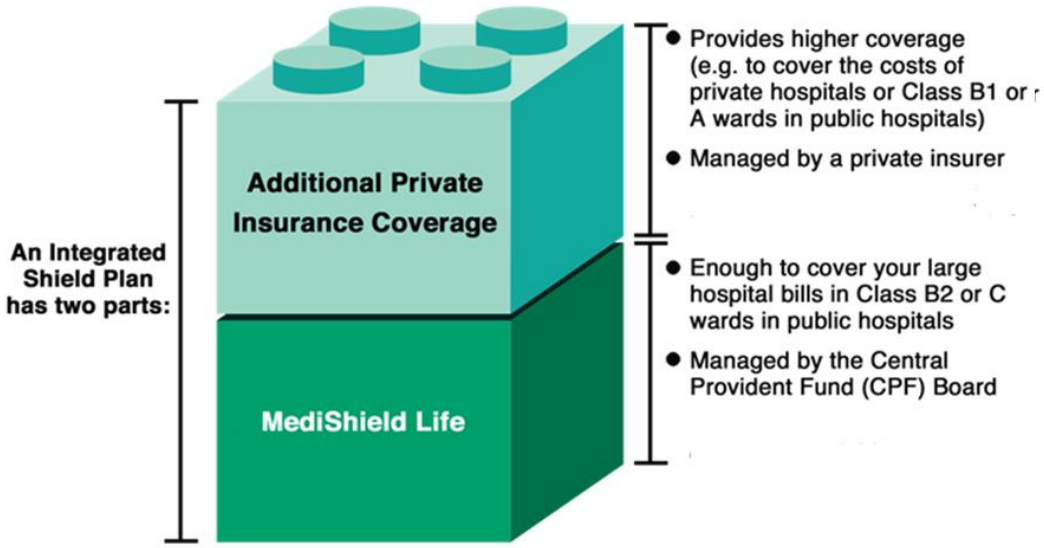


*Diagram is not drawn to scale

With the different IPs available, it is necessary for the sellers of such plans to understand the different plans offered in the insurance market, and to advise their prospective clients, based on the needs and long-term affordability of each individual client's position.

(a) As part of due diligence, clients should be informed of the key differences in premiums, benefits, exclusions, deductibles, co-insurance and other co-payment features between the various IPs offered by their insurer, versus MediShield Life. There are different benefits provided in the IP policy, and plans can be "as charged" or "non-as-charged" (i.e. they have sub-limits imposed). Information provided should be easy to understand, unambiguous and clearly explained to help clients make an informed decision.

(b) Clients should consider if they would wish to stay in a private or subsidised ward in a public hospital, or in a private hospital, and if they wish to choose their own doctors. To aid them in this decision, agents should explain to clients how a given plan's coverage might differ according to their choice of ward, hospital, and doctor (e.g., in the case of panel providers). Subsidised treatments in public hospitals (B2/C wards) currently make up two-thirds of all admissions from Singapore residents. For the vast majority of these treatments, MediShield Life provides sufficient coverage, meaning that having an IP plan would not provide any additional payout. As such, members may not need to purchase an IP if they intend to stay in Class B2/C wards.

(c) Premiums for IPs are higher than for MediShield Life. IP premiums increase significantly as an insured person gets older. Premiums for health insurance usually increase with age and are subject to change. The private insurance component of the IP premiums could be up to 4 times the MediShield Life premiums for those in their 70s or 80s this year. Clients should consider if they can afford their IP premiums in the long term.

(d) The additional private insurance component of IP premiums is payable by MediSave only up to the Additional Withdrawal Limit (AWL), which is often exceeded at older ages. The policyholders may have to pay a substantial portion of their IP premiums in cash, especially at the older ages.

(e) Unlike MediShield Life which provides coverage for pre-existing medical conditions (with Additional Premiums for the first 10 years), the coverage for the private insurance component of the IP may be declined or imposed with exclusions for pre-existing conditions. The private insurance component may also have premium loading, arising from pre-existing conditions. Clients should be advised to disclose their medical history truthfully and completely, to avoid unexpected policy exclusions subsequently. Once their policy has been approved, clients should be made to understand their full list of policy exclusions from their insurer or agent, and be advised of their free-look period where they can review their purchase and obtain a full refund of premiums if they choose to cancel their policy. Where possible, clients should be reminded again of their exclusions prior to any treatment, procedure or admission, including both general exclusions and specific medical exclusions of pre-existing conditions.

A. Integrated Structure Of IPs

5.4 Under the integrated structure of IPs, if a Singapore Citizen or Permanent Resident purchases an IP, he will enjoy the benefits of MediShield Life within his IP. However, he will be serviced by his private insurer. In other words, he will continue to pay one premium and needs to make only one claim with just his private insurer. His private insurer will then arrange with the CPF Board on the amount claimable under the MediShield Life component of the plan. The insured will not need to liaise with both parties (i.e. his insurer and the CPF Board).

A1. Coverage

5.5 As mentioned above, a person insured with an IP already benefits from the MediShield Life component within his IP. He will have coverage for pre-existing conditions and be assured of lifelong coverage under the MediShield Life component of his IP. This is so, even if the condition is excluded from the additional private insurance coverage by the IP insurer.

5.6 Due to COVID-19, the seven authorised IP insurers have extended their coverage of hospitalisation resulting from COVID-19 vaccine complications until Dec 31, 2022, as mentioned by the Life Insurance Association, Singapore (LIA Singapore). The extended coverage will continue to apply to all IP policyholders who received COVID-19 vaccines under the national vaccination programme, as well as those approved by the World Health Organisation (WHO) under its emergency use listing and administered in Singapore under the special access route.

A2. Premiums & MediShield Life Subsidies

5.7 The IP premiums paid to private insurers also comprise two parts, namely the premium for the MediShield Life component, and the premiums for the additional private insurance component. A person insured under an IP will also be able to receive the applicable MediShield Life subsidies (i.e. Premium Subsidies for lower- to middle-income; Pioneer and Merdeka Generation Subsidies; Transitional Subsidies) if he meets the eligibility criteria, but will not be eligible for Additional Premium Support. Those who cannot afford to pay for IP premiums should remain on MediShield Life.

5.8 When deciding on the level of premiums for the additional private insurance component, private insurers will also need to factor in claims experience and medical inflation along with the benefits offered. Clients concerned with the affordability of IP premiums should consider more affordable insurance options if it is within their means, such as IPs with a lower ward entitlement, or consider whether MediShield Life (which provides sufficient coverage for the vast majority of subsidised treatments (B2/C wards) already adequately suits their needs.

5.9 The main differences between the MediShield Life Scheme and an IP are described in **Table 9.3** below.

Table 9.3: Differences Between MediShield Life & IP

MediShield Life Scheme	Integrated Shield Plan (IP)
(a) It is administered by the CPF Board.	(a) It is administered by private insurers, as approved by MOH.
(b) Its coverage is sized for stays in Class B2/C wards of public hospitals.	(b) It provides for enhanced coverage beyond MediShield Life, with various plan types available for stays in private hospitals and/or Class A/B1 wards of public hospitals.
(c) It covers all pre-existing conditions.	(c) Coverage for the private insurance component of the IP may be declined or imposed with exclusions and/or premium loading, arising from pre-existing conditions.
(d) There is no minimum or maximum age limit.	(d) It may have a minimum or maximum entry age limit.
(e) There are sub-limits applicable.	(e) It may have sub-limits, although most do not have sub-limits.
(f) MediShield Life premiums are fully payable by MediSave.	(f) MediShield Life component of the IP is fully payable by MediSave, while private insurance component of the IP is payable by MediSave up to Additional Withdrawal Limit, and the remainder is payable by cash.

(g) All Singapore Citizens and Permanent Residents are automatically covered for life. No application is required.	(g) Application to private insurers is required.

B. Standard IP

5.10 The Government has worked with IP insurers to develop the Standard IP, a "no frills" product targeted at covering large Class B1 ward hospital bills and selected outpatient treatments.

5.11 From 1 May 2016, all IP insurers were required to sell the Standard IP. The benefits of the Standard IP are regulated by MOH and are identical across all IP insurers. The Standard IP has claim limits sized to fully cover nine out of ten Class B1 bills. Like other IPs, it also has co-insurance and deductible components.

5.12 As a private plan that provides coverage beyond MediShield Life, the Standard IP is managed by insurers. Like all other IPs, premiums and underwriting decisions for the plan are determined by each insurer, based on their own commercial considerations and risk assessment frameworks. Therefore, premiums vary, depending on each insurer's approach.

5.13 Nonetheless, the Standard IP is an affordable option for Singapore Citizens and Permanent Residents who want additional coverage beyond MediShield Life and may find other higher coverage IPs too expensive. It is also a viable option for those who want to switch from their Class A and Private Hospital IPs to a more affordable plan.

C. MediSave Use For IP Premiums

5.14 MediSave can be used to pay premiums for IPs, either in full or in part, depending on the age group and the IP plan type. The MediShield Life component of the IP premiums is fully payable by MediSave. This takes into account any Additional Premiums (for those with serious pre-existing conditions) and MediShield Life subsidies (where applicable). From 1 November 2015, MediSave use for the additional private insurance component of the IP premiums is subject to the new Additional Withdrawal Limit (AWL). The AWL is set per insured person per policy year, as stated below:

(a) Age Next Birthday (ANB) 40 years and below: S$300

(b) ANB 41 to 70 years: S$600

(c) ANB 71 years and above: S$900

D. Riders

5.15 IP insurers also sell rider plans, which pay for the co-insurance and deductible portion of the IP, and may make cash payouts upon hospitalisation. These riders are not approved for MediSave use, and insurers are not allowed to market riders as part of IPs. Sellers of such riders should highlight the distinction between IPs and riders to policyholders and share that riders can be paid using only cash. Importantly, they should remind policyholders that rider premiums rise significantly with age. Instead of paying for a rider, the deductible and co-insurance portion incurred in the event of hospitalisation can be saved for and paid via MediSave or cash.

5.16 On 8 March 2018, MOH introduced requirements for new IP riders to have:

(a) a co-payment of 5% or more, to encourage prudent use and appropriate charging of healthcare services, and

(b) a co-payment cap for panel/pre-authorised treatment to protect policyholders against the unlikely event of large bills. Insurers can set the cap at $3,000 or more per policy year.

5.17 These requirements apply to new policyholders who purchase riders on and after 8 March 2018.

D1. The Principle Underlying The Need For Co-Payments[16]

5.18 Co-payment is an important principle in the design of healthcare insurance. It encourages policyholders and their doctors, to consider the necessity of the medical treatment and its cost, so that they can make an informed decision on the appropriate healthcare services. This encourages prudence and keeps healthcare cost, and health insurance premiums, affordable and sustainable in the long term.

5.19 This principle applies regardless of hospital category. Integrated Shield Plan (IP) full riders that covered the entire co-payment under the IPs were not in line with this principle. Such riders allowed policyholders to avoid co-payment regardless of their bill size, and had contributed to over-consumption, over-servicing and over-charging.

5.20 This was one of the reasons why MOH had announced the requirement for a minimum 5% co-payment for new riders across all settings in March 2018. This applied for new riders sold from 1 April 2019, while riders sold after the announcement, between 8 March 2018 and 31 March 2019, had to transition onto these new co-payment riders by 1 April 2021.

5.21 While this co-payment requirement was not mandated for riders purchased before 8 March 2018, some insurers announced that they will also be including a co-payment component to these riders. This is allowed under their

[16] Partially extracted and adapted from https://www.moh.gov.sg/news-highlights/details/co-payment-in-integrated-shield-plans-for-specific-hospital-categories-and-breakdown-of-average-claims-made-through-full-riders-of-integrated-shield-plans

contractual terms with their policyholders. MOH has encouraged the insurers, in considering these changes, to ensure that their policyholders' interests are safeguarded even as insurers seek to ensure the sustainability of their portfolios. As an additional safeguard, insurers are required to clearly explain these changes to their policyholders at least 30 days before they take effect.

5.22 To provide their policyholders more assurance after these changes, some insurers had also introduced co-payment limits for treatments that are provided by their panel doctors, or for pre-authorised treatments. However, even if policyholders do not seek treatment with a panel doctor or are unable to seek pre-authorisation prior to treatment, they can still claim under their IP and rider, though additional benefits such as the co-payment limit may not apply. Policyholders can also continue to tap on MediSave to pay the co-payment amount under their riders, subject to the MediSave withdrawal limits.

E. Terminating or Switching IP/Switching Insurer

5.23 An IP policyholder who cannot afford, or does not wish to continue paying the premium for his IP, can switch his plan to a lower coverage plan within the same insurer at any point in time, without additional underwriting involved. He can also terminate his IP at any point in time, and still be covered by MediShield Life which provides basic health insurance, regardless of any pre-existing conditions.

5.24 In the event that the person with an existing IP switches to a new IP with another insurer, his original IP with the previous insurer will be automatically terminated. Moreover, under the new IP with the new insurer, he will undergo underwriting again. As such, he may lose coverage for his existing medical conditions covered by his original plan with his existing insurer and may not be able to re-apply for his original coverage subsequently.

5.25 Any policyholder who switches his IP from one insurer to another will have the option to go back to the previous insurer within 30 days from the date of notification of termination given to the previous insurer. No re-underwriting is allowed by the previous insurer, and it would be as if the first IP had never been terminated.

5.26 If a claim is received by the new insurer and the claim incurred date falls within 30 days from the commencement date of the new policy and the new insurer is not able to admit the claim for any reason, the new insurer has the option to request the policyholder to reinstate his policy with the previous insurer. The previous insurer will take the claim incurred date (or claim event date) to be the date of request to reinstate the policy. Once reinstated, the claim will be assessed by the previous insurer, and the claim will be paid by the previous insurer if the liability under the previous insurer's policy is established.

F. Risk-Loading By Private Insurers

5.27 With effect from the launch of MediShield Life, MOH allows IP insurers to risk-load insured members with pre-existing conditions for the private insurance component of the IPs. This will help to reduce uncertainty of coverage owing to exclusions, and afford insured members who prefer to pay higher private insurance premiums the peace of mind, knowing that they are also covered for their pre-existing conditions by the private insurance component of their IPs. More details on this will be shared by private insurers if and when they decide to offer risk-loading to their insured members.

G. Pre-Authorisation for IP, Claim Process For MediShield Life/IP, Other Private Insurance & MediSave

5.28 The LIA has issued a guidance paper on Pre-Authorisation Process for IPs. Pre-authorisation is a service where the IP insurer gives prior approval to the hospitalisation and/or medical treatment and associated costs before the actual surgery or admission. It is designed for elective treatment in the private healthcare sector, for patients (policyholders) seeking specialist care by private doctors in private hospitals.

5.29 The benefits in having pre-authorisation are:

(a) Insurers can assess the medical necessity and cost of treatment to ensure it is within the terms and conditions of the policy's coverage;

(b) Patients will have a peace of mind in knowing that their procedure is within their insurance coverage; and

(c) Healthcare providers have better clarity on the type of procedures covered by insurance to better advise their patients prior to the actual procedure.

Policyholders are thus encouraged to seek pre-authorisation for planned procedures as far as possible if the option is provided by the insurer.

5.30 All IP insurers offering pre-authorisation services to its IP policyholders have to use the standard LIA Pre-Authorisation Form. (See **Appendix 9C**)

5.31 IP insurers will directly settle pre-authorised bills with the hospital, day surgery centre or clinic.

5.32 Any insured CPF member who wishes to claim from his MediShield Life, IP and/or MediSave will need to complete the Medical Claims Authorisation Form to:

(a) allow the hospital to claim from his insurer; and

(b) instruct the CPF Board to deduct from his MA to pay for his hospital bill, while the insurer settles the claim, which may take some time. The patient may be required to pay a deposit in cash upon his hospital admission, as his MediSave may not cover the full hospital charges. This is usually the case for non-subsidised ward classes.

G1. Claiming From MediShield Life/IP & MediSave

5.33 If there is no pre-authorisation, the insured CPF member under an IP can approach the hospital to trigger a request for a Letter of Guarantee (LOG) from his insurer upon hospital admission. The LOG is a service provided by all IP insurers for insured members, to ease the admission process to the hospital for inpatient treatment/day surgery. It waives the upfront cash required by the hospital, up to the eligible LOG amount. The LOG amount will be computed based on the estimated IP payout in respect of the plan's benefits, subject to the respective caps imposed by the insurer(s). The hospital may fully or partially waive the deposit in such a case. An insured CPF member may not get the LOG if he does not meet the eligibility criteria, for example, if the reason for hospitalisation is within his pre-excluded conditions. It is important that the insured CPF member understands that a LOG may not mean that the insurer will pay for the specified amount. To obtain assurance that their bill will be covered, the insured CPF member may wish to apply for pre-authorisation instead, if available.

5.34 For any insured CPF member who wants to claim from MediShield Life, IP and/or MediSave, the hospital will submit the claim on his behalf through the MediClaim online system after he has been discharged.

5.35 For MediShield Life claims, the CPF Board will calculate how much MediShield Life will pay and settle the amount directly with the hospital.

5.36 For IP claims, the hospital will submit the claim electronically to the insurers directly. For payouts, the IP insurer will calculate how much the IP will pay based on the IP benefits, and the CPF Board will independently calculate how much MediShield Life will pay based on the MediShield Life benefits. The eventual payout will be the higher of the two amounts. For example, if the payout computed based on the full IP benefits is S$2,000, and the payout based on MediShield Life benefits is S$500, the policyholder will receive S$2,000, which comprises S$500 from the MediShield Life payout, and S$1,500 from the IP's additional coverage payout. In the case where the payout based on MediShield Life benefits is higher than the IP benefits, the eventual payout will be based on the MediShield Life benefits.

5.37 If the CPF member is making use of his MediSave to pay for part of his bill, the hospital will have to submit the claim electronically based on the prevailing MediSave withdrawal limits. Once the claim is approved, the CPF Board will make payment to the hospital from the CPF member's MA. Any outstanding amount not covered by MediShield Life/IP, MediSave or other private insurance (e.g. Group Hospital & Surgical Insurance policy effected by the employer of the CPF member) will have to be settled by the patient in cash.

G2. Claiming From Non-IP Private Insurance

5.38 For someone who is covered by his employer's medical benefits or other private insurance plans, he will need to show his insurance card (provided by some insurers for certain Medical Expense Insurance plans) to the hospital admission staff. The hospital may fully or partially waive the deposit in such a case.

5.39 Some hospitals will send the hospitalisation bill directly to the CPF member's non-IP private insurer or employer. In other cases, the insured CPF member will have to submit the bill himself to the insurer. If the bill is more than the reimbursement from the insurer or the employer, he can choose to claim the remainder from MediShield Life/his IP and/or his MediSave, up to prevailing limits, where applicable.

APPENDIX 9A

Withdrawal Limits for Inpatient, Outpatient, Long-Term Care and Insurance Premiums

MediSave Limits for Inpatient Treatments

MediSave limits for hospital charges	
Type of hospital stay	**MediSave limits for hospital charges**
Inpatient episodes	$550 for the first two days, $400 per day afterwards
Inpatient psychiatric episodes	$150 per day. Maximum of $5,000 a year
Day surgery episodes	$300 per day
Surgery episodes	Between $250 and $7,550 depending on the complexity of the surgery.
MediSave limits for non-acute hospital stays	
Non-acute hospital type	**MediSave non-acute hospital limits**
Approved community hospitals	$250 per day. Maximum of $5,000 a year
Approved convalescent hospitals	$50 per day. Maximum of $3,000 a year
Approved day hospitals	$150 per day. Maximum of $3,000 a year
MediSave limits for Assisted Conception Procedure (ACP) Treatments	
ACP Cycle	MediSave Withdrawal Limit
1st	$6,000
2nd	$5,000
3rd and subsequent	$4,000 (capped at lifetime MediSave withdrawal limit of $15,000 per patient)
MediSave limits for delivery of a child	
MediSave Maternity Package	Prevailing inpatient limits (up to $550 for the first two days and $400 for the third and subsequent day in the hospital and applicable surgical withdrawal limit depending on the delivery procedure) plus an additional $900 for pre-delivery medical expenses.

MediSave Limits for Outpatient Treatments

MediSave limits for chronic disease management, health screenings and vaccinations	
MediSave500 or MediSave700 Scheme	Patients with complex chronic conditions will be able to use up to $700 per patient yearly, while other patients will be able to use up to $500 per patient yearly (treatment for approved chronic conditions are subject to 15% co-payment).
Additional MediSave limits for elderly	
Flexi-MediSave for Elderly	Patients aged 60 and above can use up to $300 per patient per year for outpatient medical treatment, approved vaccinations and screenings. Spouse's MediSave savings can also be used if he or she is also over 60 years old.
MediSave limits for other outpatient treatments	
Outpatient treatment	**MediSave outpatient limits**
Renal dialysis treatment	$450 a month
Outpatient radiotherapy for cancer patients	$80 per treatment for external radiotherapy or hemi-body radiotherapy $360 per treatment for brachytherapy with or without external radiotherapy $2,800 per treatment for stereotactic radiotherapy
Radiosurgery treatment for cancer patients (Gamma Knife or Novalis shaped beam)	Up to $7,500 per treatment
Chemotherapy for cancer patients (includes analgesic medication and suppressive treatments)	$1,200 per month per patient
Scans and other diagnostics for cancer patients	$600 per year per patient
Scans for diagnosis or treatment of a medical condition (non-cancer)	$300 per year per patient
Anti-retroviral treatment for HIV patients	$550 per month per patient
Hyberbaric oxygen therapy	$100 per treatment cycle
Intravenous antibiotic treatment	$600 per weekly cycle. Up to $2,400 a year
Long term oxygen therapy and infant continuous positive airway pressure therapy	$150 per month per patient
Immuno-suppressants for patients after organ transplants	$300 per month per patient
Long-term parenteral nutrition	$200 per month
Autologous bone marrow transplant for multiple myeloma treatment	$2,800 per year per patient
Desferrioxamine drug and blood transfusion for thalessaemia	$550 per month per patient

MediSave Limits for Long-Term Care

<table>
<tr><th colspan="2">MediSave limits for Long-Term Care</th></tr>
<tr><td>Approved inpatient hospice palliative care services</td><td>Up to S$250 per day for general palliative care, and up to $350 per day for specialised palliative care</td></tr>
<tr><td>Day Rehabilitation at approved day rehabilitation centres</td><td>Up to $25 per day for day rehabilitation charges, subject to a maximum of $1,500 a year</td></tr>
<tr><td>Home palliative and day hospice care</td><td>A combined lifetime withdrawal limit of $2,500 per patient for day hospice and home palliative care (adults and paediatrics)</td></tr>
<tr><td>MediSave Care</td><td><table><tr><th>MediSave Balance</th><th>Monthly Withdrawal Quantum</th></tr><tr><td>$20,000 and above</td><td>$200</td></tr><tr><td>$15,000 and above</td><td>$150</td></tr><tr><td>$10,000 and above</td><td>$100</td></tr><tr><td>$5,000 and above</td><td>$50</td></tr><tr><td>Below $5,000</td><td>Nil</td></tr></table></td></tr>
</table>

MediSave Limits for IP and ElderShield or CareShield Life Supplement Premiums

Additional Withdrawal Limit (AWL) for IP	
Age next birthday	AWL for IP policyholders17
40 and below	$300
41 to 70	$600
71 and above	$900
Additional Withdrawal Limit (AWL) for ElderShield or CareShield Life Supplements	
ElderShield or CareShield Life Supplements	$600 per calendar year per person insured

[17] https://www.cpf.gov.sg/member/infohub/educational-resources/read-this-before-buying-ip

APPENDIX 9B

MediShield Life Benefits[18]

Inpatient/Day Surgery	**Claims limits**		
Daily Ward and Treatment Charges[19]			
- Normal Ward	$800 per day		
- Intensive Care Unit Ward	$2,200 per day		
*An additional claim limit of $200 per day applies for the first two inpatient days			
- Psychiatric (Up to 60 days per policy year)	$160 per day		
- Community Hospital(Rehabilitative)	$350 per day		
- Community Hospital (Sub-acute)	$430 per day		
- Inpatient Palliative Care Service (General)	$250 per day		
- Inpatient Palliative Care Service (Specialised)	$350 per day		
Surgical Procedures	A	B	C
- Table 1 A/B/C (less complex procedures)	$240	$340	$340
- Table 2 A/B/C	$580	$760	$760
- Table 3 A/B/C	$1,060	$1,160	$1,280
- Table 4 A/B/C	$1,540	$1,580	$1,640
- Table 5 A/B/C	$1,800	$2,180	$2,180
- Table 6 A/B/C	$2,360	$2,360	$2,360
- Table 7 A/B/C (more complex procedures)	$2,600	$2,600	$2,600
Implants	$7,000 per treatment		
Radiosurgery	$10,000 per course of treatment		
Autologous Bone Marrow Transplant Treatment for Multiple Myeloma	$6,000 per treatment		
Outpatient Treatment			
Chemotherapy for Cancer	$3,000 per month		
Radiotherapy for Cancer			
- External (Except Hemi-Body)	$300 per treatment		
- Brachytherapy	$500 per treatment		
- Hemi-Body	$900 per treatment		
- Stereotactic	$1,800 per treatment		
Kidney Dialysis	$1,100 per month		
Immunosuppressants for Organ Transplant	$550 per month		
Erythropoietin for Chronic Kidney Failure	$200 per month		
Long-term Parenteral Nutrition	$1,700 per month		
Maximum Claim Limits			
Per Policy Year	$150,000		
Lifetime	No Limit		

[18] https://www.moh.gov.sg/home/our-healthcare-system/medishield-life/what-is-medishield-life/what-medishield-life-benefits

[19] Includes meal charges, prescription, professional charges, investigations and other miscellaneous charges

Deductible[20] **(Based on age next birthday at the start of the policy year. Applicable for admissions or treatments received on or after 1/3/2021.)**		
Ward Class / Treatment	Age 80 and below	81 and above
Class C[1]	$1,500	$2,000
Class B2 and above (including stay in private hospital)	$2,000	$3,000
Day Surgery	$1,500	$2,000
Outpatient Treatments	Not Applicable	
[1]Subsidised patients will follow the deductible for Class C and non-subsidised patients will follow the deductible for class B2 for Community Hospital, Inpatient Palliative Care Service, Short Stay Wards and Continuation of Autologous Bone Marrow Transplant for Multiple Myeloma.		
Co-insurance		
Inpatient/Day Surgery Claimable amount accumulated within a policy year		
First S$5,000[2]	10%	
Next $5,000	5%	
Above $10,000	3%	
Outpatient Treatment	10%	
[2]Inclusive of deductible		

[20] https://www.moh.gov.sg/home/our-healthcare-system/medishield-life/what-is-medishield-life/how-to-make-a-medishield-life-claim

Insert Company Logo, if applicable

APPENDIX 9C

LIA Standardise Pre-Authorisation Form (To Be Completed By Attending Doctor)

PRE-AUTHORISATION FORM TO BE COMPLETED BY ATTENDING DOCTOR
(Indicate "NA" if not applicable.)

Fill dates in format "DDMMYYYY"

<table>
<tr><td colspan="2">Name of Patient</td><td colspan="3">NRIC / FIN No</td></tr>
<tr><td colspan="5">A. Details of Hospitalisation</td></tr>
<tr><td colspan="2">Name of Principal Doctor and Clinic</td><td colspan="3">Name of Hospital / Surgery Centre</td></tr>
<tr><td colspan="2" rowspan="2">Preferred Ward Type
<u>Private</u>
☐ Day Surgery ☐ 2 Bed
☐ Standard Single Bed ☐ 4 Bed
☐ Others:

<u>Public/Restructured</u>
☐ Day Surgery (subsidised) ☐ Class B1/B1+
☐ Day Surgery (non-subsidised) ☐ Class B2/B2+
☐ Class A ☐ Class C</td><td>Date of Admission</td><td>Est. Length of Stay (No. of days)</td></tr>
<tr><td colspan="2">Is the condition typically managed on an outpatient basis? If Yes, please provide reason for <u>this</u> hospitalisation.
☐ No ☐ Yes, reasons are:</td></tr>
<tr><td>Date of first consultation of symptoms</td><td>Date of diagnosis/ provisional diagnosis</td><td colspan="3">Diagnosis / Provisional diagnosis in ICD 10 AM with description</td></tr>
<tr><td colspan="2">Date of onset of symptoms / Duration of symptoms</td><td colspan="3">Description of symptoms</td></tr>
<tr><td colspan="2">Did the patient come to see you with a referral letter?
☐ No ☐ Yes
(If a referral letter is available, please attach a copy to speed up the pre-authorisation process.)</td><td colspan="3">Based on the information available to you, does the patient have any of the following major co-morbidities? (Note: Only co-morbidities that have impact on the patient's treatment, impact on the duration of hospitalisation, or which are medically related to the patient's condition, need to be indicated.)</td></tr>
<tr><td colspan="2" rowspan="6">Based on the information available to you, is the event for which pre-authorisation is being requested:

☐ For a routine check-up/screening
☐ Related to a clinical trial/study
☐ Related to self-inflicted injuries/attempted suicide
☐ Related to alcohol/drug abuse
☐ Related to a congenital anomaly/genetic disorder</td><td>Comorbidities</td><td>Date of diagnosis, if available</td></tr>
<tr><td>☐ Cancer</td><td></td></tr>
<tr><td>☐ Stroke, Heart Failure, Cardiovascular Disease</td><td></td></tr>
<tr><td>☐ Diabetes</td><td></td></tr>
</table>

☐ Related to a mental/psychiatric disorder ☐ Related to an elective cosmetic procedure ☐ Related to a dental procedure ☐ Related to an STD or HIV/AIDS	☐ Hyperlipidaemia	
	☐ Hypertension	
Name of Clinic and Doctor who had treated the patient for the above comorbidity, if available	☐ Kidney Failure	
	☐ Other Significant Comorbidities that impact the patient's care (Please state):	

B. Best Estimated Costs	**S$**
1. Total Professional Fees Breakdown as:	…… ……

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

TOSP Code and Description:	
Surgeon fees	S$
Anaesthetist fees	S$

2. Total Attendance Fees		……
3. Total of Other Fees (E.g. Secondary treating doctors' fees, surgical implants, medical consumables, and other charges.) Breakdown as:		
a.		S$
b.		S$
c.		S$
d.		S$
		…… …… …
4. Total Hospital Charges		…… …… …
5. Total Bill Size = 1 + 2 + 3 + 4		…… ……

C. Principal Doctor's Declaration & Signature

1. I represent and warrant that:

(a) I have personally examined and treated the Insured (i.e. patient) in respect of the medical condition described above and that the information stated above represent my genuine and honest opinion of his/her condition and my recommended treatment; and

(b) the answers given above are true, accurate and complete to the best of my knowledge and belief and that no information has been withheld.

2. I agree and authorize (name of insurer) to release this medical information, with the patient's consent if such disclosure is required by the Financial Industry Disputes Resolution Centre Ltd (FIDReC) of Singapore or any claim dispute resolution organisation.

Official Stamp of Hospital / Clinic

Name of Doctor: _____

Doctor's MCR: _____

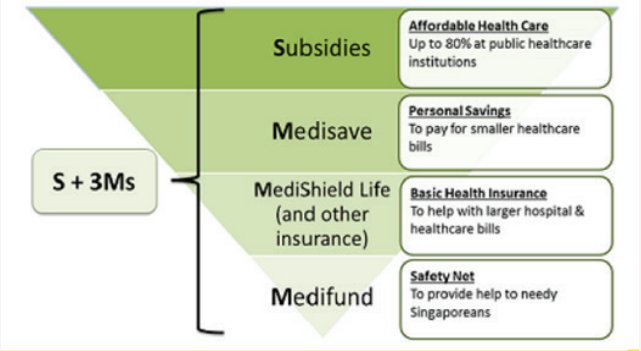
Doctor's Signature and Date: _____

Version 20220117 for implementation from April 2022

Source: https://www.lia.org.sg/media/3278/lia-pre-authorisation-form_-20220117.pdf

CHAPTER 09

HEALTHCARE FINANCING PART I & II

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Singapore government subsidies	• Government provides funding to public healthcare institutions (e.g. public hospitals, national specialty centres and polyclinics), as well as selected private clinics and voluntary welfare organisations (VWOs). • Means-test is used to target subsidies, so that needy patients can receive more help; lower-income patients receive more subsidies than higher-income patients.
Main components of Singapore's Healthcare Financing System	
MediSave	• National healthcare savings scheme in Singapore under the Central Provident Board (CPF) umbrella. • Contributions to the Medisave Account (MA) are subject to a maximum amount, known as the Basic Healthcare Sum (BHS). The BHS is designed to be enough for a CPF member's basic, subsidised healthcare needs in his old age. Hence, amounts in the MA up to the BHS cannot be withdrawn as cash. • Amounts above the BHS will flow to the CPF member's Special or Retirement Accounts to boost his monthly payouts. If the CPF member has already met his Full Retirement Sum, the amounts will flow to his Ordinary Account, and can be withdrawn as cash from the age of 55 years. • Can be used to pay for the CPF member's medical expenses at all accredited institutions, in both the public and private sector. • Can also be used to pay for medical expenses of the CPF member's approved dependents, namely his spouse, children, parents, siblings, and grandparents. If paying for a sibling or grandparent, the patient must be a Singapore Citizen or Singapore Permanent Resident (SPR).

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Uses of MediSave Account</td><td>
<table>
<tr><th>Uses of Medisave</th><th>Items that can be paid using MediSave</th></tr>
<tr><td>Outpatient Treatments</td><td>Selected outpatient treatments such as:
• Approved chronic conditions under the chronic disease management programme
• Vaccinations
• Health screenings</td></tr>
<tr><td>Inpatient Treatments</td><td>Inpatient care which includes:
• Inpatient episodes
• Inpatient psychiatric episodes
• Day surgery
• Assisted Conception Procedures</td></tr>
<tr><td>Long-Term Care</td><td>Long-Term Care treatments which include:
• Rehabilitative care
• Palliative care
• Disability care</td></tr>
<tr><td>Insurance Premiums</td><td>Premium payments of:
• MediShield Life
• ElderShield/CareShield Life
which can be fully paid with MediSave

• Integrated Shield Plans and ElderShield/CareShield Life supplements
which are subject to withdrawal limits periodically reviewed by MOH</td></tr>
</table>
</td></tr>
<tr><td>How much Medisave can be used</td><td>The use of MediSave is subject to:
• Withdrawal Limit.
• Additional Withdrawal Limit (AWL).

Payments via MediSave are allowed in all public healthcare institutions, as well as approved private hospitals and medical institutions</td></tr>
<tr><td>Distribution Of MediSave Upon Demise</td><td>• If a patient was hospitalised just before death and had authorised the use of his MediSave to pay for his medical bill, his MediSave balance would be used in full, without being subject to the existing MediSave withdrawal limits, to pay for his last inpatient medical bill.
• If the patient had not authorised the use of his MediSave before his demise, his immediate family member (spouse, parent, or child who is aged 21 years and above), or donee or deputy can also do so for the last inpatient medical bill, provided that it has not been paid out to the patient's nominated beneficiaries.
• In the event that the patient does not have any immediate family member, or donee or deputy to authorise the use of the patient's MediSave, a relative who has been taking care of the patient may also write to MOH through the hospital to seek approval for the relative to authorise the withdrawal of patient's MediSave, to pay for the last inpatient medical bill.
• Remaining MediSave balance, after the payment of the last medical bill, would be distributed to the nominated beneficiaries of the patient's CPF account if a nomination was made before his death. If there was no nomination made, the balance in the deceased patient's MA would be distributed by the Public Trustee to his family members under the intestacy laws for non-Muslims, or the Muslim inheritance law for Muslims.</td></tr>
</table>

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
MediShield Life	• Basic healthcare insurance scheme. • Covers all Singapore Citizens and Singapore Permanent Residents against large medical bills for life, regardless of age or health conditions. • The claim limits are sized to cover subsidised bills incurred for hospitalisation in class B2/C wards, day surgery, and selected costly outpatient treatments (e.g., dialysis and chemotherapy) in the public hospitals. • However, MediShield Life benefits are designed based on Class B2/C bills, so as to keep premiums affordable. Those who would like additional coverage in Class A/B1 wards or private hospitals may consider buying Integrated Shield Plans (IP). • No need to apply for MediShield Life. All SCs and PRs are automatically covered under MediShield Life from 1 Nov 2015. New SCs are covered from birth or from the day they attain citizenship. PRs are covered from the day they attain permanent residency. • MediShield Life premiums may be fully paid from MediSave. • Please refer to the Study Text for a list of treatment items, procedures, conditions, activities which are not covered by MediShield Life and cannot be claimed.
MediShield Life Premiums	• Actuarially priced based on the health risks and expected healthcare utilisation of each age group so that each age group's payouts are broadly supported by their own premiums. • Those with pre-existing medical conditions can enjoy coverage for their conditions. Only those with serious pre-existing medical conditions listed in the MOH website need to pay a nominal Additional Premium of 30% for the first 10 years, in addition to the standard MediShield Life premiums. • One can pay premiums from own MediSave, or family members may pay one's premium using their MediSave. Parents may also tap on the MediSave Grant for newborns to pay for their child's MediShield Life premiums.
How Are MediShield Life Claim Payouts Computed?	• Pays on a reimbursement basis, subject to the claim limits imposed on the covered medical expenses, as well as deductible, co-insurance and pro-ration factors. • The deductible is the fixed amount payable by the insured each policy year (the year following his policy renewal month), before the MediShield Life payout starts. The deductible is payable only once every policy year. • Co-insurance is the patient's share of the claimable amount which the insured will have to pay, along with the deductible. Please refer to the Study Text for example of how the reimbursement under MediShield Life is arrived at.
Integrated Shield Plans	Integrated Shield Plans (IPs) are MediSave-approved hospitalisation insurance plans made up of two parts. • MediShield Life component administered by the CPF Board. • An additional private insurance coverage component administered by approved private insurers, typically to cover Class A/B1 wards of public hospitals or private hospitals. No duplication of coverage between IPs and MediShield Life.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Consideration on Integrated Shield Plans (IP)</td><td>
• With the different IPs available, it is necessary for the sellers of such plans to understand the different plans offered in the insurance market, and to advise their prospective clients, based on the needs and long-term affordability of each individual client's position.
• As part of due diligence, clients should be informed of the key differences in premiums, benefits, exclusions, deductibles, co-insurance and other co-payment features between the various IPs offered by their insurer, versus MediShield Life. There are different benefits provided in the IP policy, and plans can be "as charged" or "non -as-charged" (i.e. they have sub-limits imposed). Information provided should be easy to understand, unambiguous and clearly explained to help clients make an informed decision.
• Clients should consider if they would wish to stay in a private or subsidised ward in a public hospital, or in a private hospital, and if they wish to choose their own doctors.
• Clients should consider if they can afford their IP premiums in the long term as the policyholders may have to pay a substantial portion of their IP premiums in cash, especially at the older ages.
• Unlike MediShield Life which provides coverage for pre-existing medical conditions (with Additional Premiums for the first 10 years), the coverage for the private insurance component of the IP may be declined or imposed with exclusions for pre-existing conditions. The private insurance component may also have premium loading, arising from pre-existing conditions.
</td></tr>
<tr><td>How MediSave can be used to meet a CPF member's healthcare needs and buy approved Medical Expense Insurance?</td><td>
MediSave can be used to pay premiums for IPs, either in full or in part, depending on the age group and the IP plan type. From 1 November 2015, MediSave use for the additional private insurance component of the IP premiums is subject to the new Additional Withdrawal Limit (AWL). The AWL is set per insured person per policy year, as stated below:
• Age Next Birthday (ANB) 40 years and below: S$300
• ANB 41 to 70 years: S$600
• ANB 71 years and above: S$900
</td></tr>
<tr><td>How MediShield Life premiums are kept affordable?</td><td>
• Premium Subsidies for lower- to middle-income.
• Pioneer and Merdeka Generation Subsidies.
• COVID-19 Subsidies.
• Additional premium support.
</td></tr>
<tr><td>How MediShield Life interacts with Integrated Shield Plans?</td><td>
<table>
<tr><th>MediShield Life Scheme</th><th>Integrated Shield Plan (IP)</th></tr>
<tr><td>It is administered by the CPF Board</td><td>It is administered by private insurers, as approved by MOH.</td></tr>
<tr><td>Its coverage is sized for stays in Class B2/C wards of public hospitals.</td><td>It provides for enhanced coverage beyond MediShield Life, with various plan types available for stays in private hospitals and/or Class A/B1 wards of public hospitals.</td></tr>
<tr><td>It covers all pre-existing conditions.</td><td>Coverage for the private insurance component of the IP may be declined or imposed with exclusions and/or premium loading, arising from pre-existing conditions.</td></tr>
<tr><td>There is no minimum or maximum age limit.</td><td>It may have a minimum or maximum entry age limit.</td></tr>
<tr><td>There are sub-limits applicable.</td><td>It may have sub-limits, although most do not have sub-limits.</td></tr>
<tr><td>MediShield Life premiums are fully payable by MediSave.</td><td>MediShield Life component of the IP is fully payable by MediSave, while private insurance component of the IP is payable by MediSave up to Additional Withdrawal Limit, and the remainder is payable by cash.</td></tr>
<tr><td>All Singapore Citizens and Permanent Residents are automatically covered for life. No application is required.</td><td>Application to private insurers is required.</td></tr>
</table>
</td></tr>
</table>

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Standard IP	• "No frills" product targeted at covering large Class B1 ward hospital bills and selected outpatient treatments. • Affordable option for Singapore Citizens and Permanent Residents who want additional coverage beyond MediShield Life and may find other higher coverage IPs too expensive.
Riders	• Pay for the co-insurance and deductible portion of the IP, and may pay cash payouts upon hospitalisation.
Need for Co-Payments	• Co-payment is an important principle in the design of healthcare insurance. It encourages policyholders and their doctors, to consider the necessity of the medical treatment and its cost, so that they can make an informed decision on the appropriate healthcare services. This encourages prudence and keeps healthcare cost, and health insurance premiums, affordable and sustainable in the long term.
Terminating or Switching IP/Switching Insurer	• An IP policyholder who cannot afford, or does not wish to continue paying the premium for his IP, can switch his plan to a lower coverage plan within the same insurer at any point in time, without additional underwriting involved. • He can also terminate his IP at any point in time, and still be covered by MediShield Life which provides basic health insurance, regardless of any pre-existing conditions. • If the person with an existing IP switches to a new IP with another insurer, Original IP with the previous insurer will be automatically terminated. • Option to go back to the previous insurer within 30 days from the date of notification of termination from the previous insurer.
Risk-Loading by private insurers	• MOH allows IP insurers to risk-load insured members with pre-existing conditions for the private insurance component of the IPs.
Benefits in having Pre-Authorisation for IP	• Insurers can assess the medical necessity and cost of treatment to ensure it is within the terms and conditions of the policy's coverage. • Patients will have a peace of mind in knowing that their procedure is within their insurance coverage; and • Healthcare providers have better clarity on the type of procedures covered by insurance to better advise their patients prior to the actual procedure. Policyholders are thus encouraged to seek pre-authorisation for planned procedures as far as possible if the option is provided by the insurer.
Claims process of MediShield Life, Integrated Shield Plans, other Medical Expense Insurance and MediSave	Any insured CPF member who wishes to claim from his MediShield Life, IP and/or MediSave will need to complete the Medical Claims Authorisation Form to: • Allow the hospital to claim from his insurer; and • Instruct the CPF Board to deduct from his MA to pay for his hospital bill, while the insurer settles the claim. For any insured CPF member who wants to claim from MediShield Life, IP and/or MediSave, the hospital will submit the claim on his behalf through the MediClaim online system after he has been discharged. If there is no pre-authorisation, the insured CPF member under an IP can approach the hospital to trigger a request for a Letter of Guarantee (LOG) from his insurer upon hospital admission. It is important that the insured CPF member understands that a LOG may not mean that the insurer will pay for the specified amount. To obtain assurance that their bill will be covered, the insured CPF member may wish to apply for pre-authorisation instead, if available. For someone who is covered by his employer medical benefits or other private insurance plans, he will need to show his insurance card (provided by some insurers for certain Medical Expense Insurance plans) to the hospital admission staff. The hospital may fully or partially waive the deposit in such a case. • Some hospitals will send the hospitalisation bill directly to the CPF member's non-IP private insurer or employer. In other cases, the insured CPF member will have to submit the bill himself to the insurer.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Withdrawal Limits for Inpatient, Outpatient, Long-Term Care and Insurance Premiums	Please refer to the Study Text for the full list.
MediShield Life Benefits	Please refer to the Study Text for the full list.
ElderShield & ElderShield Supplements	ElderShield is a long-term care insurance scheme launched in September 2002. It provides basic financial protection to those who need long-term care, especially during old age. ElderShield Supplement plans complement the current ElderShield scheme, by offering additional benefits at different pricing levels which increase the insured's coverage through: • Increasing the monthly payout; • Extending the payout period; or • A combination of both.
How ElderShield and ElderShield Supplements work?	• To purchase and maintain an ElderShield Supplement, an insured must have an ElderShield policy. • Premiums for ElderShield Supplement can be paid using MediSave (up to a limit of S$600 per insured per calendar year) and/or by cash. • The ElderShield scheme will pay a monthly benefit of either S$300 up to 60 months, or S$400 up to 72 months, depending on the type of the scheme in which the CPF member is covered.
Eligibility Criteria For Payment Of ElderShield benefits	• Meets the waiting period requirement. • Unable to perform the specified number of activities of daily living • Meets the deferment period requirement (If he recovers from the disability within the period, then no benefits are payable). • Please also note on making a claim under ElderShield and how the benefits are paid.
Features of ElderShield	• Non-forfeiture feature. • Guaranteed renewability on an annual basis. • Worldwide coverage. • Minimum (i.e. 40 years old) and maximum entry age (i.e. 64 years old). • Grace period of 75 days is allowed for payment of the overdue premiums. • Reinstatement of the policy is allowed within 180 days from the expiry of the grace period, subject to evidence of insurability at the insured's expense and payment of the overdue premiums with interest. • Insurer has the right to appoint an assessor to examine the insured periodically. • Where the insured is overseas at the time of a claim, the insurer has the right to commute the benefit payments to a single payment reflecting the present value of future benefit payments, or withhold the claim payment if it is unable to assess the claim after having made reasonable attempts to do so. • No cash surrender value. • Free-look period of 60 days from the policy commencement date during which the insured may cancel his policy, and receive a full refund of the premiums paid.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Exclusions of ElderShield	• Self-inflicted injury, suicide or attempted suicide; • Alcoholism or drug addiction; or • War, whether declared or undeclared. • CPF members who are suffering from pre-existing disabilities, will not be covered under ElderShield.
Termination of cover for ElderShield	• Expiry of the grace period if the ElderShield policy is not eligible for the non-forfeiture benefit (i.e. it has been in force for too short a period for it to acquire sufficient reserves to be converted into a paid-up policy); • Death of the insured; • Date in which the last benefit payment has been received; or • Date in which the written notice from the insured to cancel the policy is received by the insurer (if the policy does not have sufficient reserves, it will not be converted into a paid-up policy).
ElderShield to CareShield Life	• ElderShield became a closed scheme from 1 August 2021. • The Government had taken over the ElderShield administration from 1 November 2021. • New cohorts born in 1980 or later were covered under CareShield Life from 1 Oct 2020 but Singapore Citizens and SPRs born in 1979 or earlier could still opt in to the ElderShield scheme up till 1 Aug 2021 if they are below 65. • Existing ElderShield policyholders could continue to remain covered under the scheme with no changes to their coverage and benefits.
CareShield Life & CareShield Life Supplements	CareShield Life was introduced in 2020, as an enhancement of ElderShield and is administered by the Government on a not-for-profit basis, and offers; • Better protection and higher payouts that increase over time, so that claimants can better afford their basic long-term care needs; and • Protection for life. Any CareShield Life policyholder who wishes to obtain higher long-term care insurance coverage can also purchase Supplements. Supplements are plans which complement one's basic CareShield Life plan by offering additional benefits, such as higher monthly payout amounts, which enhances the coverage.
CareShield Life premium subsidies and support	To ensure that no one will lose CareShield Life coverage due to genuine inability to pay, the Government provides the following premium subsidies and support: • Means-tested premium subsidies of up to 30% of premiums of CareShield Life, to help lower- to middle-income households. • Participation incentives of up to $2,500 for Singapore Citizens, if they join CareShield Life by 31 December 2023, to encourage those born in 1979 or earlier to join CareShield Life. • Additional participation incentives of $1,500 for Merdeka and Pioneer Generation citizens if they join CareShield Life by 31 December 2023. • Additional Premium Support for Singaporeans who are unable to pay their CareShield Life premiums even after premium subsidies, so that no one will lose coverage under CareShield Life due to genuine inability to pay premiums.
Enhanced benefits under CareShield Life	CareShield Life features higher payouts that increase over time with no cap on payout duration, to provide better protection against the uncertainty of long-term care costs in the event of severe disability. • Lifetime cash payouts for as long as the policyholder is severely disabled. • Payouts increase until age 67 or when a claim is made, whichever is earlier, with payouts starting at S$600 per month in 2020.
CareShield Life Premiums	• The CareShield Life scheme makes use of pre-funded premiums i.e. the insured CPF members pay more than the cost of their health risk, while they are younger, to cover for the higher risk in their later years. • For Singapore Residents born 1980 or later (future cohorts), premiums are paid from the age of enrolment until age 67. Premiums will increase over time, to support payout increases. • Singapore Residents born in 1979 or earlier (existing cohorts) will pay a base premium. • Fully payable by MediSave.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Eligibility Criteria for Payment of CareShield Life Benefits</td><td>Similar to that of ElderShield.</td></tr>
<tr><td>Other key features of CareShield Life</td><td>• Guaranteed renewable on an annual basis.
• Worldwide coverage.
• Minimum entry age of 30 years old, but no maximum entry age.
• CareShield Life policy will be terminated if the insured is no longer a Singapore Citizen or SPR.
• No cash surrender value.</td></tr>
<tr><td>Other healthcare financing schemes set up by the Singapore government</td><td>• Pioneer Generation Package;
• Merdeka Generation Package;
• Interim Disability Assistance Programme For The Elderly (IDAPE);
• ElderFund and
• Medifund.
• COVID-19 Medical Bills</td></tr>
<tr><td>Interim Disability Assistance Programme For The Elderly (IDAPE)</td><td>• IDAPE was launched by the Government to take care of Singaporeans who were not eligible to join the ElderShield scheme, when it was launched in September 2002, either because they exceeded the maximum entry age or they had a pre-existing disability.

Singaporean will qualify for IDAPE if:
• He is unable to perform three or more of the 6 Activities of Daily Living (ADL) - washing, feeding, dressing, toileting, mobility and transferring.
• He is a Singapore citizen born before 30 September 1932 OR born between 1 October 1932 and 30 September 1962 (both dates inclusive) but with pre-existing disabilities as at 30 September 2002.
• His per capita household monthly income is $2,800 or less OR he has no household income and is living in a residence with Annual Value of $13,000 and below.</td></tr>
<tr><td>IDAPE Payout</td><td><table><tr><th>Per Capita Household Income*</th><th>IDAPE Payout
(With Effect From 1 July 2013)</th></tr><tr><td>(a) S$0 to S$2,000</td><td>(a) S$250 per month for up to 72 months</td></tr><tr><td>(b) S$2,001 to S$2,800</td><td>(b) S$150 per month for up to 72 months</td></tr></table>*An IDAPE applicant from a household with no income will qualify for the S$250 monthly payout if the annual value of his place of residence is S$13,000 or lower.</td></tr>
<tr><td>ElderFund</td><td>ElderFund is a discretionary assistance scheme launched on 31 January 2020. It is targeted at severely disabled lower-income Singapore Citizens aged 30 and older, who are not able to benefit from CareShield Life, ElderShield, and the Interim Disability Assistance Programme for the Elderly (IDAPE), have low MediSave balances and have inadequate personal savings to meet their long-term care needs.</td></tr>
<tr><td>MediFund</td><td>MediFund is an endowment fund set up by the Government. It provides a safety net for needy Singaporeans who face difficulties paying for their remaining healthcare bills after Government subsidies, insurance and MediSave.</td></tr>
</table>

CHAPTER 9

PART II
HEALTHCARE FINANCING

CHAPTER OUTLINE

6. ElderShield & ElderShield Supplements
7. CareShield Life & CareShield Life Supplements
8. Other Healthcare Financing Schemes Set Up By The Singapore Government

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- describe how ElderShield and ElderShield Supplements work
- explain the shift from ElderShield to CareShield Life
- describe the enhanced benefits under CareShield Life
- describe other healthcare financing schemes set up by the Singapore Government:
  - Pioneer Generation Package
  - Merdeka Generation Package
  - Interim Disability Assistance Programme for the Elderly (IDAPE)
  - ElderFund
  - MediFund
  - COVID-19 Medical Bills paid by the Singapore Government

Contents

CHAPTER OUTLINE 203
LEARNING OUTCOMES 203
6. ELDERSHIELD & ELDERSHIELD SUPPLEMENTS 205
A. Eligibility Criteria For Payment Of ElderShield Benefits 206
A1. Meets The Waiting Period Requirement 206
A2. Unable To Perform The Specified Number Of Activities Of Daily Living As Defined 206
A3. Meets The Deferment Period Requirement 207
B. How To Make A Claim Under ElderShield? 207
C. How Are ElderShield Benefits Paid? 207
D. Non-Forfeiture Feature 208
E. Other Key Features Of ElderShield 208
F. Exclusions 208
G. Termination Of Cover 209
H. Government Administration of ElderShield 209
7. CARESHIELD LIFE AND CARESHIELD LIFE SUPPLEMENTS 210
A. Coverage 211
B. Benefits Under CareShield Life 211
C. CareShield Life Premiums 212
D. Pioneer and Merdeka Generation Incentives 213
E. Eligibility Criteria for Payment of CareShield Life Benefits 214
E1. Unable To Perform The Specified Number Of Activities Of Daily Living As Defined 214
E2. Meets The Deferment Period Requirement 214
F. How to Make a Claim Under CareShield Life? 214
G. Other Key Features of CareShield Life 214
8. OTHER HEALTHCARE FINANCING SCHEMES SET UP BY THE SINGAPORE GOVERNMENT 215
A. Pioneer Generation Package 215
A1. Outpatient Care 215
A2. MediShield Life 215
A3. MediSave Top-ups 215
A4. Pioneer Generation Disability Assistance Scheme 216
A5. CareShield Life 216
B. Merdeka Generation Package 216
B1. Passion Silver Card Top-Ups 216
B2. MediSave Top-Ups 217
B3. Outpatient Care 217
B4. MediShield Life 217
B5. CareShield Life 217
C. Interim Disability Assistance Programme For The Elderly (IDAPE) 217
D. ElderFund 218
E. MediFund 219
F. COVID-19 Medical Bills 219

6. ELDERSHIELD & ELDERSHIELD SUPPLEMENTS

6.1 ElderShield is a long-term care insurance scheme launched in September 2002. It provides basic financial protection to those who need long-term care, especially during old age.

6.2 Unlike MediShield Life, which is compulsory for all, ElderShield is an opt-out scheme. That means that all Singaporeans and Permanent Residents (PRs) can choose to opt-out of the insurance scheme if they wish to. For new cohorts born in 1980 and after, they would be enrolled into CareShield Life instead of ElderShield on 1 Oct 2020 or when they turned 30, whichever is later. Those born in 1979 or earlier have the option to enroll in CareShield Life.

6.3 Premiums can be paid fully through MediSave. There are currently two ElderShield schemes, namely ElderShield300 and ElderShield400. ElderShield300 was launched on 30 September 2002 offering a cash payout of S$300 per month for a maximum of 60 months. ElderShield400 was introduced in 2007 offering an improved coverage with cash payout of S$400 per month for a maximum of 72 months. Singapore Citizens and SPRs who join ElderShield after 30 September 2007 will be on the ElderShield400 scheme.

6.4 Before 1 November 2021, the Government had appointed three private insurers, Aviva Ltd (now known as Singlife with Aviva), Great Eastern Life Assurance Co Ltd and Income Insurance Limited, to offer ElderShield. Any CPF member who is a Singapore Citizen or SPR and who attains the age of 40 years is automatically covered under the scheme if he/she does not opt out. No registration or medical assessment is needed. SCs or SPRs between the ages of 40 and 64 can also choose to opt in to the ElderShield scheme, but with medical underwriting.

6.5 The Government had taken over the ElderShield administration from 1 November 2021 and ElderShield had become a closed scheme from 1 August 2021 onwards. New cohorts born in 1980 or later were covered under CareShield Life from 1 Oct 2020 (more details in Section 7 of this Chapter), but Singapore Citizens and SPRs born in 1979 or earlier could still opt in to the ElderShield scheme up till 1 Aug 2021 if they are below 65. Existing ElderShield policyholders could continue to remain covered under the scheme with no changes to their coverage and benefits.

6.6 It should be noted that any existing ElderShield insured who wishes to obtain higher severe disability insurance coverage can purchase ElderShield Supplements. ElderShield Supplement plans complement the current ElderShield scheme, by offering additional benefits at different pricing levels which increase the insured's coverage through:

(a) increasing the monthly payout;

(b) extending the payout period; or

(c) a combination of both.

6.7 To purchase and maintain an ElderShield Supplement, an insured must have an ElderShield policy. Premiums for ElderShield Supplement can be paid using MediSave (up to a limit of S$600 per insured per calendar year) and/or by cash. As ElderShield and ElderShield Supplements are structured as stand-alone policies, claims can be made under both policies if the insured fulfils the claim eligibility criteria. The Supplement plans are only offered by the three approved insurers who were administering ElderShield prior to 1 November 2021.

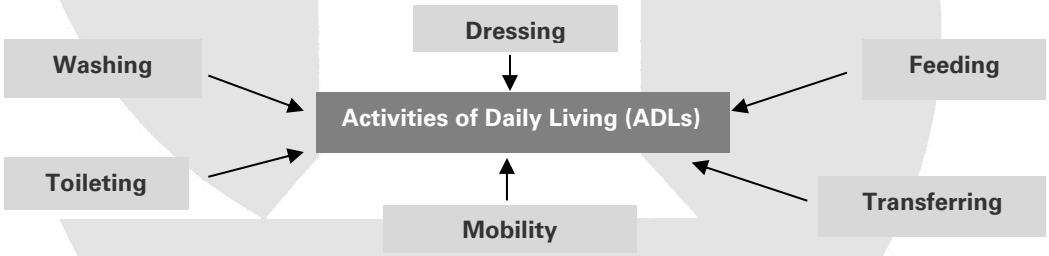
A. Eligibility Criteria For Payment Of ElderShield Benefits

A1. Meets The Waiting Period Requirement

6.8 There is a waiting period of 90 days from the policy commencement date. The benefit will not be payable if the insured becomes disabled in the first 90 days of coverage. Instead, the insurer will terminate the policy and refund all the premiums paid. However, the waiting period does not apply if the disablement is due solely to an accident. The waiting period is waived for policyholders who were auto enrolled.

A2. Unable To Perform The Specified Number Of Activities Of Daily Living As Defined

6.9 The ElderShield scheme will pay a monthly benefit of either S$300 up to 60 months, or S$400 up to 72 months, depending on the type of the scheme in which the CPF member is covered. It pays the benefits if the insured is unable to perform at least three of the six Activities of Daily Living (ADLs) as illustrated in the diagram below:



6.10 The ADLs are defined as below:

(a) **Washing** – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash by other means.

(b) **Dressing** – the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical and medical appliances.

(c) **Feeding** – the ability to feed oneself after the food has been prepared and made available.

(d) **Toileting** – the ability to use the lavatory or manage bowel and bladder function through the use of protective undergarments (e.g. diapers) or surgical appliances (e.g. urinary catheters) if appropriate.

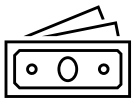
(e) **Mobility** – the ability to move indoors from room to room on level surfaces.

(f) **Transferring** – the ability to move from a bed to an upright chair or wheelchair, and vice versa.

A3. Meets The Deferment Period Requirement

6.11 There is a deferment period of 90 days starting from the claim date, i.e. the date that the claim application is received by the AIC. If the insured is still disabled after this period, he will then be eligible for the benefit, provided that he satisfies the other conditions as specified in the policy. If he recovers from the disability within the period, then no benefits are payable.

6.12 However, the deferment period will not apply if the insured suffers a relapse from the same cause within 180 days of recovery, provided that he has been disabled for at least 90 days during the first disability.



B. How To Make A Claim Under ElderShield?

6.13 To make a claim, the insured needs to complete a claim form. In the event that he is not able to complete it on his own, his immediate family member or caregiver may do so on his behalf.

6.14 Next, he has to make an appointment with an MOH-accredited severe disability assessor to have a disability assessment done. The assessor will then complete the assessment form and return it to the insurer for processing. The list of accredited assessors can be found on the Agency for Integrated Care (AIC)'s website.

6.15 It will cost S$100 for an assessment at the assessor's clinic, and S$250 if the insured requires the assessor to make a house call. The fees for the initial or subsequent assessments will be reimbursed to the insured, by the insurer, if the claim is assessed to be payable.

C. How Are ElderShield Benefits Paid?

6.16 As mentioned earlier, the ElderShield benefits are payable on a monthly basis. The premium under the policy will be waived during the benefit payout period. If an insured recovers from his disability, the monthly cash payout will stop and the premium payment will re-commence. However, if he becomes disabled again some years later, he can still make a claim under his policy, as long as he has not claimed more than 60 months or 72 months in total, depending on the ElderShield plan under which the insured is covered. The cash payout under this scheme is not tied to institutional care, and can be used to pay for any expenses, such as home nursing services, nursing home stay, day rehabilitation, medical bills, or household expenses, etc.

D. Non-Forfeiture Feature

6.17 ElderShield premiums are pre-funded. This enables the policy to acquire a reserve. The accumulated reserve enables the insured to enjoy reduced benefits (i.e. the policy will be converted into a paid-up policy) if he decides to stop paying his premiums after the policy has been in force for a number of years.

6.18 For example, an insured who joins ElderShield at the age of 40 years will be eligible for a reduced benefit of around S$100 per month if he decides to stop paying his premiums 11 years after the policy has been in force.

E. Other Key Features Of ElderShield

6.19 The other key features of the ElderShield scheme are described below:

(a) It is guaranteed renewability on an annual basis.

(b) It provides worldwide coverage.

(c) It has minimum (i.e. 40 years old) and maximum entry age (i.e. 64 years old).

(d) A grace period of 75 days is allowed for payment of the overdue premiums.

(e) Reinstatement of the policy is allowed within 180 days from the expiry of the grace period, subject to evidence of insurability at the insured's expense and payment of the overdue premiums with interest.

(f) The insurer has the right to appoint an assessor to examine the insured periodically.

(g) Where the insured is overseas at the time of a claim, the insurer has the right to commute the benefit payments to a single payment reflecting the present value of future benefit payments, or withhold the claim payment if it is unable to assess the claim after having made reasonable attempts to do so.

(h) There is no cash surrender value.

(i) There is a free-look period of 60 days from the policy commencement date during which the insured may cancel his policy and receive a full refund of the premiums paid.

F. Exclusions

6.20 The ElderShield policy does not cover any disability arising directly or indirectly, wholly or partly, from any one of the following occurrences:

(a) self-inflicted injury, suicide or attempted suicide;

(b) alcoholism or drug addiction; or

(c) war, whether declared or undeclared.

6.21 CPF members who are suffering from pre-existing disabilities, will not be covered under ElderShield.

G. Termination Of Cover

6.22 The cover under the ElderShield policy will be terminated upon the happening of any one of the following events:

(a) expiry of the grace period if the ElderShield policy is not eligible for the non-forfeiture benefit (i.e. it has been in force for too short a period for it to acquire sufficient reserves to be converted into a paid-up policy);

(b) death of the insured;

(c) date in which the last benefit payment has been received; or

(d) date in which the written notice from the insured to cancel the policy is received by the insurer (if the policy does not have sufficient reserves, it will not be converted into a paid-up policy).

H. Government Administration of ElderShield

6.23 From 1 November 2021, the Government has taken over the administration of ElderShield from private insurers (Singlife with Aviva, Great Eastern Life Assurance Co Ltd, and Income Insurance Limited). This allowed ElderShield policyholders to upgrade to CareShield Life more smoothly, and benefit from improvements to the claims assessment process that is being implemented for CareShield Life.

6.24 ElderShield policyholders that did not upgrade to CareShield Life remains covered by their existing ElderShield policies. The Government administers the ElderShield scheme on a not-for-profit basis. In the event that the actual claims experience turns out better than expected, there will continue to be premium rebates for ElderShield policyholders.

6.25 Holders of ElderShield Supplements were not affected. They continue to be served by their existing ElderShield Supplement insurers.

6.26 With the launch of CareShield Life for existing cohorts on 6 November 2021, ElderShield no longer accepted new applications.

7. CARESHIELD LIFE AND CARESHIELD LIFE SUPPLEMENTS

7.1 CareShield Life was introduced in 2020, as an enhancement of ElderShield and is administered by the Government. As Singapore's population ages and more people need long-term care, the role of risk-pooling via insurance was strengthened to help Singaporeans better prepare for their long-term care needs.

7.2 CareShield Life provides worldwide coverage with lifetime payouts. Singaporeans will continue to be covered for life once they have completed paying all their premiums, which will happen in the year they turn age 67 or 10 years after they join the scheme, whichever is later. Regardless of the place of residence, Singaporeans will remain covered, and be able to make a claim and receive payouts, if they are severely disabled and continue to pay their premiums.

7.3 In order to make a claim, the insured needs to be assessed by a MOH-accredited severe disability assessor as being unable to perform at least three out of the six Activities of Daily Living (ADLs).

7.4 CareShield Life is administered by the Government on a not-for-profit basis, and offers:

- better protection and higher payouts that increase over time, so that claimants can better afford their basic long-term care needs;
- protection for life;

7.5 To ensure that no one will lose CareShield Life coverage due to genuine inability to pay, the Government provides the following premium subsidies and support:

- Means-tested premium subsidies of up to 30% of premiums of CareShield Life, to help lower- to middle-income households.
- Participation incentives of up to $2,500 for Singapore Citizens, if they join CareShield Life by 31 December 2023, to encourage those born in 1979 or earlier to join CareShield Life.
- Additional participation incentives of $1,500 for Merdeka and Pioneer Generation citizens if they join CareShield Life by 31 December 2023.
- Additional Premium Support for Singaporeans who are unable to pay their CareShield Life premiums even after premium subsidies, so that no one will lose coverage under CareShield Life due to genuine inability to pay premiums.

7.6 ElderShield became a closed scheme from 1 August 2021. However, existing ElderShield300 and ElderShield400 policyholders can continue participating in the ElderShield scheme with no change to their benefits and coverage, unless they choose to join CareShield Life.

7.7 It is important to note that any CareShield Life policyholder who wishes to obtain higher long-term care insurance coverage can also purchase Supplements. Supplements are plans which complement one's basic

CareShield Life plan by offering additional benefits, such as higher monthly payout amounts, which enhances the coverage.

7.8 An insured must have a CareShield Life or ElderShield policy in order to purchase a Supplement (might vary by insurer). Premiums for Supplements can be paid using MediSave (up to a limit of S$600 per insured per calendar year) and/or by cash. As CareShield Life and Supplements are structured as stand-alone policies, claims can be made under both policies if the insured fulfils the claim eligibility criteria. The Supplement plans are currently only offered by the three insurers (Great Eastern, Income Insurance Limited , Singlife with Aviva) who were previously administering ElderShield.

A. Coverage

7.9 For Singapore Citizens and SPRs born in 1980 or later, CareShield Life is compulsory. There is no need to apply for CareShield Life. They will be automatically covered on their 30th birthday or when the scheme was launched in October 2020, whichever is later, even if they have pre-existing disabilities. The following are worth noting:

- There was a one-time enrollment of Singapore Citizens and SPRs born between 1980 and 1989 (i.e. age 31 to 40 in 2020).
- Similarly, Singapore Citizens and SPRs born in 1980 or later will be automatically covered under CareShield Life regardless of their disability status.

7.10 For Singapore Citizens and SPRs born in 1979 or before , joining CareShield Life is optional. They can choose to apply to join CareShield Life from 6 November 2021 onwards as long as they do not have any pre-existing severe disability. They can still join the scheme if they have pre-existing conditions (e.g. diabetes, hypertension). There is no age limit to join CareShield Life. However, once they join CareShield Life, they will not be able to leave the scheme after the 60-day free look period expires. The following are worth noting:

- To increase the convenience of joining, Singapore Citizens and SPRs born between 1970 and 1979, and who are insured under ElderShield400, had been auto-enrolled into CareShield Life from 1 December 2021. They have up to 31 December 2023 to opt-out of the scheme. If they opt-out, they will be reinstated onto ElderShield400.
- Unlike existing Singapore Citizens and SPRs born in 1979 or before, new Singapore Citizens and SPRs will be mandated to join CareShield Life, as long as they do not have any pre-existing severe disability.

B. Benefits Under CareShield Life

7.11 CareShield Life features higher payouts that increase over time with no cap on payout duration, to provide better protection against the uncertainty of long-term care costs in the event of severe disability. The following points are worth noting:

- Lifetime cash payouts are given for as long as the policyholder is severely disabled

- Payouts increase annually until age 67 or when a successful claim is made, whichever is earlier, with payouts starting at S$600 per month in 2020

7.12 For more details on the estimated monthly payouts applicable, please refer to https://www.moh.gov.sg/careshieldlife/about-careshield-life

C. CareShield Life Premiums

7.13 The CareShield Life scheme makes use of pre-funded premiums i.e. the insured CPF members pay more than the cost of their health risk, while they are younger, to cover for the higher risk in their later years. Insured CPF members will pay premiums until the year they turn age 67 or for 10 years, whichever is longer, but will remain insured for life, even after completion of the premium payments. Premiums are not guaranteed and are subject to review. The premiums are fully payable by MediSave.

7.14 For Singapore Residents born 1980 or later (future cohorts), premiums are paid from the age of enrolment until age 67. Premiums will increase over time, to support payout increases. For the first five years of CareShield Life's implementation, payouts and premiums will both increase by 2% per year. Beyond 2025, an independent CareShield Life council will advise the Government on premium and payout adjustments based on actuarially sound adjustment framework.

7.15 Singapore Residents born in 1979 or earlier (existing cohorts) will pay a base premium. The base premium is generally paid from the age of enrolment until age 67, but Singapore residents who join at age 59 or older in 2021 will be able to spread their catch-up premiums over 10 years, beyond age 67. Other points in this regard are as follows:

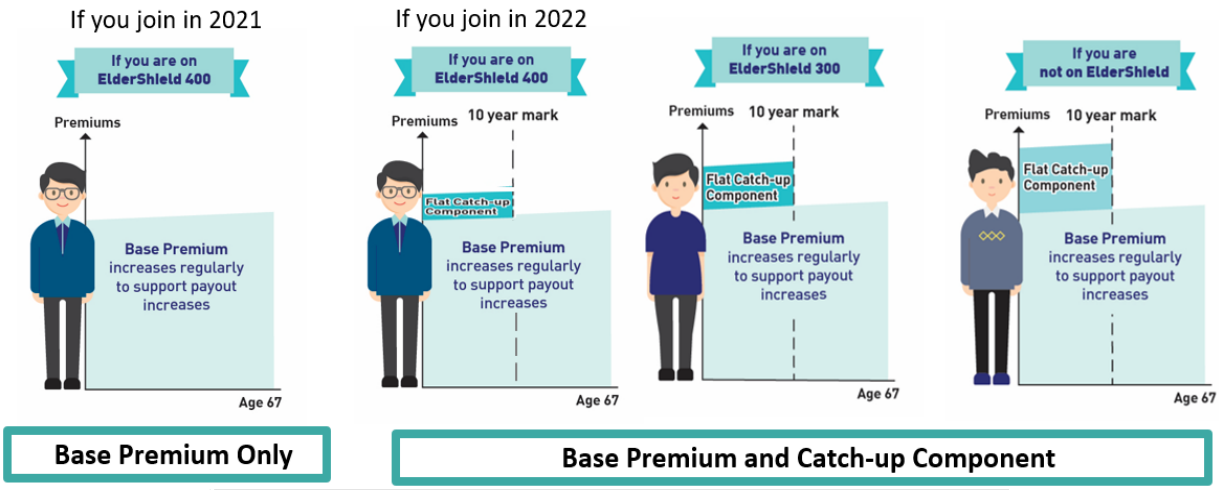
- Base premiums will increase over time to support payout increases, until the year policyholders turn 67. Premiums and payouts do not increase after the year policyholders turn 67. For the first five years of CareShield Life's implementation, payouts and base premiums for policyholders age 67 and below will both increase by 2% per year.

- ElderShield 400 policyholders who have been consistently on an ElderShield policy (i.e. never opted out, or upgraded from ElderShield 300 to ElderShield 400 in 2007 when they had the chance to) will only pay the base premium each year, if they join CareShield Life in 2021.

- Other groups, including existing ElderShield 300 policyholders, existing ElderShield 400 policyholders who joined later than 2021 as well as those not insured under ElderShield, will need to pay an additional catch-up component (which differs for each group), as they would not have paid as much premiums as those in their same cohort who are insured under the ElderShield 400 scheme and joined in 2021. The catch-up component will be paid over 10 years and will remain flat.

  The diagram below further illustrates the points highlighted above.

Illustration of Base Premium and Catch-up Component Payable by Singapore Residents from Existing Cohorts who join CareShield Life



Note: Existing Cohorts who join CareShield Life at age of 59 or older will end their premium payment after age 67 as they will have a 10-year premium payment term.
Diagram not drawn to scale

7.16 Singapore Residents may obtain estimates of the premiums and subsidies through the online premium calculator, available at www.careshieldlife.sg.

7.17 CareShield Life premiums can be fully payable by MediSave. Subsidies and support are available to make sure the premiums remain affordable, so the insured does not need to worry about losing coverage if he/she has an genuine inability to pay premiums.

D. Pioneer and Merdeka Generation Incentives

7.18 Pioneer and Merdeka Generation seniors who join CareShield Life by 31 Dec 2023, will receive additional Pioneer Merdeka Generation incentives of S$1,500, spread over 10 years (total incentives of S$4,000 for MG and PG members).

7.19 Pioneer Generation Seniors refer to living Singapore Citizens born on or before 31 December 1949 and obtained citizenship on or before 31 December 1986. Merdeka Generation Seniors refers to:

(i) living Singapore Citizens who were born from 1 January 1950 to 31 December 1959 and had obtained citizenship on or before 31 December 1996; and

(ii) those who were born on or before 31 December 1949, had obtained citizenship on or before 31 December 1996 and do not receive the Pioneer Generation Package.

E. Eligibility Criteria for Payment of CareShield Life Benefits

7.20 The eligibility criteria for CareShield Life benefits is similar to that of ElderShield.

E1. Unable To Perform The Specified Number Of Activities Of Daily Living As Defined

7.21 CareShield Life will pay a monthly benefit of at least S$600 for as long as the insured is severely disabled. It pays the benefits if the insured is unable to perform at least three of the six Activities of Daily Living (ADLs) as defined.

E2. Meets The Deferment Period Requirement

7.22 There may be a deferment period of 90 days starting from the claim date, i.e. the date that the claim application is received by the AIC. If the insured is still disabled after this period, he will then be eligible for the benefit, provided that he satisfies the other conditions as specified in the policy.

F. How to Make a Claim Under CareShield Life?

7.23 To make a claim, the insured needs to submit a claim application to the Agency of Integrated Care (AIC). In the event that he is not able to complete it on his own e.g. if he lacks mental capacity, his donee/deputy/immediate family member or caregiver may do so on his behalf.

7.24 Next, he has to make an appointment with an MOH-accredited severe disability assessor to have a disability assessment done. The assessor will then complete the assessment and submit it to AIC directly. The list of accredited assessors can be found on AIC's website.

7.25 The fees for the first CareShield Life disability assessment are waived regardless of whether the claim is eventually assessed to be payable. Thereafter, the fees for subsequent assessments will only be reimbursed to the insured if the claim is assessed to be payable. More details on the applicable assessment fees can be found on AIC's website.

G. Other Key Features of CareShield Life

7.26 The other key features of the CareShield Life scheme are stated below:

(a) It is guaranteed renewable on an annual basis.

(b) It provides worldwide coverage.

(c) It has a minimum entry age of 30 years old, but no maximum entry age.

(d) The CareShield Life policy will be terminated if the insured is no longer a Singapore Citizen or SPR.

(e) There is no cash surrender value.

8. OTHER HEALTHCARE FINANCING SCHEMES SET UP BY THE SINGAPORE GOVERNMENT

8.1 Besides the Government subsidies, MediSave and insurance schemes as discussed above, the Government has also put in place a number of other schemes, to help Pioneers not to mention poor and needy Singaporeans. The schemes are as follows:

(a) Pioneer Generation Package;

(b) Merdeka Generation Package;

(c) Interim Disability Assistance Programme For The Elderly (IDAPE);

(d) ElderFund and

(e) Medifund.

(f) COVID-19 Medical Bills

A. Pioneer Generation Package

8.2 The Government introduced the Pioneer Generation Package in 2014 to honour and thank the pioneers for their significant contributions in the early years of nation-building.

8.3 The "Pioneer Generation" refers to living Singaporeans who meet two criteria, namely:

(a) aged 16 years and above in 1965 (born on or before 31 December 1949, which also means that they were aged 65 years and above in 2014); and

(b) obtained citizenship on or before 31 December 1986.

8.4 The package provides the benefits (as described below) which the Pioneer Generation will enjoy for life.

A1. Outpatient Care

(a) Additional 50% off remaining bill for subsidised services and medications at polyclinics and Specialist Outpatient Clinics.
(b) Special subsidies at participating GP and dental clinics under CHAS.
(c) Cash of S$1,200 a year for those with moderate to severe functional disabilities under the Pioneer Generation Disability Assistance Scheme.

A2. MediShield Life

8.5 Pioneers will receive Pioneer Generation subsidies for MediShield Life.

A3. MediSave Top-ups

8.6 All Pioneers will receive annual MediSave top-ups for life, which range from $250-$900 depending on birth cohort. These top-ups can be used to further offset premiums for MediShield Life, ElderShield, and CareShield Life. Older Pioneers with serious pre-existing conditions will receive additional MediSave

top-ups of $50-$200 from 2021-2025, to help with their higher MediShield Life premiums.

A4. Pioneer Generation Disability Assistance Scheme

8.7 This scheme is for Pioneers who permanently need assistance in at least three of these ADLs:

- Eating
- Bathing
- Dressing
- Transferring
- Toileting
- Walking or moving around

8.8 Lifelong cash assistance of S$100 each month is provided to help Pioneers with their care expenses.

A5. CareShield Life

8.9 Pioneers will receive a participation incentive if they join CareShield Life within the first two years of scheme launch. Do refer to earlier section of this Chapter for more information on this.

B. Merdeka Generation Package

8.10 The Government introduced the Merdeka Generation Package (MGP) in 2019 to honour and thank our Merdeka Generation (MG) for their contributions. The MGP supports the aspirations of MG seniors in their silver years by helping them to stay active and healthy, and providing them better peace of mind over future healthcare costs.

8.11 The "Merdeka Generation" refers to living Singaporeans who:

(a) were born from 1 January 1950 to 31 December 1959, and

(b) had obtained citizenship on or before 31 December 1996.

8.12 The MGP is also extended to living Singaporeans who:

(a) were born on or before 31 December 1949,

(b) had obtained citizenship on or before 31 December 1996, and

(c) do not receive the Pioneer Generation Package.

8.13 The package comprises the following benefits:

B1. Passion Silver Card Top-Ups

8.14 MG seniors receive a one-time S$100 top-up to their PAssion Silver cards. They can use this to pay for use on active ageing programmes, public transport, entries to swimming pools and other purchases at all EZ-Link merchants.

B2. MediSave Top-Ups

8.15 MG seniors receive a MediSave top-up of $200 per year for five years, from 2019 to 2023. This will help them save more for their healthcare needs. This is on top of the GST Voucher – MediSave top-ups that eligible seniors aged 65 and above receive every year.

B3. Outpatient Care

(a) Additional 25% off remaining bill for subsidised services and medications at polyclinics and Specialist Outpatient Clinics .
(b) Special subsidies at participating GP and dental clinics under CHAS.

B4. MediShield Life

8.16 MG seniors receive Additional MediShield Life Premium Subsidies.

B5. CareShield Life

8.17 MG seniors will receive CareShield Life Additional Participation Incentives i.e. a participation incentive if they join CareShield Life within the first two years of scheme launch. Do refer to earlier section of this Chapter for more information on this.

C. Interim Disability Assistance Programme For The Elderly (IDAPE)

8.18 IDAPE was launched by the Government to take care of Singaporeans who were not eligible to join the ElderShield scheme, when it was launched in September 2002, either because they exceeded the maximum entry age or they had a pre-existing disability. It is aimed at helping this group of people to cope with their medical expenses, in the event that they suffer any severe disability. Individuals covered under the scheme need not pay any premiums.

8.19 A Singaporean will qualify for IDAPE if:

- He is unable to perform three or more of the 6 Activities of Daily Living (ADL) - washing, feeding, dressing, toileting, mobility and transferring.
- He is a Singapore citizen born before 30 September 1932 OR born between 1 October 1932 and 30 September 1962 (both dates inclusive) but with pre-existing disabilities as at 30 September 2002.
- His per capita household monthly income is $2,800 or less OR he has no household income and is living in a residence with Annual Value of $13,000 and below.

8.20 The payment under the scheme is dependent on the individual's per capita household income as shown in **Table 9.4**.

Table 9.4: IDAPE Payout

Per Capita Household Income*	IDAPE Payout (With Effect From 1 July 2013)
(a) S$0 to S$2,000	(a) S$250 per month for up to 72 months
(b) S$2,001 to S$2,800	(b) S$150 per month for up to 72 months

*An IDAPE applicant from a household with no income will qualify for the S$250 monthly payout if the annual value of his place of residence is S$13,000 or lower.

Source: MOH Website

8.21 IDAPE is currently administered by the Agency for Integrated Care (AIC). Other than the fact that the payout is lower than the ElderShield scheme, the definition of disability and the claim procedures are the same as those for ElderShield with the following exceptions.

(a) those making claims under IDAPE will be subject to a means testing administered by the Ministry of Health Holdings (MOHH); and

(b) the recipient of the payout will need to pay a nominal fee of S$10 for a clinic assessment (or S$40 if assessment is done at home) for each assessment in the event of a claim. The rest of the fees are subsidised by the Government.

8.22 As you can see, the payouts under ElderShield and IDAPE are basic and limited to 72 months.Those on Eldershield can consider purchasing additional Long-Term Care Insurance coverage, if they wish to have higher payouts or longer payout periods, and can afford the premiums for the extra coverage. Existing and prospective CareShield Life clients can do likewise to purchase additional Long-Term Care Insurance coverage, if they wish to have higher payouts.

D. ElderFund

8.23 ElderFund is a discretionary assistance scheme launched on 31 January 2020. It is targeted at severely disabled lower-income Singapore Citizens aged 30 and older, who are not able to benefit from CareShield Life, ElderShield, and the Interim Disability Assistance Programme for the Elderly (IDAPE), have low MediSave balances and have inadequate personal savings to meet their long-term care needs. Eligible Singapore Citizens can receive up to $250 cash per month for as long as they remain eligible, and meet the terms and conditions needed for receipt of payment.

E. MediFund

8.24 MediFund is an endowment fund set up by the Government. It provides a safety net for needy Singaporeans who face difficulties paying for their remaining healthcare bills after Government subsidies, insurance and MediSave.

8.25 MediFund Silver and MediFund Junior are carved out from MediFund to provide more targeted assistance for the needy elderly and children respectively.

8.26 As an endowment fund, interest income generated from the capital sum are allocated to MediFund-approved healthcare institutions, for them to assist with the healthcare bill payments of needy patients. Every MediFund-approved institution has an independent MediFund Committee to consider and approve applications, and decide on the appropriate quantum of assistance.

8.27 To apply for MediFund assistance, one must:

- be a Singapore citizen;
- be a subsidised patient;
- have received or require treatment from a MediFund-approved institution; and
- be having difficulties paying for his remaining healthcare bills after Government subsidies and other means including MediShield Life and MediSave.

8.28 The patient's application will be assessed holistically by the medical social workers and the MediFund Committees, taking into consideration his and his family's financial, health and social circumstances.

F. COVID-19 Medical Bills[1]

8.29 In Singapore, healthcare support in the form of S+3Ms (Government Subsidies, MediSave, MediShield Life and MediFund) are extended widely to all Singaporeans. Notwithstanding such support, as part of the pandemic response, COVID-19 treatments have been provided at a very low cost or free of charge, going beyond the scope of the regular S+3Ms. As life reverts to normal and COVID-19 becomes endemic, the need to progressively reduce such subsidies and support is obvious. It is therefore not surprising to witness the current gradual reverting to pre-COVID-19 S+3Ms healthcare financing frameworks underpinning the Singapore healthcare system.

8.30 Since February 2020, more than 1,000 Public Health Preparedness Clinics (PHPCs) have been activated to provide subsidised care for patients with respiratory infection symptoms, whether due to COVID-19 or not. Singapore residents pay a flat subsidised rate of $10 and seniors from the Pioneer Generation and Merdeka Generation pay a lower rate of $5.

[1] https://www.moh.gov.sg/news-highlights/details/further-rationalisation-of-smms-boosting-vaccinations-and-updates-to-covid-19-subsidies

8.31 From 1 July 2022, subsidies at PHPCs and polyclinics for the treatment of respiratory infections have reverted to pre-COVID-19 levels. The $10/$5 fee no longer applies, but Singaporeans continue enjoying prevailing subsidies under the Community Health Assist Scheme (CHAS) at CHAS General Practitioner (GP) clinics.

8.32 The above does not affect ART and Polymerase Chain Reaction (PCR) tests, where PHPCs and polyclinics will continue to provide government-funded swabs to eligible symptomatic individuals at no charge.

8.33 Currently, individuals under Protocol 2, i.e. mildly symptomatic, low risk, and recovering from home, and who requested for telemedicine care enjoy full subsidy.

8.34 In line with the above change for PHPCs, from 1 July 2022, the government has reverted to pre-COVID-19 subsidy levels. Full subsidy for telemedicine will cease, but Singaporeans will continue to enjoy CHAS subsidies if they visit a CHAS GP clinic for treatment. Individuals under Protocol 1, i.e. those at high medical risk or with severe symptoms but are discharged for home recovery and under telemedicine surveillance, will continue to enjoy fully subsidised telemedicine care.

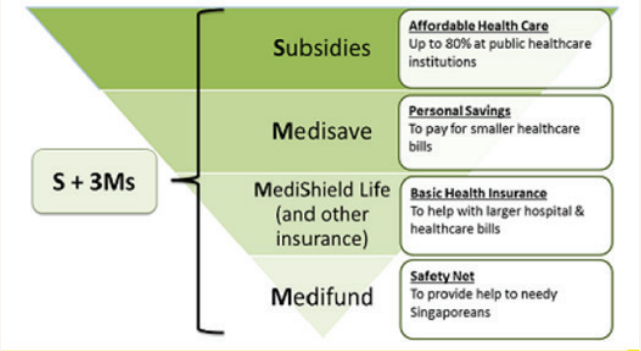
8.35 Currently, Singapore Citizens/ Permanent Residents /Long-Term Pass Holders (SC/PR/LTPHs) who seek emergency treatment for COVID-19 in Emergency Departments (ED) of public acute hospitals do not have to pay any ED charges if they are fully vaccinated or certified to be medically ineligible for vaccination.

8.36 From 1 July 2022, this will no longer apply to those who do not require admission after visiting the ED. Those who are assessed to require hospitalisation or undergo treatment at a COVID-19 Treatment Facility (CTF) will continue to have their ED, inpatient and/or CTF bills fully subsidised by the government, if they are fully vaccinated or certified to be medically ineligible for vaccination. This will help MOH manage the demand for ED services and cater to those who need them.

8.37 To understand more about the charging policies for SC/PR/LTPHs travelers who are subjected to General Travel Category or Restricted Category border measures, please refer to:
https://www.moh.gov.sg/news-highlights/details/easing-of-community-smms-and-border-measures

CHAPTER 09

HEALTHCARE FINANCING PART I & II

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Singapore government subsidies	• Government provides funding to public healthcare institutions (e.g. public hospitals, national specialty centres and polyclinics), as well as selected private clinics and voluntary welfare organisations (VWOs). • Means-test is used to target subsidies, so that needy patients can receive more help; lower-income patients receive more subsidies than higher-income patients.
Main components of Singapore's Healthcare Financing System	
MediSave	• National healthcare savings scheme in Singapore under the Central Provident Board (CPF) umbrella. • Contributions to the Medisave Account (MA) are subject to a maximum amount, known as the Basic Healthcare Sum (BHS). The BHS is designed to be enough for a CPF member's basic, subsidised healthcare needs in his old age. Hence, amounts in the MA up to the BHS cannot be withdrawn as cash. • Amounts above the BHS will flow to the CPF member's Special or Retirement Accounts to boost his monthly payouts. If the CPF member has already met his Full Retirement Sum, the amounts will flow to his Ordinary Account, and can be withdrawn as cash from the age of 55 years. • Can be used to pay for the CPF member's medical expenses at all accredited institutions, in both the public and private sector. • Can also be used to pay for medical expenses of the CPF member's approved dependents, namely his spouse, children, parents, siblings, and grandparents. If paying for a sibling or grandparent, the patient must be a Singapore Citizen or Singapore Permanent Resident (SPR).

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Uses of MediSave Account</td><td>
<table>
<tr><th>Uses of Medisave</th><th>Items that can be paid using MediSave</th></tr>
<tr><td>Outpatient Treatments</td><td>Selected outpatient treatments such as:
• Approved chronic conditions under the chronic disease management programme
• Vaccinations
• Health screenings</td></tr>
<tr><td>Inpatient Treatments</td><td>Inpatient care which includes:
• Inpatient episodes
• Inpatient psychiatric episodes
• Day surgery
• Assisted Conception Procedures</td></tr>
<tr><td>Long-Term Care</td><td>Long-Term Care treatments which include:
• Rehabilitative care
• Palliative care
• Disability care</td></tr>
<tr><td>Insurance Premiums</td><td>Premium payments of:
• MediShield Life
• ElderShield/CareShield Life
which can be fully paid with MediSave

• Integrated Shield Plans and ElderShield/CareShield Life supplements
which are subject to withdrawal limits periodically reviewed by MOH</td></tr>
</table>
</td></tr>
<tr><td>How much Medisave can be used</td><td>The use of MediSave is subject to:
• Withdrawal Limit.
• Additional Withdrawal Limit (AWL).

Payments via MediSave are allowed in all public healthcare institutions, as well as approved private hospitals and medical institutions</td></tr>
<tr><td>Distribution Of MediSave Upon Demise</td><td>• If a patient was hospitalised just before death and had authorised the use of his MediSave to pay for his medical bill, his MediSave balance would be used in full, without being subject to the existing MediSave withdrawal limits, to pay for his last inpatient medical bill.
• If the patient had not authorised the use of his MediSave before his demise, his immediate family member (spouse, parent, or child who is aged 21 years and above), or donee or deputy can also do so for the last inpatient medical bill, provided that it has not been paid out to the patient's nominated beneficiaries.
• In the event that the patient does not have any immediate family member, or donee or deputy to authorise the use of the patient's MediSave, a relative who has been taking care of the patient may also write to MOH through the hospital to seek approval for the relative to authorise the withdrawal of patient's MediSave, to pay for the last inpatient medical bill.
• Remaining MediSave balance, after the payment of the last medical bill, would be distributed to the nominated beneficiaries of the patient's CPF account if a nomination was made before his death. If there was no nomination made, the balance in the deceased patient's MA would be distributed by the Public Trustee to his family members under the intestacy laws for non-Muslims, or the Muslim inheritance law for Muslims.</td></tr>
</table>

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
MediShield Life	• Basic healthcare insurance scheme. • Covers all Singapore Citizens and Singapore Permanent Residents against large medical bills for life, regardless of age or health conditions. • The claim limits are sized to cover subsidised bills incurred for hospitalisation in class B2/C wards, day surgery, and selected costly outpatient treatments (e.g., dialysis and chemotherapy) in the public hospitals. • However, MediShield Life benefits are designed based on Class B2/C bills, so as to keep premiums affordable. Those who would like additional coverage in Class A/B1 wards or private hospitals may consider buying Integrated Shield Plans (IP). • No need to apply for MediShield Life. All SCs and PRs are automatically covered under MediShield Life from 1 Nov 2015. New SCs are covered from birth or from the day they attain citizenship. PRs are covered from the day they attain permanent residency. • MediShield Life premiums may be fully paid from MediSave. • Please refer to the Study Text for a list of treatment items, procedures, conditions, activities which are not covered by MediShield Life and cannot be claimed.
MediShield Life Premiums	• Actuarially priced based on the health risks and expected healthcare utilisation of each age group so that each age group's payouts are broadly supported by their own premiums. • Those with pre-existing medical conditions can enjoy coverage for their conditions. Only those with serious pre-existing medical conditions listed in the MOH website need to pay a nominal Additional Premium of 30% for the first 10 years, in addition to the standard MediShield Life premiums. • One can pay premiums from own MediSave, or family members may pay one's premium using their MediSave. Parents may also tap on the MediSave Grant for newborns to pay for their child's MediShield Life premiums.
How Are MediShield Life Claim Payouts Computed?	• Pays on a reimbursement basis, subject to the claim limits imposed on the covered medical expenses, as well as deductible, co-insurance and pro-ration factors. • The deductible is the fixed amount payable by the insured each policy year (the year following his policy renewal month), before the MediShield Life payout starts. The deductible is payable only once every policy year. • Co-insurance is the patient's share of the claimable amount which the insured will have to pay, along with the deductible. Please refer to the Study Text for example of how the reimbursement under MediShield Life is arrived at.
Integrated Shield Plans	Integrated Shield Plans (IPs) are MediSave-approved hospitalisation insurance plans made up of two parts. • MediShield Life component administered by the CPF Board. • An additional private insurance coverage component administered by approved private insurers, typically to cover Class A/B1 wards of public hospitals or private hospitals. No duplication of coverage between IPs and MediShield Life.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Consideration on Integrated Shield Plans (IP)</td><td>
• With the different IPs available, it is necessary for the sellers of such plans to understand the different plans offered in the insurance market, and to advise their prospective clients, based on the needs and long-term affordability of each individual client's position.
• As part of due diligence, clients should be informed of the key differences in premiums, benefits, exclusions, deductibles, co-insurance and other co-payment features between the various IPs offered by their insurer, versus MediShield Life. There are different benefits provided in the IP policy, and plans can be "as charged" or "non -as-charged" (i.e. they have sub-limits imposed). Information provided should be easy to understand, unambiguous and clearly explained to help clients make an informed decision.
• Clients should consider if they would wish to stay in a private or subsidised ward in a public hospital, or in a private hospital, and if they wish to choose their own doctors.
• Clients should consider if they can afford their IP premiums in the long term as the policyholders may have to pay a substantial portion of their IP premiums in cash, especially at the older ages.
• Unlike MediShield Life which provides coverage for pre-existing medical conditions (with Additional Premiums for the first 10 years), the coverage for the private insurance component of the IP may be declined or imposed with exclusions for pre-existing conditions. The private insurance component may also have premium loading, arising from pre-existing conditions.
</td></tr>
<tr><td>How MediSave can be used to meet a CPF member's healthcare needs and buy approved Medical Expense Insurance?</td><td>
MediSave can be used to pay premiums for IPs, either in full or in part, depending on the age group and the IP plan type. From 1 November 2015, MediSave use for the additional private insurance component of the IP premiums is subject to the new Additional Withdrawal Limit (AWL). The AWL is set per insured person per policy year, as stated below:
• Age Next Birthday (ANB) 40 years and below: S$300
• ANB 41 to 70 years: S$600
• ANB 71 years and above: S$900
</td></tr>
<tr><td>How MediShield Life premiums are kept affordable?</td><td>
• Premium Subsidies for lower- to middle-income.
• Pioneer and Merdeka Generation Subsidies.
• COVID-19 Subsidies.
• Additional premium support.
</td></tr>
<tr><td>How MediShield Life interacts with Integrated Shield Plans?</td><td>
<table>
<tr><th>MediShield Life Scheme</th><th>Integrated Shield Plan (IP)</th></tr>
<tr><td>It is administered by the CPF Board</td><td>It is administered by private insurers, as approved by MOH.</td></tr>
<tr><td>Its coverage is sized for stays in Class B2/C wards of public hospitals.</td><td>It provides for enhanced coverage beyond MediShield Life, with various plan types available for stays in private hospitals and/or Class A/B1 wards of public hospitals.</td></tr>
<tr><td>It covers all pre-existing conditions.</td><td>Coverage for the private insurance component of the IP may be declined or imposed with exclusions and/or premium loading, arising from pre-existing conditions.</td></tr>
<tr><td>There is no minimum or maximum age limit.</td><td>It may have a minimum or maximum entry age limit.</td></tr>
<tr><td>There are sub-limits applicable.</td><td>It may have sub-limits, although most do not have sub-limits.</td></tr>
<tr><td>MediShield Life premiums are fully payable by MediSave.</td><td>MediShield Life component of the IP is fully payable by MediSave, while private insurance component of the IP is payable by MediSave up to Additional Withdrawal Limit, and the remainder is payable by cash.</td></tr>
<tr><td>All Singapore Citizens and Permanent Residents are automatically covered for life. No application is required.</td><td>Application to private insurers is required.</td></tr>
</table>
</td></tr>
</table>

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Standard IP	• "No frills" product targeted at covering large Class B1 ward hospital bills and selected outpatient treatments. • Affordable option for Singapore Citizens and Permanent Residents who want additional coverage beyond MediShield Life and may find other higher coverage IPs too expensive.
Riders	• Pay for the co-insurance and deductible portion of the IP, and may pay cash payouts upon hospitalisation.
Need for Co-Payments	• Co-payment is an important principle in the design of healthcare insurance. It encourages policyholders and their doctors, to consider the necessity of the medical treatment and its cost, so that they can make an informed decision on the appropriate healthcare services. This encourages prudence and keeps healthcare cost, and health insurance premiums, affordable and sustainable in the long term.
Terminating or Switching IP/Switching Insurer	• An IP policyholder who cannot afford, or does not wish to continue paying the premium for his IP, can switch his plan to a lower coverage plan within the same insurer at any point in time, without additional underwriting involved. • He can also terminate his IP at any point in time, and still be covered by MediShield Life which provides basic health insurance, regardless of any pre-existing conditions. • If the person with an existing IP switches to a new IP with another insurer, Original IP with the previous insurer will be automatically terminated. • Option to go back to the previous insurer within 30 days from the date of notification of termination from the previous insurer.
Risk-Loading by private insurers	• MOH allows IP insurers to risk-load insured members with pre-existing conditions for the private insurance component of the IPs.
Benefits in having Pre-Authorisation for IP	• Insurers can assess the medical necessity and cost of treatment to ensure it is within the terms and conditions of the policy's coverage. • Patients will have a peace of mind in knowing that their procedure is within their insurance coverage; and • Healthcare providers have better clarity on the type of procedures covered by insurance to better advise their patients prior to the actual procedure. Policyholders are thus encouraged to seek pre-authorisation for planned procedures as far as possible if the option is provided by the insurer.
Claims process of MediShield Life, Integrated Shield Plans, other Medical Expense Insurance and MediSave	Any insured CPF member who wishes to claim from his MediShield Life, IP and/or MediSave will need to complete the Medical Claims Authorisation Form to: • Allow the hospital to claim from his insurer; and • Instruct the CPF Board to deduct from his MA to pay for his hospital bill, while the insurer settles the claim. For any insured CPF member who wants to claim from MediShield Life, IP and/or MediSave, the hospital will submit the claim on his behalf through the MediClaim online system after he has been discharged. If there is no pre-authorisation, the insured CPF member under an IP can approach the hospital to trigger a request for a Letter of Guarantee (LOG) from his insurer upon hospital admission. It is important that the insured CPF member understands that a LOG may not mean that the insurer will pay for the specified amount. To obtain assurance that their bill will be covered, the insured CPF member may wish to apply for pre-authorisation instead, if available. For someone who is covered by his employer medical benefits or other private insurance plans, he will need to show his insurance card (provided by some insurers for certain Medical Expense Insurance plans) to the hospital admission staff. The hospital may fully or partially waive the deposit in such a case. • Some hospitals will send the hospitalisation bill directly to the CPF member's non-IP private insurer or employer. In other cases, the insured CPF member will have to submit the bill himself to the insurer.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Withdrawal Limits for Inpatient, Outpatient, Long-Term Care and Insurance Premiums	Please refer to the Study Text for the full list.
MediShield Life Benefits	Please refer to the Study Text for the full list.
ElderShield & ElderShield Supplements	ElderShield is a long-term care insurance scheme launched in September 2002. It provides basic financial protection to those who need long-term care, especially during old age. ElderShield Supplement plans complement the current ElderShield scheme, by offering additional benefits at different pricing levels which increase the insured's coverage through: • Increasing the monthly payout; • Extending the payout period; or • A combination of both.
How ElderShield and ElderShield Supplements work?	• To purchase and maintain an ElderShield Supplement, an insured must have an ElderShield policy. • Premiums for ElderShield Supplement can be paid using MediSave (up to a limit of S$600 per insured per calendar year) and/or by cash. • The ElderShield scheme will pay a monthly benefit of either S$300 up to 60 months, or S$400 up to 72 months, depending on the type of the scheme in which the CPF member is covered.
Eligibility Criteria For Payment Of ElderShield benefits	• Meets the waiting period requirement. • Unable to perform the specified number of activities of daily living • Meets the deferment period requirement (If he recovers from the disability within the period, then no benefits are payable). • Please also note on making a claim under ElderShield and how the benefits are paid.
Features of ElderShield	• Non-forfeiture feature. • Guaranteed renewability on an annual basis. • Worldwide coverage. • Minimum (i.e. 40 years old) and maximum entry age (i.e. 64 years old). • Grace period of 75 days is allowed for payment of the overdue premiums. • Reinstatement of the policy is allowed within 180 days from the expiry of the grace period, subject to evidence of insurability at the insured's expense and payment of the overdue premiums with interest. • Insurer has the right to appoint an assessor to examine the insured periodically. • Where the insured is overseas at the time of a claim, the insurer has the right to commute the benefit payments to a single payment reflecting the present value of future benefit payments, or withhold the claim payment if it is unable to assess the claim after having made reasonable attempts to do so. • No cash surrender value. • Free-look period of 60 days from the policy commencement date during which the insured may cancel his policy, and receive a full refund of the premiums paid.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Exclusions of ElderShield	• Self-inflicted injury, suicide or attempted suicide; • Alcoholism or drug addiction; or • War, whether declared or undeclared. • CPF members who are suffering from pre-existing disabilities, will not be covered under ElderShield.
Termination of cover for ElderShield	• Expiry of the grace period if the ElderShield policy is not eligible for the non-forfeiture benefit (i.e. it has been in force for too short a period for it to acquire sufficient reserves to be converted into a paid-up policy); • Death of the insured; • Date in which the last benefit payment has been received; or • Date in which the written notice from the insured to cancel the policy is received by the insurer (if the policy does not have sufficient reserves, it will not be converted into a paid-up policy).
ElderShield to CareShield Life	• ElderShield became a closed scheme from 1 August 2021. • The Government had taken over the ElderShield administration from 1 November 2021. • New cohorts born in 1980 or later were covered under CareShield Life from 1 Oct 2020 but Singapore Citizens and SPRs born in 1979 or earlier could still opt in to the ElderShield scheme up till 1 Aug 2021 if they are below 65. • Existing ElderShield policyholders could continue to remain covered under the scheme with no changes to their coverage and benefits.
CareShield Life & CareShield Life Supplements	CareShield Life was introduced in 2020, as an enhancement of ElderShield and is administered by the Government on a not-for-profit basis, and offers; • Better protection and higher payouts that increase over time, so that claimants can better afford their basic long-term care needs; and • Protection for life. Any CareShield Life policyholder who wishes to obtain higher long-term care insurance coverage can also purchase Supplements. Supplements are plans which complement one's basic CareShield Life plan by offering additional benefits, such as higher monthly payout amounts, which enhances the coverage.
CareShield Life premium subsidies and support	To ensure that no one will lose CareShield Life coverage due to genuine inability to pay, the Government provides the following premium subsidies and support: • Means-tested premium subsidies of up to 30% of premiums of CareShield Life, to help lower- to middle-income households. • Participation incentives of up to $2,500 for Singapore Citizens, if they join CareShield Life by 31 December 2023, to encourage those born in 1979 or earlier to join CareShield Life. • Additional participation incentives of $1,500 for Merdeka and Pioneer Generation citizens if they join CareShield Life by 31 December 2023. • Additional Premium Support for Singaporeans who are unable to pay their CareShield Life premiums even after premium subsidies, so that no one will lose coverage under CareShield Life due to genuine inability to pay premiums.
Enhanced benefits under CareShield Life	CareShield Life features higher payouts that increase over time with no cap on payout duration, to provide better protection against the uncertainty of long-term care costs in the event of severe disability. • Lifetime cash payouts for as long as the policyholder is severely disabled. • Payouts increase until age 67 or when a claim is made, whichever is earlier, with payouts starting at S$600 per month in 2020.
CareShield Life Premiums	• The CareShield Life scheme makes use of pre-funded premiums i.e. the insured CPF members pay more than the cost of their health risk, while they are younger, to cover for the higher risk in their later years. • For Singapore Residents born 1980 or later (future cohorts), premiums are paid from the age of enrolment until age 67. Premiums will increase over time, to support payout increases. • Singapore Residents born in 1979 or earlier (existing cohorts) will pay a base premium. • Fully payable by MediSave.

<table>
<tr><th>IMPORTANT CONCEPTS</th><th>DEFINITIONS/EXPLANATIONS</th></tr>
<tr><td>Eligibility Criteria for Payment of CareShield Life Benefits</td><td>Similar to that of ElderShield.</td></tr>
<tr><td>Other key features of CareShield Life</td><td>• Guaranteed renewable on an annual basis.
• Worldwide coverage.
• Minimum entry age of 30 years old, but no maximum entry age.
• CareShield Life policy will be terminated if the insured is no longer a Singapore Citizen or SPR.
• No cash surrender value.</td></tr>
<tr><td>Other healthcare financing schemes set up by the Singapore government</td><td>• Pioneer Generation Package;
• Merdeka Generation Package;
• Interim Disability Assistance Programme For The Elderly (IDAPE);
• ElderFund and
• Medifund.
• COVID-19 Medical Bills</td></tr>
<tr><td>Interim Disability Assistance Programme For The Elderly (IDAPE)</td><td>• IDAPE was launched by the Government to take care of Singaporeans who were not eligible to join the ElderShield scheme, when it was launched in September 2002, either because they exceeded the maximum entry age or they had a pre-existing disability.

Singaporean will qualify for IDAPE if:
• He is unable to perform three or more of the 6 Activities of Daily Living (ADL) - washing, feeding, dressing, toileting, mobility and transferring.
• He is a Singapore citizen born before 30 September 1932 OR born between 1 October 1932 and 30 September 1962 (both dates inclusive) but with pre-existing disabilities as at 30 September 2002.
• His per capita household monthly income is $2,800 or less OR he has no household income and is living in a residence with Annual Value of $13,000 and below.</td></tr>
<tr><td>IDAPE Payout</td><td><table><tr><th>Per Capita Household Income*</th><th>IDAPE Payout
(With Effect From 1 July 2013)</th></tr><tr><td>(a) S$0 to S$2,000</td><td>(a) S$250 per month for up to 72 months</td></tr><tr><td>(b) S$2,001 to S$2,800</td><td>(b) S$150 per month for up to 72 months</td></tr></table>*An IDAPE applicant from a household with no income will qualify for the S$250 monthly payout if the annual value of his place of residence is S$13,000 or lower.</td></tr>
<tr><td>ElderFund</td><td>ElderFund is a discretionary assistance scheme launched on 31 January 2020. It is targeted at severely disabled lower-income Singapore Citizens aged 30 and older, who are not able to benefit from CareShield Life, ElderShield, and the Interim Disability Assistance Programme for the Elderly (IDAPE), have low MediSave balances and have inadequate personal savings to meet their long-term care needs.</td></tr>
<tr><td>MediFund</td><td>MediFund is an endowment fund set up by the Government. It provides a safety net for needy Singaporeans who face difficulties paying for their remaining healthcare bills after Government subsidies, insurance and MediSave.</td></tr>
</table>

CHAPTER 10
COMMON POLICY PROVISIONS

CHAPTER OUTLINE

1. Introduction
2. Sections Of A Policy Contract
3. Policy Schedule
4. Insuring Clause & Definitions
5. General Conditions
6. Benefit Provisions
7. Exclusions
8. Claim Conditions
9. Endorsements
10. Conclusion

Appendix 10A – Policy Schedule

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- list the sections of a Health Insurance policy contract
- know the information contained in a Health Insurance policy schedule
- outline what an insuring clause is
- define the following common terms under a Health Insurance policy:
  - dependant
  - insured/insured person
  - accident
  - hospital
  - any one disability
  - covered charges
  - day of hospital confinement
  - registered medical practitioner/physician
  - medically necessary service, supply or day of hospital confinement
  - period of hospital confinement
  - pre-existing condition
  - policyholder/policy owner
  - usual, customary and reasonable
  - waiting period
  - illness
  - pre-hospitalisation benefits
  - per policy year limit
  - lifetime limit
  - deductible and co-insurance
  - pro-ration factor

- explain the general conditions sections that outline the rights of the policy owner and the insurer:
  - entire contract clause
  - effective date of cover
  - premium clauses
  - free-look period
  - actively at work
  - termination of cover
  - cover abroad
  - renewal
  - mis-statement of age or gender
  - grace period
  - reinstatement
  - incontestability
  - change of occupation
  - co-ordination of benefits
  - cancellation
  - change of plan
  - currency
  - last payer status
  - nomination of beneficiaries
  - Policy Owners' Protection Scheme
- explain the various bases upon which Health Insurance policies can be issued:
  - cancellable
  - optionally renewable
  - conditionally renewable
  - guaranteed renewable
  - non-renewable
- understand the purposes and functions of the benefit provisions section of the Health Insurance policy
- list the common exclusions that are found in Health Insurance policies
- explain some of the important general claim conditions commonly found in Health Insurance policies:
  - notification of claim condition
  - physical examination provision
  - mediation/arbitration and legal actions provision
- explain what an endorsement is

Contents

CHAPTER OUTLINE 221
LEARNING OUTCOMES 221
1. INTRODUCTION 225
2. SECTIONS OF A POLICY CONTRACT 225
3. POLICY SCHEDULE 225
4. INSURING CLAUSE & DEFINITIONS 226
A. Insuring Clause 226
B. Definitions 226
5. GENERAL CONDITIONS 231
A. Entire Contract Clause 231
B. Effective Date Of Cover 231
C. Premium Clauses 231
D. Free-look Period 232
E. Actively At Work 232
F. Termination Of Cover 233
G. Cover Abroad 233
H. Renewal 234
H1. Cancellable Policy 234
H2. Optionally & Conditionally Renewable Policies 234
H3. Guaranteed Renewable Policy 235
H4. Non-renewable 236
I. Mis-statement Of Age Or Gender 236
J. Grace Period 236
K. Reinstatement 236
L. Incontestability 237
M. Change Of Occupation 237
N. Co-ordination Of Benefits 237
O. Cancellation 237
P. Change Of Plan 238
Q. Currency 238
R. Last Payer Status 238
S. Nomination Of Beneficiaries 238
T. Policy Owners' Protection Scheme 239
6. BENEFIT PROVISIONS 239
7. EXCLUSIONS 241
8. CLAIM CONDITIONS 242

A. Notification Of Claim Condition 242
B. Submission Of Claim 243
C. Physical Examination Provision 243
D. Mediation/Arbitration & Legal Action Provision 243
9. ENDORSEMENTS 244
10. CONCLUSION 244
Appendix 10A 245

1. INTRODUCTION

1.1 A Health Insurance policy is the written evidence of a contract between the insurer and the policy owner who can be an individual or a corporation. It specifies the precise terms of the agreement between the two parties to the contract. The details of the contract terms are clearly laid out in various policy provisions. This chapter will describe the common and important provisions of Individual and Group Health Insurance contracts.

1.2 It is very important to fully understand the various policy provisions to avoid any dispute later on.

2. SECTIONS OF A POLICY CONTRACT

2.1 There are basically seven sections in a Health Insurance policy contract.

2.2 The sequence or header of the sections in a policy document may vary among the different insurers.

3. POLICY SCHEDULE

3.1 The schedule contains details of the policy owner, insured person(s), as well as the insurance coverage, coverage limits and sum insured. The schedule is not a stand-alone document and must always be read together with the policy wording "as one contract". The schedule will also outline additional clauses or exclusions specific to the policy owner's own circumstances.

3.2 The schedule will include information as follows:

- policy number;
- effective date of cover;
- expiry date of cover;
- date at which the policy is issued;
- contract currency;
- name and identity number of the policy owner;
- name, age, gender and identity number of the insured person;
- name of insurance plan;
- types of riders and the coverage limits (if any);
- premiums for the insurance plan and riders;
- coverage details on benefits limits or sum insured; and
- special provisions/endorsements indicating the types of endorsements attached to the policy.

3.3 The policy schedule gives the specific details of the policy contract (refer to **Appendix 10A** of this chapter for a sample copy of the first page of a policy schedule. For a detailed schedule of benefits, refer to **Appendix 2A** of **Chapter 2** of this Study Guide). When you promptly deliver the policy to the policy owner, you need to go through this schedule with the policy owner thoroughly, to ensure that there is no typographical error, and that the insurance coverage tallies with what the policy owner has agreed to purchase.

4. INSURING CLAUSE & DEFINITIONS

A. Insuring Clause

4.1 The insuring clause also known as the operative clause states the purpose of the policy and outlines the conditions under which the policy will pay. The insuring clause serves to:

- describe the general scope of coverage;
- provide any definitions required; and
- set forth the conditions under which the benefits are payable.

4.2 This clause is often viewed as the foundation of a Health Insurance policy in terms of the insurer's general agreement to provide the coverage.

B. Definitions

4.3 To ensure a common understanding for both parties, the policy contains definitions of key words used in the policy. In this section, we highlight the important terms in a Health Insurance policy and their sample definitions (note that the actual definitions vary from insurer to insurer).

(a) Dependant

Some Health Insurance policies provide coverage to the dependants (spouse and children) of the policy owner (or of the employee in the case of Group Insurance) and the definitions are important.

A spouse is typically defined as the person to whom the policy owner is legally married under the laws of the country.

A spouse is no longer considered a dependant in the case of legal separation. As for a child, he must typically be unmarried, under the age of 18 years, and principally dependent on the insured for support. This definition also includes the legally adopted children and stepchildren of the insured. Most insurers will extend the cover up to age of 18 or 25 years if the child is pursuing a tertiary education.

(b) Insured/Insured Person

The insured person is the person covered by the insurance. The insured person, more often than not, is the policy owner. At times, the policy owner opts to cover his dependants (spouse and children) under the policy, and in such instance, the dependants will be the insured persons.

A policy will specify that the insured person may include the policy owner, or any one of his insured dependants as defined in the policy.

(c) Accident

It means an incident caused by accidental, violent, external and visible means.

Note that some insurers may not have the "violent" requirement in their definition of "accident".

(d) Hospital

It is defined as any lawfully operating institution which has 24-hour a day nursing services by registered graduate nurses, one or more physicians available at all times and organised facilities for diagnosis and major surgery. It is not primarily a clinic, a place for alcoholics or drug addicts, nursing, rest or convalescent home, or home for the aged, or similar establishment.

(e) Any One Disability

It means disabilities resulting from illness or bodily injury and their complications arising from the same cause. However, if any subsequent disability arising after a specified number of days (e.g. 45 or 90 days, depending on the policy wording of the insurer) has lapsed following the latest discharge from hospital, then it shall be considered a new disability, regardless of the cause.

(f) Covered Charges

They refer to the charges incurred by the insured person, while the policy is in force, for a service, supply or period of confinement, which has been ordered or prescribed by a physician.

A covered charge is deemed to be incurred at the time the service or supply is received or rendered. The covered charges for a period of hospital confinement are deemed to be incurred at the time of admission to a hospital. However, some insurers take into account the actual date of provision of service.

(g) Day Of Hospital Confinement

It refers to a full 24 hours during a period of hospital confinement. The first day of confinement will commence at the time of admission to the hospital and each subsequent day will commence 24 hours after the commencement of the previous day of confinement, and the day of discharge will also be regarded as a day of confinement.

(h) Registered Medical Practitioner/Physician

It means a qualified medical practitioner registered with the Singapore Medical Council to render medical and surgical services. It excludes a physician who is the policy owner, insured person himself or his spouse or any of his lineal relatives[1].

[1] Lineal relatives refer to people who are descendants from the same ancestor.

(i) Medically Necessary Service, Supply Or Day Of Hospital Confinement

It means a service, supply or day of hospital confinement, which is ordered by a physician and which is:

- provided for the diagnosis or direct treatment of a disability;
- appropriate and consistent with the symptoms and findings or diagnosis and treatment of the insured person's disability;
- provided in accordance with generally accepted medical practices on a national basis;
- the most appropriate supply or level of service which can be provided on a cost effective basis; and
- not of an experimental or investigative nature, or research purposes.

The fact that the insured person's physician prescribes a service, supply or day of hospital confinement does not automatically mean that such service, supply or day of hospital confinement is medically necessary.

(j) Period Of Hospital Confinement

It means a continual period of time where an insured person is confined to a hospital as a registered inpatient. Two or more periods of hospital confinement resulting from the same or related causes, are considered as the same period of hospital confinement, unless the break between the date of discharge of the earlier period of hospital confinement and the date of admission of the following period of hospital confinement is more than a specified number of days (e.g. 45 days). Insurers normally require patients to stay in a hospital for 6 to 24 hours, before being considered to be "hospitalised".

(k) Pre-existing Condition

It is usually defined as a condition which has existed and:

- for which the insured person received treatment or medical advice;
- in respect of which the insured person showed symptoms;
- of which the insured person was aware; and
- of which the insured person should reasonably have been aware;

before the date of policy issue or the date that the cover was reinstated.

Note that insurers may adopt one or more of the above-mentioned conditions in their definition of the term "pre-existing condition".

Almost all insurers require the insured person to declare any known pre-existing condition. These pre-existing conditions may be excluded from coverage, and the policy being put in force with the required exclusions. In recent years, some insurers use a moratorium underwriting method. This means that the insured person does not need to make any medical declaration when he applies for coverage. Pre-existing conditions can be covered after a continuous period (e.g. five years) from the effective date of coverage, reinstatement, or upgrade of plan, whichever is the later. For the specified number of years, the insured person must not have experienced any symptom, seek consultation, or receive treatment or medication for the condition.

In addition, the insurer may also have a list of pre-existing conditions that are permanently excluded from coverage, e.g. cancer, stroke, heart attack, kidney failure, etc.

(l) Policyholder/ Policy Owner

The policy owner owns the policy and is responsible for the payment of premiums and receipt of claims and benefits under the policy. He has the right to make changes to the contract and receive all payments due under the policy.

(m) Usual, Customary & Reasonable

It means the charges for a specific service, supply or period of hospital confinement:

- is within standard charge for the specific provider; and
- must not be more than the general level of charges of other medical care providers with similar standing in the same geographical area, for an equivalent treatment, services or supplies to individuals of the same gender, of comparable age, for a similar illness or injury.

(n) Waiting Period

For **Medical Expense Insurance**, it refers to the period of time starting from the date of policy issue or reinstatement date, where the insured person's medical expenses are not covered by the policy. Waiting period differs from insurer to insurer and applies only to medical expenses arising from an illness, not from an accident.

For **Disability Income Insurance**, it refers to a specified period of time, beginning with the onset of the disability, where benefits are not payable. The waiting period in a Disability Income Insurance policy is sometimes called the "elimination period" or the "probationary period".

For **Long-Term Care (LTC) Insurance**, it refers to a period of time beginning from the first day the insured person is unable to perform the specified Activities of Daily Living (ADLs), during which no LTC Insurance benefit will be payable. For LTC Insurance, this may also be known as the deferred period.

(o) Illness

Illness refers to a physical condition marked by a pathological deviation from the normal healthy state.

(p) Pre-hospitalisation Benefits

This refers to the diagnostic X-ray, laboratory tests and specialist consultation for an illness or injury which occurred within a specified number of days prior to hospitalisation. The insurer will pay only for such outpatient treatments if they lead to hospitalisation or surgical operation, within the time frame as specified in the policy.

(q) Per Policy Year Limit

This is the maximum amount that a Medical Expense Insurance (MEI) policy will pay for all the eligible medical expenses that an insured person incurs within each policy year.

(r) Lifetime Limit

This is the maximum amount that a MEI policy will pay for all the eligible medical expenses that an insured person incurs under the policy.

(s) Deductible & Co-insurance

A deductible is a flat amount of covered medical expenses that an insured person must first incur, before the insurer will make any benefit payment under a MEI policy. This amount will have to be borne by the insured person.

Co-insurance, on the other hand, is a percentage of all eligible medical expenses, in excess of the deductible, that the insured person must personally pay under a MEI policy.

(t) Pro-ration Factor

This is the percentage that the insurer will use to pro-rate the hospital bills before it computes the claim payout, if the insured person is admitted to a ward/hospital higher than what he is entitled to under the policy. The percentage is applied on the actual charges incurred and covered under the policy, including charges of pre-hospital and post-hospital treatments received in connection with the hospitalisation. Therefore, the benefit payable is reduced to take into account the difference in Government subsidies applicable to the ward type of the selected plan.

If the life assured receives inpatient treatment in a luxury or deluxe suite or any other special room of a hospital, the room charge benefit will be pro-rated to the actual charges which the life assured has to pay for each type of plan.

Here is an example of how an insurer would pro-rate the room charges.

Insured's Plan Entitlement	**Pro-ration formulae**
Private Hospital – any standard ward	$\frac{Charge\ for\ a\ single-bedded\ A1\ ward\ in\ Mount\ Elizabeth\ Orchard\ Hospital}{Room\ charge\ which\ the\ \boldsymbol{life\ assured}\ had\ to\ pay}$ x total bill
Restructured Hospital – any standard ward	$\frac{Charge\ for\ a\ standard\ A1\ ward\ in\ Singapore\ General\ Hospital}{Room\ charge\ which\ the\ \boldsymbol{life\ assured}\ had\ to\ pay}$ x total bill
Restructured Hospital – any standard B1 Ward	$\frac{Charge\ for\ a\ standard\ B1\ ward\ in\ Singapore\ General\ Hospital}{Room\ charge\ which\ the\ \boldsymbol{life\ assured}\ had\ to\ pay}$ x total bill

5. GENERAL CONDITIONS

5.1 The general conditions section outlines the rights of both the policy owner and the insurer. In this section, we highlight some of the important conditions as found in a typical Health Insurance policy.

A. Entire Contract Clause

5.2 All insurance contracts have an "Entire Contract Clause". In some policies, it is referred to as "The Policy Contract Clause". This clause states that the present contract, together with any specified attachments/endorsements, make up the entire contract, and no other documents form another part of the contract. In a Health Insurance contract, the policy document and the proposal form (as well as proposal forms of the insured persons, if required in the case of a family or group policy) are the entire contract between the insured and the insurer.

5.3 This clause also states that, in consideration of the first premium being received in full, the insurer will start providing benefits as set out in the policy.

B. Effective Date Of Cover

5.4 The effective date of cover is established in the policy by agreement between the insurer and the policy owner. It is the date on which the insured person begins to be covered under the Health Insurance policy.

5.5 Usually, the effective date of cover applies to all types of covers under the policy, unless there is a special arrangement to have one or more of the covers to become effective at some later date.

5.6 For instance, the effective date of cover for an accident or illness may be different. For an accident, cover will commence as at the effective date of the insurance. For an illness, the cover can commence only after the waiting period is over.

C. Premium Clauses

5.7 Health Insurance policies are issued by life insurers. Policies such as medical expense insurance can also be issued by general insurers.

5.8 As far as individual Health Insurance policies issued by life insurers are concerned, when the policy is first incepted, the premiums must be paid before inception of cover. When the policy is renewed during the second year onwards, it is subject to a Grace Period whereby the premium must be paid within 30 days from inception of cover.

5.9 For Group Health insurance policies issued by life insurers, there is a **Grace Period** provision within such policies which states that the premium has to be paid within 30 days from the commencement date or renewal date (whichever is applicable); **or** the date of the insurer's premium tax invoice, **whichever is later**.

5.10 We now turn to Health Insurance policies issued by general insurers. For individual health insurance policies issued by general insurers, they are subject to the **Payment Before Cover Warranty** which states that the policy shall not be in force, unless the premium is paid to the insurer or intermediary on or before the date of inception of the policy. In the event that the total premium due is not paid to the insurer or the intermediary on or before the inception date or the renewal date of the policy or Bond, then no benefits whatsoever shall be payable by the insurer.

5.11 As for Group Health insurance policies (e.g. Group Medical Insurance or Group Hospital and Surgical Insurance) issued by general insurers, they are subject to the **Premium Payment Warranty** which states that if the period of insurance is more than 60 days, the policyholder is required to pay the premium due under the policy in full, within 60 days from the date of inception of the policy. If this warranty is not complied with, then the policy is automatically terminated from the expiry of the 60-day period, and the insurer will be entitled to a pro-rata premium for the 60-day period that the insurer has been on risk. If the period of insurance is less than 60 days, then the insured is required to pay the premium due under the policy in full, within the period of insurance.

D. Free-look Period

5.12 The free-look period is the period of time after delivery of the policy document during which the policy owner may review the policy and return it for a refund of the premium paid to the insurer (less any medical fees incurred). Full coverage is in force during this period. This can vary from 14 to 30 days from the date of receipt of the policy document. The policy document is deemed to have been received by the policy owner within seven days after the insurer has despatched it.

E. Actively At Work

5.13 This provision is usually found in Group Insurance, as well as Disability Income Insurance. When applied to Group Insurance, it provides that an employee is not eligible for coverage, if he is absent from work because of an illness, injury and other reasons on the effective date of his coverage. However, in Disability Income Insurance, it provides that the cover will automatically terminate, when the person is not working owing to illness or termination of service.

F. Termination Of Cover

5.14 This clause lists the situations, whereby the cover for Health Insurance will cease:

- when the insured person dies;
- when the policy owner fails to pay the renewal premium at the end of the grace period;
- when the total amount of claims paid by the insurer has reached the limit of indemnity; or
- when the insured person reaches the specified maximum age during which the insurer is not willing to offer cover.

5.15 It also states that the termination of a policy will not prejudice or affect the payment of any claim that has arisen before the termination, and that there will be no refund of premium if the policy is terminated before the expiry of the cover.

G. Cover Abroad

5.16 This clause is applicable only to the covered charges incurred in the "Country" as specified in the policy schedule. It is also applicable under the following circumstances:

- the insured person, travelling abroad for a reason other than for medical treatment, needs to be confined to a hospital outside the "Country" as a consequence of a medical emergency occurring within 90 days of leaving the "Country"; or
- the insured person, upon recommendation of a physician and with the prior written approval of the chief medical officer of the insurer, has to be transferred to a hospital outside the "Country" because the specialised nature of the treatment, aid, information or decision required can neither be rendered, nor furnished, nor taken, in that "Country".

5.17 All covered charges incurred during the period of confinement will be subject to the exclusions, limitations and conditions as specified in the policy, and all benefits will be payable in the "Currency"[2] based on the "Exchange Rate"[3] on the last day of the period of confinement.

5.18 The purpose of this clause is to restrict the Health Insurance coverage to the country where the policy is issued; except when the insured person is travelling abroad and, at the time of an emergency, the charges for an overseas hospital treatment will be covered. As the cost of healthcare varies from country to country, pricing of the product does not usually take into account any foreign country's claim costs. Furthermore, it complicates claim administration and adjudication.

---

2 "Currency" refers to any currency other than Singapore dollars.

3 "Exchange Rate" refers to the rate of exchange used for the settlement of a claim.

H. Renewal

5.19 The Renewal Provision describes:

- the circumstances under which the insurer has the right to refuse to renew or the right to cancel the coverage; and
- the insurer's right to increase the amount of premium payable on the policy.

5.20 Health Insurance policies can be issued on any of the following bases:

- cancellable;
- optionally renewable;
- conditionally renewable;
- guaranteed renewable; or
- non-renewable.

5.21 Let us look at each of the five types of Health Insurance policies in turn.

H1. Cancellable Policy

5.22 The Renewal Provision included in a cancellable policy (e.g. some Medical Expense Insurance policies) grants the insurer the right to terminate the policy at any time, for any reason, simply by notifying the policy owner in writing that the policy is cancelled, and by refunding any advance premium that has been paid for the policy.

5.23 All things being equal, cancellable policies are generally cheaper than other types of policies.

H2. Optionally & Conditionally Renewable Policies

5.24 To remain in force, Health Insurance policies must be renewed periodically; that is, the coverage remains in force only for the length of time for which the premiums have been paid. When the premium is due again, the policy may be renewed, or it may expire. Both the policy owner and the insurer have a role to play in the renewal process.

5.25 The policy owner has the option to cancel the policy at any time by notifying the insurer within a specified period during the currency of the policy, or by allowing it to lapse at a premium due date by not paying the premium.

5.26 Health Insurance policies also include specific provisions that will determine whether the insurer may refuse to renew a policy. When the insurer has the option to refuse to renew, the policy may be one of two types:

- **Optionally Renewable Policy**
  The insurer has the right to refuse to renew an optionally renewable policy on certain dates as specified in the policy, usually either on the policy anniversary date or on any premium due date. The insurer is also allowed to increase its premium rate and to add coverage limitations, such as eliminating coverage for injuries to certain parts of the body, or limiting the

extent of coverage for certain occurrences.

- **Conditionally Renewable Policy**
  The insurer may elect not to renew only under conditions as specified in the policy. These conditions cannot be related to the insured person's health. Provided that the insurer is still selling this line of business, the age and employment status of the insured person are often listed as reasons for possible non-renewal. For example, an individual Disability Income Insurance policy may state that the insurer will renew the policy until the insured person reaches a certain age (e.g. 65 years), or until the insured person retires from gainful employment. A conditionally renewable policy also gives the insurer the right to increase the premium rate.
  To protect the insured person when a valid claim is being paid or is eligible for payment at the time when the premium is due, the insurer may not prejudice that claim. That is, the claim will be paid if the insurer elects not to renew the policy.

H3. Guaranteed Renewable Policy

5.27 In some policies, the insurer relinquishes the rights to cancel the policy at any time, as well as to refuse renewal at a premium due date. This type of policy is said to be guaranteed renewable, and it includes several important features, such as:

- renewal is guaranteed, as long as the policy owner pays the premium;
- the insurer may not cancel the policy, unless the policy owner fails to pay the premium;
- premiums may be increased on the basis of an entire classification, such as occupation or sub-plan; and
- guaranteed policy renewal until the specified age, such as 60, 65, 70 or 75 years, depending on the insurer's policy.

5.28 Non-payment of premium is the only reason that an insurer may cancel or refuse to renew a guaranteed renewable policy.

5.29 However, it may increase the premiums based on a *class* basis. One common classification, for example, is by occupational groups. Based on experience, the insurer knows that certain occupations are subject to a higher risk of accidental injury or death than other occupations. For example, compare the different risks faced by an office administrator and by a construction worker.

5.30 With a guaranteed renewable policy, the insurer *must* renew the policy when it is due. However, based on new experience ratings within the insured person's occupational class, the insurer may increase the premiums for *all* insured persons in that class of risk.

5.31 The guaranteed renewable feature is often *limited*. In some policies, the insurer regains the right to cancel and to refuse to renew, when the insured person reaches a specified age. Commonly, the policy will stipulate this right, when the insured person reaches a normally accepted retirement age, such as 60, 65, 70 or 75 years.

5.32 Since insurers expose themselves to higher risks by relinquishing the rights to refuse renewal and to cancel such policies, premiums for guaranteed renewable policies are generally higher than those for cancellable policies.

H4. Non-renewable

5.33 In some situations, an individual may need Health Insurance for a fixed, limited period of time. Coverage that extends only for a specified length of time is called Term Insurance. Such a policy cannot be renewed at all. When it expires, the insured person must purchase another policy.

5.34 Travel Insurance is a typical example of a form of Term Insurance. It essentially covers from the start to the end of the trip. Student Personal Accident Insurance policy is another example, beginning when the school term starts and ending when the school term is over.

I. Mis-statement Of Age Or Gender

5.35 The provision specifies that, in the case of an insured person mis-stating his age or gender, the insurer will adjust the premium based on his correct age and gender. Any excess premium paid will be refunded by the insurer, and any shortfall in premium will have to be made up by the policy owner. However, if at the correct age, an insured person would not have been eligible for coverage under the policy, then no benefit would be payable by the insurer.

J. Grace Period

5.36 Individual Health Insurance policies contain a Grace Period provision that allows the policy owner to pay a renewal premium, within a stated grace period, following the premium due date. The length of the grace period may vary depending on how frequently the renewal premium is payable. The grace period is usually 30 days for most policies. Coverage remains in force during the grace period.

K. Reinstatement

5.37 An individual Health Insurance policy typically includes a Reinstatement provision stating that, if certain conditions are met, the insurer will reinstate a policy that has lapsed for non-payment of premiums. The policy owner must pay any overdue premium (with or without interest as determined by the insurer) and the insured person must complete a reinstatement application/health warranty. The insurer has the right to evaluate the reinstatement application, and to decline to reinstate the policy on the basis of statements made in that application. Coverage under a reinstated policy can be limited to any accident or illness that will occur only after the effective date of reinstatement.

5.38 Thus, the insurer can protect against anti-selection by excluding from cover, those losses that occur only after the lapse of the policy and before it is being reinstated.

L. Incontestability

5.39 Health Insurance riders attached to Life Insurance policies will be subject to the Incontestability Clause. The Incontestability provision makes Life Insurance policies indisputable after they have been in force for a certain minimum period (usually one year), with the exception of fraud. In other words, this provision stops the insurer from repudiating liability under a policy purely on grounds of breach of utmost good faith, except when fraud has been proven.

M. Change Of Occupation

5.40 Many individual Disability Income Insurance policies contain a Change Of Occupation provision that permits the insurer to adjust the premium rate or the amount of benefits payable under the policy if the insured person changes occupation. The insured person's occupation has a direct effect on his morbidity risk. The Change Of Occupation provision typically permits the insurer to reduce the maximum benefit amount payable under the policy should the insured person change to a more hazardous occupation. Should the insured person change to a less hazardous occupation, this provision would also permit the insurer to reduce the premium rate of the policy.

N. Co-ordination Of Benefits

5.41 Many individual Health Insurance policies contain a Co-ordination of Benefits provision (may also be known as Over-insurance provision or Contribution provision) that is intended to prevent the insured person from profiting from a claim. This provision states that the benefits payable under the policy will be reduced if the insured person is eligible for reimbursement from other sources.

5.42 Co-ordination of Benefits provision will apply whether or not the insurer has been notified of the other coverage at the application stage. Should there be over-insurance, the insurer would reduce the amount of benefits that would otherwise be payable under the policy. In cases, whereby the insurer realises that the insured person has also received benefits from other sources only after it has paid out the benefits, the insurer may, at its discretion, demand a return of all or part of the benefits previously paid under the policy.

O. Cancellation

5.43 A Health Insurance policy may have a provision that allows the policy owner to cancel the policy by giving written notice to the insurer within a certain period of time (e.g. seven days). In such a case, the policy owner is usually entitled to a return of the excess premium paid less any administrative cost as determined by the insurer. The policy owner must also state when such cancellation shall become effective, usually not less than 30 days thereafter.

5.44 After such return of premium, the insurer will not be liable for any benefits in respect of covered charges incurred during the policy year in which the cancellation becomes effective.

5.45 This provision often goes hand-in-hand with the renewal provision of a cancellable policy, such that the insurer also has the right to terminate the policy at any time, simply by notifying the policy owner in writing, and by refunding any advance premium that has been paid for the policy. This applies not only to an Individual Health Insurance policy, but also to a Group Health Insurance policy (where the policy owner is usually the employer).

P. Change Of Plan

5.46 A Medical Expense Insurance policy has a provision to allow the insured person to upgrade or downgrade the coverage plan. Any upgrading of plan is subject to satisfactory evidence of insurability at the policy owner's expense. He may request for a change of plan either at the next policy renewal date or the next premium due date. An application for change of plan should be submitted by the insured person to the insurer at least 30 days, before the policy renewal date or premium due date. However, the insurer may refuse to accept such an application.

5.47 Any medical condition that is covered under the plan immediately before the plan change will continue to be covered, and claims on such condition will be payable according to the limits of the plan before its change.

Q. Currency

5.48 Where payment of claims is on reimbursement basis, the policy will state the currency for the benefits payable. Generally, payment of all claims and benefits will be made in Singapore currency. Charges incurred in any other currency outside Singapore shall be payable in Singapore currency on the basis of the exchange rate used by the insurer on the date of processing the claims.

R. Last Payer Status

5.49 This clause appears in the MediShield Life and Private Integrated Shield Plans. It states that, if the insured person has any other Medical Insurance, including medical benefits (such as from Work Injury Compensation Insurance) under any employment contract, which makes provision for reimbursement of medical expenses, the insurer shall be the last payer reimbursing the claim. If benefits payable under the policy have been made to the insured person first, before a claim is made under such other Medical Insurance policies or employee benefits, the other medical insurers or the employer will need to reimburse the existing insurer its share. The insured person shall provide the insurer with the full details of such other insurance policies or employee benefits, and all relevant documentary proof necessary to make a claim.

S. Nomination Of Beneficiaries

5.50 The introduction of the Nomination Of Beneficiaries (NOB) under Part 3C of the Insurance Act 1966 as from 1 September 2009 gives policyowners of Life Insurance policies or A&H Insurance policies with death benefits, a clear and affordable legal means to distribute the policy benefits to their nominees.

5.51 Since CI Insurance policies usually have built-in death benefits payable, they will come under the NOB framework. Hence, the insured who is the policyowner can make a nomination as long as he has attained the age of 18 years. Two options of nomination as briefly described below are available:

- Trust or Irrevocable Nomination (**Section 132 of the Act**) – The insured loses all rights to the ownership of the policy. To revoke this trust nomination, the insured needs the written consent of all the nominees.
- Revocable Nomination (**Section 133 of the Act**) – The insured retains the ownership of the policy and is free to change, add or remove nominees, without their consent.

T. Policy Owners' Protection Scheme

5.52 Singapore consumers enjoy the benefits of a sound financial system. Insurers licensed in Singapore are supervised by the Monetary Authority of Singapore (MAS) whose aim is to ensure the stability of the financial system in Singapore, and to require financial institutions to have sound risk management systems and adequate internal controls. However, MAS does not guarantee the soundness of individual financial institutions. Therefore, the Policy Owners' Protection Scheme (PPF Scheme) has been set up to protect the policy owners in the event of failure of a life or general insurer which is a PPF Scheme member.

5.53 The scope of PPF Scheme includes (but not limited to) individual and group short-term or long-term accident and health (A&H) policies (e.g. Hospital Income, Medical Expense, Personal Accident, Disability Income, Long-Term Care Insurance).

5.54 The PPF Scheme is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage under the PPF Scheme is automatic, and no further action is required from the policy owners. For more information on the types of benefits that are covered under the scheme, as well as the limits of coverage, where applicable, just refer to the SDIC Website at: www.sdic.org.sg

6. BENEFIT PROVISIONS

6.1 The benefit provisions section is the essence of any insurance policy. The benefit provisions set forth the insurer's promises. Each benefit provided by the insurance policy is explained in detail, indicating what will be paid, the conditions that establish the insurer's liability to make payment, the conditions under which payment will be made, the nature and extent of benefits payable, and the applicable benefit limitations.

6.2 Benefit provisions are written with utmost care. They must be clear and precise, but at the same time broad enough to cover virtually any claim situation that can conceivably arise.

6.3 Let us take a look at some of the benefit provisions of a Medical Expense Insurance policy as an example.

BENEFIT PROVISIONS

A. Hospital And Surgical Benefits

"The Company agrees that if any disease, illness or injury necessitates the Insured Person to be confined to a Hospital as an Inpatient or for day surgery while he or she is covered under this Policy, the Company will pay the appropriate benefit stated below, subject to the limits set out in the Schedule of Benefits. Provided that the Insured Person has actually incurred the charges, the Company shall pay an amount equivalent to the actual charges incurred or the reasonable and customary charges or the maximum sum as specified in the Policy Schedule in respect of the incident concerned, whichever is the lowest.

1. **Daily Hospital Room and Board**
   Charges for room accommodation, meals and general nursing services for the insured person.

2. **Intensive Care Unit**
   Charges incurred during confinement as an Inpatient in the Intensive Care Unit of the Hospital.

3. **Hospital Miscellaneous Expenses**
   (a) Prescription of Drugs
   Charges for drugs prescribed which are medically necessary and directly in connection with the Insured Person's disability, provided that such drugs are listed in the Singapore Index Medical Supplies (SIMS) and excluding charges for drugs prescribed for use beyond sixty (60) days after discharge from the Hospital.

   (b) Inpatient Diagnostic Procedures and Inpatient Physiotherapy
   Charges for Inpatient Diagnostic Procedures or Inpatient Physiotherapy that relates directly to the Disability and is medically necessary for which the Insured Person receives treatment as an inpatient.

   (c) Ambulance Charges
   Charges incurred for necessary domestic ambulance service (inclusive of attendance) to and/or from the Hospital, provided that the Insured Person is admitted as an Inpatient.

6.4 Note: "The Company" means the insurance company named in the policy schedule.

7. EXCLUSIONS

7.1 Exclusions refer to the circumstances under which the insurer will not pay. In this section, we will highlight some important exclusions commonly found in a typical Health Insurance policy.

7.2 No benefits will be paid for charges which are in excess of the usual, customary and reasonable charges. Illness contracted within the waiting period, pre-existing conditions and the following categories will also not be covered by the policy:

(a) Surgical Procedures Or Examinations

(i) routine physical, pre-employment or premarital examination, immunisation or circumcision;
(ii) refraction, eye glasses or contact lenses, including fittings and examinations, or surgical correction of near-sightedness (such as, but not limited to, radial keratotomy and keratectomy);
(iii) examination, treatment or surgery of the teeth, gums or direct supporting structure, except as necessitated by an injury to sound natural teeth occurring while the cover for the insured person under this contract is in force;
(iv) aesthetic or cosmetic surgery, except for charges for treatment resulting from an injury which occurs while the cover for the insured person under the contract is in force. Such treatment must take place within 12 months of the injury, and while the cover for the insured person under this contract is in force;
(v) pregnancy, childbirth (including surgical delivery), abortion or miscarriage (except as a result of an injury) and pre-natal or post-natal care;
(vi) prosthesis, corrective devices or medical appliances which are not medically necessary;
(vii) donation of any body organ by the insured person; and
(viii) gender changes.

(b) Treatments

(i) test or treatment related to impotence, infertility, contraception or sterilisation;
(ii) treatment owing to birth defect, hereditary or congenital condition;
(iii) treatment of any diagnosed emotional, mental or nervous disability, including any condition caused by or resulting from such disability;
(iv) treatment which is in any way related to sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), or any infection from a human immunodeficiency virus (HIV), as well as their related complications;
(v) treatment resulting from suicide, attempted suicide, self-inflicted injury, narcotic or alcohol abuse, or participation in hazardous pursuit;
(vi) treatment of a disability that results from participation in any assault, criminal or unlawful act, strike, civil disorder or riot;
(vii) treatment directly or indirectly associated with invasion, act of foreign enemy, hostility or any act of war, whether or not declared,

civil war, rebellion, revolution, insurrection or military or usurped power, or full-time service in any of the armed forces, except for peacetime reservist training or mobilisation exercise in accordance with the Enlistment Act 1970;

(viii) treatment of a disability resulting from the use of nuclear weapon or from contact with nuclear material;

(ix) treatment of morbid obesity or related conditions; and

(x) treatment arising from the insured person's failure to act on proper medical advice.

(c) Confinement

(i) services, supplies or confinement days, which are not medically necessary;

(ii) period of confinement resulting from a disability not requiring surgery, unless the period of confinement is more than a specified period of time (e.g.12 or 18 hours); and

(iii) convalescent care, rest care, hospice care, rehabilitation or similar treatment.

(d) Other Services

(i) service performed by a person who ordinarily resides in the insured person's home or is a close relative;

(ii) transportation, other than ambulance transfer in the event of a medical emergency; and

(iii) ancillary expenses, such as (but not limited to) television, telephone, video, newspaper and family accommodation charges.

7.3 The list of exclusions changes from time to time, as new technologies surface which in turn affect medical cost.

8. CLAIM CONDITIONS

8.1 In this section, we highlight some important general claim conditions commonly found in a Health Insurance policy.

A. Notification Of Claim Condition

8.2 A typical Health Insurance policy includes provisions that define the insured's obligation to provide timely notification of loss to the insurer.

8.3 The period of time given to the policy owner to notify the insurer varies from policy to policy. For instance, instead of the usual 30 days, a Medical Expense Insurance policy may require the insured to notify the insurer, within 14 or 21 days from the date of hospital confinement.

B. Submission Of Claim

8.4 The policy owner must (at his own expense) give the insurer all certificates, forms, bills, receipts, information and evidence as required by the insurer. The policy owner must submit only original bills, invoices, receipts, discharge summary and other documents required to support a claim lodged with the insurer, unless such evidence and documents are electronically submitted on behalf of the insured person by a hospital or medical clinic or other medical establishment through the electronic submission system, MediClaim.

C. Physical Examination Provision

8.5 The Physical Examination provision included in most individual and group Disability Income policies is similar. After the policy owner submits a claim, the insurer has the right to have the insured person examined by a doctor of the insurer's choice, at the insurer's expense. Therefore, the insurer has the opportunity to verify the validity of any Disability Income claim submitted by the insured or claimant.

D. Mediation/Arbitration & Legal Action Provision

8.6 An individual Health Insurance policy will usually include a Dispute Resolution Clause. It specifies that any dispute or matter arising under the policy should be referred to the Financial Industry Disputes Resolution Centre Ltd (FIDReC) to be dealt with accordingly. The policy owner should refer such dispute or matter to FIDReC within six months from the date of failure to reach an agreement with the insurer.

8.7 If the dispute cannot be referred to or dealt with by FIDReC, the dispute will be referred to and decided using arbitration. This will be according to the Arbitration Rules of the Singapore International Arbitration Centre applicable at that point of time. The policy also states that the insurer will not be legally responsible under the policy, unless the policy owner has first received an award under arbitration.

8.8 Where both mediation and arbitration fail to settle the dispute, the policy owner may seek legal action against the insurer. The Legal Action Provision limits the time during which the policy owner who disagrees with the insurer's claim decision has the right to sue the insurer, to collect the amount which he believes is owed under the policy. The policy may state that no action in law or equity will be brought under the policy until after the expiration of 60 days from the date a satisfactory proof of claim has been furnished to the insurance company in accordance with the terms and conditions of the policy.

8.9 A policy issued by an insurer in Singapore will be construed according to and governed by the laws of the Republic of Singapore. These laws will apply in the event of any conflict or dispute under the policy, and the parties to the conflict or dispute must agree to submit themselves to the exclusive venue and jurisdiction of the Courts of the Republic of Singapore for the resolution of any conflict or dispute.

9. ENDORSEMENTS

9.1 An endorsement is a separate document that modifies the policy to which it is attached. There are several types of endorsements concerning the policy wording, benefits or exclusions, etc.

9.2 Endorsements can be passed to amend or include additional terms to the policy, so that the policy conforms to the legislative requirements.

9.3 Endorsements can also serve as supplementary agreements that provide optional benefits not previously contained in the basic policy. Such benefits require a separate additional premium. Examples of such supplementary benefits are maternity benefits for attachment to a Hospital & Surgical Insurance policy. Endorsements pertaining to supplementary benefits may be attached to the policy, when they are issued or they may be added at a later date. When added, they become part of the policy.

9.4 Endorsements on exclusions restrict the scope of coverage, by excluding a specific pre-existing condition or certain activities or avocations. The insurer may require this form of endorsement as a pre-condition for issuing a policy. This is one type of counter-offer. If the insured signs the endorsement and accepts the policy as offered, there is a binding contract. A copy of the signed endorsement remains attached to the policy.

10. CONCLUSION

10.1 As an insurance representative, you should help your prospective clients to understand the standard policy provisions and terms, as well as to explain to them the endorsements attaching to their policies.

APPENDIX 10A

POLICY SCHEDULE

ABC Insurance Company (Singapore) Limited

21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

Policy Issue Date: **POLICY SCHEDULE**

THIS SCHEDULE REFLECTS THE TERMS, CONDITIONS AND COVERAGE OF YOUR INSURANCE POLICY, SUBJECT OTHERWISE TO THE STANDARD POLICY WORDING AND/OR ANY OTHER AMENDMENTS AS SPECIFIED IN THIS SCHEDULE.

NAME OF POLICY OWNER:
NRIC OF POLICY OWNER:
ADDRESS:

NAME OF INSURED PERSON:
NRIC OFINSURED PERSON:
ADDRESS:

TERRITORIAL LIMITS : Anywhere in the Republic of Singapore, and elsewhere in the world for the purpose of travel, but not for any intended or booked medical treatment overseas by the Insured Person.

DETAILS OF POLICY
Policy Number:
Type Of Plan:
Sum insured/ Benefits:
Policy Commencement Date:
Policy Expiry Date:
Premium: S$
Endorsements: Nil

CHAPTER 10

COMMON POLICY PROVISIONS

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Sections of a Health Insurance policy contract	• Policy Schedule. • Insuring Clause & Definitions. • General Conditions. • Benefit Provisions. • Exclusions. • Claim Conditions. • Endorsements.
Information contained in a Health Insurance policy schedule	The policy schedule gives the specific details of the policy contract. • Policy number; • Effective date of cover; • Expiry date of cover; • Date at which the policy is issued; • Contract currency; • Name and identity number of the policy owner; • Name, age, gender and identity number of the insured person; • Name of insurance plan; • Types of riders and the coverage limits (if any); • Premiums for the insurance plan and riders; • Coverage details on benefits limits or sum insured; and • Special provisions/endorsements indicating the types of endorsements attached to the policy.
Insuring clause	The insuring clause also known as the operative clause states the purpose of the policy and outlines the conditions under which the policy will pay. The insuring clause serves to: • Describe the general scope of coverage; • Provide any definitions required; and • Set forth the conditions under which the benefits are payable.

Common terms under a Health Insurance policy

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Dependant	• Spouse and children of the policy owner (or of the employee in the case of Group Insurance). • A spouse is typically defined as the person to whom the policy owner is legally married under the laws of the country. A spouse is no longer considered a dependant in the case of legal separation. • As for a child, he must typically be unmarried, under the age of 18 years, and principally dependent on the insured for support. This definition also includes the legally adopted children and stepchildren of the insured. Most insurers will extend the cover up to age of 18 or 25 years if the child is pursuing a tertiary education.
Insured/insured person	• The insured person is the person covered by the insurance. The insured person, more often than not, is the policy owner.
Accident	• An incident caused by accidental, violent, external and visible means. Note that some insurers may not have the "violent" requirement in their definition of "accident"
Hospital	• Any lawfully operating institution which has 24-hour a day nursing services by registered graduate nurses, one or more physicians available at all times and organised facilities for diagnosis and major surgery.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Any one disability	• Disabilities resulting from illness or bodily injury and their complications arising from the same cause. However, if any subsequent disability arising after a specified number of days (e.g. 45 or 90 days, depending on the policy wording of the insurer) has lapsed following the latest discharge from hospital, then it shall be considered a new disability, regardless of the cause.
Covered charges	• Charges incurred by the insured person, while the policy is in force, for a service, supply or period of confinement, which has been ordered or prescribed by a physician.
Day of hospital confinement	• Refers to a full 24 hours during a period of hospital confinement.
Registered medical practitioner/physician	• Qualified medical practitioner registered with the Singapore Medical Council to render medical and surgical services. It excludes a physician who is the policy owner, insured person himself or his spouse or any of his lineal relatives.
Medically necessary service, supply or day of hospital confinement	A service, supply or day of hospital confinement, which is ordered by a physician and which is: • Provided for the diagnosis or direct treatment of a disability; • Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the insured person's disability; • Provided in accordance with generally accepted medical practices on a national basis; • Most appropriate supply or level of service which can be provided on a cost effective basis; and • Not of an experimental or investigative nature, or research purposes.
Period of hospital confinement	• Continual period of time where an insured person is confined to a hospital as a registered inpatient. • Two or more periods of hospital confinement resulting from the same or related causes, are considered as the same period of hospital confinement, unless the break between the date of discharge of the earlier period of hospital confinement and the date of admission of the following period of hospital confinement is more than a specified number of days (e.g. 45 days).
Pre-existing condition	It is usually defined as a condition which has existed and: • For which the insured person received treatment or medical advice; • In respect of which the insured person showed symptoms; • Of which the insured person was aware; and • Of which the insured person should reasonably have been aware; before the date of policy issue or the date that the cover was reinstated.
Policyholder/policy owner	• The policy owner owns the policy and is responsible for the payment of premiums and receipt of claims and benefits under the policy. He has the right to make changes to the contract and receive all payments due under the policy.
Usual, customary and reasonable	It means the charges for a specific service, supply or period of hospital confinement: • Is within standard charge for the specific provider; and • Must not be more than the general level of charges of other medical care providers with similar standing in the same geographical area, for an equivalent treatment, services or supplies to individuals of the same gender, of comparable age, for a similar illness or injury.
Waiting period	• For **Medical Expense Insurance**, it refers to the period of time starting from the date of policy issue or reinstatement date, where the insured person's medical expenses are not covered by the policy. Waiting period differs from insurer to insurer and applies only to medical expenses arising from an illness, not from an accident. • For **Disability Income Insurance**, it refers to a specified period of time, beginning with the onset of the disability, where benefits are not payable. The waiting period in a Disability Income Insurance policy is sometimes called the "elimination period" or the "probationary period". • For **Long-Term Care (LTC) Insurance**, it refers to a period of time beginning from the first day the insured person is unable to perform the specified Activities of Daily Living (ADLs), during which no LTC Insurance benefit will be payable. For LTC Insurance, this may also be known as the deferred period.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Illness	• Illness refers to a physical condition marked by a pathological deviation from the normal healthy state.
Pre-hospitalisation benefits	• Refers to the diagnostic X-ray, laboratory tests and specialist consultation for an illness or injury which occurred within a specified number of days prior to hospitalisation. The insurer will pay only for such outpatient treatments if they lead to hospitalisation or surgical operation, within the time frame as specified in the policy.
Per policy year limit	• Maximum amount that a Medical Expense Insurance (MEI) policy will pay for all the eligible medical expenses that an insured person incurs within each policy year.
Lifetime limit	• Maximum amount that a MEI policy will pay for all the eligible medical expenses that an insured person incurs under the policy.
Deductible and co-insurance	• Deductible is a flat amount of covered medical expenses that an insured person must first incur, before the insurer will make any benefit payment under a MEI policy. This amount will have to be borne by the insured person. • Co-insurance is a percentage of all eligible medical expenses, in excess of the deductible, that the insured person must personally pay under a MEI policy.
Pro-ration factor	• Percentage that the insurer will use to pro-rate the hospital bills before it computes the claim payout, if the insured person is admitted to a ward/hospital higher than what he is entitled to under the policy.

General conditions sections that outline the rights of the policy owner and the insurer

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Entire contract clause	• This clause states that the present contract, together with any specified attachments/endorsements, make up the entire contract, and no other documents form another part of the contract.
Effective date of cover	• The effective date of cover is established in the policy by agreement between the insurer and the policy owner. It is the date on which the insured person begins to be covered under the Health Insurance policy.
Premium clauses	• **Individual Health Insurance Policies Issued By Life Insurers** - When the policy is first incepted, the premiums must be paid before inception of cover. When the policy is renewed during the second year onwards, it is subject to a Grace Period whereby the premium must be paid within 30 days from inception of cover. • **Group Health Insurance Policies Issued By Life Insurers** – Grace Period provision within such policies which states that the premium has to be paid within 30 days from the commencement date or renewal date (whichever is applicable); or the date of the insurer's premium tax invoice, whichever is later. • **Health Insurance Policies Issued By General Insurers** – Subject to the **Payment Before Cover Warranty** which states that the policy shall not be in force, unless the premium is paid to the insurer or intermediary on or before the date of inception of the policy. • **Group Health Insurance Policies Issued By General Insurers** – Subject to the **Premium Payment Warranty** which states that if the period of insurance is more than 60 days, the policyholder is required to pay the premium due under the policy in full, within 60 days from the date of inception of the policy.
Free-look period	• Period of time after delivery of the policy document during which the policy owner may review the policy and return it for a refund of the premium paid to the insurer (less any medical fees incurred)
Actively at work	• **Group Insurance** - It provides that an employee is not eligible for coverage, if he is absent from work because of an illness, injury and other reasons on the effective date of his coverage. • **Disability Income Insurance** - It provides that the cover will automatically terminate, when the person is not working owing to illness or termination of service.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Termination of cover	• When the insured person dies; • When the policy owner fails to pay the renewal premium at the end of the grace period; • When the total amount of claims paid by the insurer has reached the limit of indemnity; or • When the insured person reaches the specified maximum age during which the insurer is not willing to offer cover.
Cover abroad	Applicable only to the covered charges incurred in the "Country" as specified in the policy schedule. It is also applicable under the following circumstances: • The insured person, travelling abroad for a reason other than for medical treatment, needs to be confined to a hospital outside the "Country" as a consequence of a medical emergency occurring within 90 days of leaving the "Country"; or • The insured person, upon recommendation of a physician and with the prior written approval of the chief medical officer of the insurer, has to be transferred to a hospital outside the "Country" because the specialised nature of the treatment, aid, information or decision required can neither be rendered, nor furnished, nor taken, in that "Country".
Renewal	The Renewal Provision describes: • Circumstances under which the insurer has the right to refuse to renew or the right to cancel the coverage; and • Insurer's right to increase the amount of premium payable on the policy
Mis-statement of age or gender	• Provision specifies that, in the case of an insured person mis-stating his age or gender, the insurer will adjust the premium based on his correct age and gender. • Any excess premium paid will be refunded by the insurer, and any shortfall in premium will have to be made up by the policy owner.
Grace period	• Allows the policy owner to pay a renewal premium, within a stated grace period, following the premium due date.
Reinstatement	• If certain conditions are met, the insurer will reinstate a policy that has lapsed for non-payment of premiums. The policy owner must pay any overdue premium (with or without interest as determined by the insurer) and the insured person must complete a reinstatement application/health warranty.
Incontestability	• The Incontestability provision makes Life Insurance policies indisputable after they have been in force for a certain minimum period (usually one year), with the exception of fraud.
Change of occupation	• A Change Of Occupation provision that permits the insurer to adjust the premium rate or the amount of benefits payable under the policy if the insured person changes occupation.
Co-ordination of benefits	• This provision states that the benefits payable under the policy will be reduced if the insured person is eligible for reimbursement from other sources.
Cancellation	• A provision that allows the policy owner to cancel the policy by giving written notice to the insurer within a certain period of time (e.g. seven days).
Change of plan	• A provision to allow the insured person to upgrade or downgrade the coverage plan. Any upgrading of plan is subject to satisfactory evidence of insurability at the policy owner's expense.
Currency	• Where payment of claims is on reimbursement basis, the policy will state the currency for the benefits payable. • Generally, payment of all claims and benefits will be made in Singapore currency.
Last payer status	• Appears in the MediShield Life and Private Integrated Shield Plans. • If the insured person has any other Medical Insurance, including medical benefits (such as from Work Injury Compensation Insurance) under any employment contract, which makes provision for reimbursement of medical expenses, the insurer shall be the last payer reimbursing the claim.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Nomination of beneficiaries	The insured who is the policyowner can make a nomination as long as he has attained the age of 18 years. Two options of nomination as briefly described below are available: • Trust or Irrevocable Nomination (Section 132 of the Act) – The insured loses all rights to the ownership of the policy. To revoke this trust nomination, the insured needs the written consent of all the nominees. • Revocable Nomination (Section 133 of the Act) – The insured retains the ownership of the policy and is free to change, add or remove nominees, without their consent.
Policy Owners' Protection Scheme	• Policy Owners' Protection Scheme (PPF Scheme) has been set up to protect the policy owners in the event of failure of a life or general insurer which is a PPF Scheme member. • The PPF Scheme is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage under the PPF Scheme is automatic, and no further action is required from the policy owners.

Various bases upon which Health Insurance policies can be issued

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Cancellable	• The Renewal Provision included in a cancellable policy (e.g. some Medical Expense Insurance policies) grants the insurer the right to terminate the policy at any time, for any reason, simply by notifying the policy owner in writing that the policy is cancelled, and by refunding any advance premium that has been paid for the policy.
Optionally renewable	• The insurer has the right to refuse to renew an optionally renewable policy on certain dates as specified in the policy, usually either on the policy anniversary date or on any premium due date. • The insurer is also allowed to increase its premium rate and to add coverage limitations, such as eliminating coverage for injuries to certain parts of the body, or limiting the extent of coverage for certain occurrences.
Conditionally renewable	• The insurer may elect not to renew only under conditions as specified in the policy. • These conditions cannot be related to the insured person's health.
Guaranteed renewable	In some policies, the insurer relinquishes the rights to cancel the policy at any time, as well as to refuse renewal at a premium due date. This type of policy is said to be guaranteed renewable, and it includes several important features, such as: • Renewal is guaranteed, as long as the policy owner pays the premium; • The insurer may not cancel the policy, unless the policy owner fails to pay the premium; • Premiums may be increased on the basis of an entire classification, such as occupation or sub-plan; and • Guaranteed policy renewal until the specified age, such as 60, 65, 70 or 75 years, depending on the insurer's policy.
Non-renewable	In some situations, an individual may need Health Insurance for a fixed, limited period of time. When it expires, the insured person must purchase another policy.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Common exclusions that are found in Health Insurance policies	**Surgical Procedures Or Examinations** • Routine physical, pre-employment or premarital examination, immunisation or circumcision; • Refraction, eye glasses or contact lenses, including fittings and examinations, or surgical correction of near-sightedness (such as, but not limited to, radial keratotomy and keratectomy); • Examination, treatment or surgery of the teeth, gums or direct supporting structure, except as necessitated by an injury to sound natural teeth occurring while the cover for the insured person under this contract is in force; • Aesthetic or cosmetic surgery, except for charges for treatment resulting from an injury which occurs while the cover for the insured person under the contract is in force. Such treatment must take place within 12 months of the injury, and while the cover for the insured person under this contract is in force; • Pregnancy, childbirth (including surgical delivery), abortion or miscarriage (except as a result of an injury) and pre-natal or post-natal care; • Prosthesis, corrective devices or medical appliances which are not medically necessary; • Donation of any body organ by the insured person; and • Gender changes.
Common exclusions that are found in Health Insurance policies	**Treatments** • Test or treatment related to impotence, infertility, contraception or sterilisation; • Treatment owing to birth defect, hereditary or congenital condition; • Treatment of any diagnosed emotional, mental or nervous disability, including any condition caused by or resulting from such disability; • Treatment which is in any way related to sexually transmitted disease, Acquired Immune Deficiency Syndrome (AIDS), or any infection from a human immunodeficiency virus (HIV), as well as their related complications; • Treatment resulting from suicide, attempted suicide, self-inflicted injury, narcotic or alcohol abuse, or participation in hazardous pursuit; • Treatment of a disability that results from participation in any assault, criminal or unlawful act, strike, civil disorder or riot; • Treatment directly or indirectly associated with invasion, act of foreign enemy, hostility or any act of war, whether or not declared, civil war, rebellion, revolution, insurrection or military or usurped power, or full-time service in any of the armed forces, except for peacetime reservist training or mobilisation exercise in accordance with the Enlistment Act 1970; • Treatment of a disability resulting from the use of nuclear weapon or from contact with nuclear material; • Treatment of morbid obesity or related conditions; and • Treatment arising from the insured person's failure to act on proper medical advice. **Confinement** • Services, supplies or confinement days, which are not medically necessary; • Period of confinement resulting from a disability not requiring surgery, unless the period of confinement is more than a specified period of time (e.g.12 or 18 hours); and • Convalescent care, rest care, hospice care, rehabilitation or similar treatment. **Other Services** • Service performed by a person who ordinarily resides in the insured person's home or is a close relative; • Transportation, other than ambulance transfer in the event of a medical emergency; and • Ancillary expenses, such as (but not limited to) television, telephone, video, newspaper and family accommodation charges.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Notification of claim condition	A typical Health Insurance policy includes provisions that define the insured's obligation to provide timely notification of loss to the insurer.
Physical examination provision	After the policy owner submits a claim, the insurer has the right to have the insured person examined by a doctor of the insurer's choice, at the insurer's expense.
Mediation/arbitration and legal actions provision	An individual Health Insurance policy will usually include a Dispute Resolution Clause. • Referred to the Financial Industry Disputes Resolution Centre Ltd (FIDReC) to be dealt with accordingly. The policy owner should refer such dispute or matter to FIDReC within six months from the date of failure to reach an agreement with the insurer. • If the dispute cannot be referred to or dealt with by FIDReC, the dispute will be referred to and decided using arbitration. This will be according to the Arbitration Rules of the Singapore International Arbitration Centre applicable at that point of time. • Where both mediation and arbitration fail to settle the dispute, the policy owner may seek legal action against the insurer.
Endorsement	A separate document that modifies the policy to which it is attached. • To amend or include additional terms to the policy • Serve as supplementary agreements that provide optional benefits not previously contained in the basic policy. • Exclusions to restrict the scope of coverage.

CHAPTER 11
HEALTH INSURANCE PRICING

CHAPTER OUTLINE

1. Introduction
2. Key Factors Used In Premium Computation
3. Parameters For Premium Rating

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- explain the key factors used in the premium computation:
  - morbidity experience
  - investment income
  - operating expenses
  - medical inflation
  - scope of benefits covered
  - insurer's profit
  - modes of premium payment
  - extent of underwriting
- know the parameters for premium rating:
  - age
  - gender
  - physical condition
  - occupation
  - persistency
  - claims experience
  - group participation level

Contents

CHAPTER OUTLINE 246
LEARNING OUTCOMES 246
1. INTRODUCTION 248
2. KEY FACTORS USED IN PREMIUM COMPUTATION 248
A. Morbidity Experience 248
B. Investment Income 248
C. Operating Expenses 249
D. Medical Inflation 249
E. Scope Of Benefits Covered 249
F. Insurer's Profit 250
G. Modes Of Premium Payment 250
H. Extent Of Underwriting 251
3. PARAMETERS FOR PREMIUM RATING 251
A. Age 251
B. Gender 251
C. Health Status 251
D. Lifestyle 252
E. Occupation 252
F. Persistency 253
G. Claims Experience 253
H. Group Participation Level 253

1. INTRODUCTION

1.1 This chapter discusses the factors used in the premium computation for the Health Insurance products, the premium system and the various forms of premium payment modes. It also summarises the parameters on which the premium rates for the Individual and Group Health Insurance policies are based.

2. KEY FACTORS USED IN PREMIUM COMPUTATION

2.1 It is important for you to get an idea of how insurers set prices for their insurance products. If you understand the key factors used in the computing premiums, you will have a better understanding of the Health Insurance products themselves.

2.2 The key factors used to calculate Health Insurance premiums are:

- morbidity experience;
- investment income;
- operating expenses;
- medical inflation;
- scope of benefits covered;
- insurer's profit;
- modes of premium payment; and
- extent of underwriting.

A. Morbidity Experience

2.3 Morbidity experience or morbidity rate means the actual number of illness, injury, or failure of health cases occurring in a given group of people. In Health Insurance, the primary consideration in pricing insurance coverage is the morbidity experience (i.e. morbidity rate), although death experience is taken into consideration, where death benefit is available. For the purpose of computing premiums easily, the insurers make use of morbidity tables. A morbidity table is a table that shows the rates of illness, injury, or failure of health (i.e. morbidity rates) occurring among the given groups of people categorised by age. All things being equal, the morbidity rate of women is higher than men. That is why women pay higher premium rates than men for most Health Insurance policies.

B. Investment Income

2.4 The second key factor that affects pricing is investment income. Simply, investment income is the money that is earned, when an insurer invests the premiums which it receives from many insureds (policyowners or policyholders).

2.5 As you know, premiums are the main source of money for paying out claims on the different types of medical benefits (or even death benefits for those policies that include both medical and death coverage). However, not all of the premiums that an insurer receives each year are needed to pay benefits in that year. Some insureds live for many years and pay premiums to keep their policies in force throughout those years. These premiums are not left idle. Insurers invest these premium dollars to earn more money. As such, investment income can be looked upon as an additional source of funds for the insurer to meet its obligations.

2.6 Investment income also helps to reduce the amount of money that insurers have to charge for their insurance. Based on market conditions, if the insurers expect to earn greater investment income, the premiums that they charge will likely be lower.

C. Operating Expenses

2.7 A third factor, expenses, increases the price of insurance. It is not sufficient for insurers to collect enough premiums to just cover the costs of insurance. They must also collect enough money, to pay for the costs of operating the company, such as staff salaries, commissions for sellers, taxes, office rent, advertising, computer systems, supplies, etc. All of these expenses are necessary to run an insurance company and must be added to the costs of insurance. Otherwise, the insurers will not be able to operate.

D. Medical Inflation

2.8 Over the years, there has been a consistent upward trend in medical care claim costs experienced by both individual and group plans. These rising costs of claims are associated with increases in medical care charges and higher utilisation of services, especially when there is a growing ageing population in Singapore.

2.9 To ensure that the insurers can meet their obligations, they also take into account the medical inflation factor. Otherwise, the premiums charged will not be adequate to cover the rising medical costs.

E. Scope Of Benefits Covered

2.10 In a competitive insurance market, insurers attempt to attract more insured persons and retain them for a long time through activities, such as effective customer promotion, innovative product design, efficient distribution channels, good before-sales and after-sales service, etc.

2.11 Providing several types of benefits under one policy is another way of producing a product that is appealing to customers. However, this strategy comes with a price – additions of each benefit actually increase the final premium that the insurer charges.

2.12 The effect of differences in benefits can be explained using a Hospital & Surgical (H&S) Insurance policy. Generally, some of the most common types of benefits covered under a H&S Insurance policy are:

- Hospital Expense Benefits;
- Surgical Expense Benefits;
- Outpatient Medical Expense Benefits; and
- Other Medical Expense & Auxiliary Benefits.

2.13 H&S Insurance policies may provide very limited cover and only one or two types of benefits, such as hospital or surgical expenses only. Other policies may be more broadly written to cover virtually all medical expenses resulting from accident or sickness, with only some specific exceptions. Insurers often offer a few types of plans under a H&S Insurance policy, and each type of plan has its own benefit limits, deductible and co-insurance features. Policies with higher benefit limits, smaller deductible; and smaller co-insurance will be more expensive.

2.14 In Singapore, the most common type of H&S Insurance policies is the Integrated Shield Plans that are paid using Medisave savings (as discussed in **Chapter 8** of this Study Guide). The benefits that are offered by the insurers are very similar. All of them offer an assortment of plans to cater for different needs, with a choice of ward class that the insured prefers. Naturally, those who prefer to stay in Private Hospitals will buy a plan that is more expensive than one that caters for only Class A (Public Hospitals) and below.

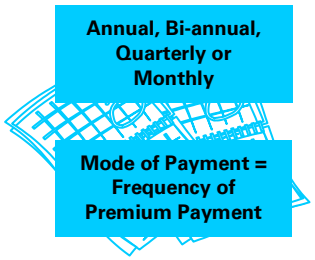
F. Insurer's Profit

2.15 Insurers enter the market with the primary objective to profit from the business. When pricing a product, insurers include a loading in the net premium to provide a profit margin. This loading depends on the insurer's profit target and strategy, as well as the nature of the business. For example, an insurer who is going for market share may settle for a thinner profit margin. On the other hand, a line of business that is volatile or requires more capital support will result in an increase in the amount of loading.

G. Modes Of Premium Payment

2.16 This means the frequency with which the premiums are payable. Payments may be made:

- annually – once a year;
- bi-annually – twice a year;
- quarterly – once every three months; or
- monthly – once a month.



2.17 Insurers generally calculate premiums on an annual basis. If the insured wants to pay any of the other modes, the premium increases slightly as the frequency increases. The increases allow the insurer to recoup:

- the additional billing and handling costs; and
- the lost interest that the insurer could have earned, by having the full annual premium to invest all at once.

2.18 Thus, a monthly premium is slightly higher than a sixth of a semi-annual premium; and a semi-annual premium that is slightly higher than half of an annual premium.

H. Extent Of Underwriting

2.19 The time and effort required to gather medical declaration from the insured person at the point of policy application can be lengthy. Some insurers choose to do minimal risk assessment, by reducing the number of health declarations on the proposal form. To do so, insurers will charge a higher premium.

3. PARAMETERS FOR PREMIUM RATING

3.1 After covering the seven key determinants that insurers use in computing premiums, let us now look at the parameters pertaining to a particular individual or a group by age, gender, health status, lifestyle, occupation, claims experience, moral hazard, etc., and see how each of them has an effect on the level of premiums to be charged.

A. Age

3.2 Age is a key parameter in arriving at the premium rates, regardless of whether it is an individual or group plan. Among different age groups, there are differences in claim frequency and claim severity. For example, a 50-year-old person is more likely to experience a long illness or need a longer recovery period than a 30-year-old person.

B. Gender

3.3 Gender is also an important factor in developing the premium rates for group and individual products. Statistics shows that women in general made more medical claims than men. That is why a female pays a higher premium for Medical Insurance as compared to a male of the same age.

C. Health Status

3.4 The health status of the proposed insured person is a major consideration in the policy pricing. An individual with a pre-existing medical condition can expect his proposal to attract special underwriting terms and conditions, or even declined.

D. Lifestyle

3.5 The lifestyle of the proposed insured can also influence the premium charge. Participation in a hazardous sport which exposes him to a higher risk of injuries (e.g. recreational flying, mountaineering or scuba-diving) will require extra premiums. The alternative by the insurer is to exclude injuries sustained in specified activities from the insurance coverage.

3.6 The most important lifestyle factor for determining premium rate is smoking. For example, a proposed insured who is a non-smoker is usually at less risk, and can expect to pay a lower premium for insurance than a person who smokes.

E. Occupation

3.7 A proposed insured's occupation can have a strong influence on the risk that he presents. Some occupation has occupational risk or hazard. This means that he has a higher chance of an injury or illness by reason of the duties of a specific occupation.

3.8 Based on an analysis of information compiled over the years, insurers have grouped various occupations into classes with basically the same degree of accident or illness hazard. This permits a fair means to establish premium rates based upon occupational hazard. For example, a high-rise construction worker could be more likely to suffer an injury by reason of occupation than would an office administrator.

3.9 Many insurers issue manuals to their insurance representatives on which occupational classifications are listed. The insurers cannot list every possible occupation, but most jobs have been broadly classified.

3.10 As you would expect, the higher the risk of injury or illness resulting from an occupation, the *higher* the insurance premium is likely to be.

F. Persistency

3.11 Persistency, which refers to the percentage of policies renewed each year, is a parameter in pricing both Individual and Group Health Insurance. Persistency usually improves as the policies age. For some types of coverage, the annual persistency rate may reach 95% or higher by the fifth policy year.

3.12 Persistency also varies by age groups. A group of younger insureds (e.g. ages of 20 to 29 years) may have poorer persistency than a group of older insureds (e.g. ages of 50 to 59 years). The older insureds will tend to see the policy as more valuable, because they may have more difficulty satisfying the underwriting requirements associated with buying a new policy.

3.13 If the persistency rate of a type of coverage is expected to be high, then the insurer will reduce the amount of premium charged.

G. Claims Experience

3.14 Claims experience of the portfolio or population is important when pricing Health Insurance. An actuary has to ensure that, above all other expenses, the premiums must be sufficient to pay expected claims. For group plans, claims experience of the group is a key factor affecting the premium rate charged. For example, for group outpatient plans, claims experience demonstrates the general health condition of the group and the propensity of the group members to file claims. The importance of the claims experience data in pricing increases as the group size gets bigger, and more years of data are available.

H. Group Participation Level

3.15 For voluntary group plans, the extent of participation by employees in the plan is an important parameter in the development of premium rates. If the participation is low, there will be a greater chance that a higher than normal proportion of unhealthy lives will seek coverage. This is called adverse selection or anti-selection. If the participation level is high, there will likely be more healthy lives to compensate for anti-selection. Thus, many insurers vary premium rates based on the participation level.

CHAPTER 11

HEALTH INSURANCE PRICING

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Morbidity experience	Morbidity experience or morbidity rate means the actual number of illness, injury, or failure of health cases occurring in a given group of people.
Investment income	Investment income is the money that is earned, when an insurer invests the premiums which it receives from many insureds (policyowners or policyholders).
Operating expenses	Expenses increases the price of insurance. It is not sufficient for insurers to collect enough premiums to just cover the costs of insurance. They must also collect enough money, to pay for the costs of operating the company, such as staff salaries, commissions for sellers, taxes, office rent, advertising, computer systems, supplies, etc.
Medical inflation	• Consistent upward trend in medical care claim costs experienced by both individual and group plans. • Rising costs of claims are associated with increases in medical care charges and higher utilisation of services.
Scope of benefits covered	Providing several types of benefits under one policy is another way of producing a product that is appealing to customers. However, this strategy comes with a price – additions of each benefit actually increase the final premium that the insurer charges.
Insurer's profit	Insurers enter the market with the primary objective to profit from the business. When pricing a product, insurers include a loading in the net premium to provide a profit margin.
Modes of premium payment	Frequency with which the premiums are payable. • Annually – once a year; • Bi-annually – twice a year; • Quarterly – once every three months; or • Monthly – once a month.
Extent of underwriting	Time and effort required to gather medical declaration from the insured person at the point of policy application.
Parameters for premium rating	• Age. • Gender. • Health status. • Lifestyle. • Occupation. • Persistency. • Claims experience. • Group participation level.

CHAPTER 12
HEALTH INSURANCE UNDERWRITING

CHAPTER OUTLINE

1. Introduction
2. What Is Underwriting?
3. Underwriting Factors That Affect The Risk
4. Sources Of Underwriting Information
5. How An Insurance Representative Can Help In The Underwriting Process
6. Final Underwriting Decision
7. Commencement Of Risk
8. Conclusion

Appendix 12A – Sample Supplementary Lifestyle Questionnaire
Appendix 12B – Sample Individual Hospital & Surgical Insurance Proposal Form
Appendix 12C – Sample Group Hospital & Surgical Insurance Proposal And Health Declaration Form

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- explain what underwriting is
- explain the underwriting factors that affect a risk:
  - medical factors
  - non-medical factors
- know the underwriting factors that are specifically important for each type of Health Insurance
- know the types of underwriting methods for Medical Expense Insurance
- know the various underwriting factors for Group Insurance
- identify the sources of underwriting information
- know how an insurance representative can help in the underwriting process
- understand the various terms of acceptance for Health Insurance proposals
- know when the risk commences

Contents

CHAPTER OUTLINE 254
LEARNING OUTCOMES 254
1. INTRODUCTION 257
2. WHAT IS UNDERWRITING? 257
3. UNDERWRITING FACTORS THAT AFFECT THE RISK 257
A. Medical Factors 257
A1. Medical History 257
A2. Current Physical Conditions 258
B. Non-medical Aspects Of Underwriting 258
B1. Financial Factor 258
B2. Occupational Factor 259
B3. Age Factor 259
B4. Residency Factor 259
B5. Additional Underwriting Considerations 259
C. Factors That Are Specifically Important For Each Type Of Health Insurance 260
C1. Medical Expense Insurance 260
C2. Disability Income Insurance 260
C3. Long-Term Care Insurance 261
C4. Critical Illness Insurance 261
C5. Managed Healthcare 261
D. Types Of Underwriting Methods For Health Insurance 261
D1. Full Medical Underwriting 262
D2. Moratorium Underwriting (Used for Medical Expense Insurance) 262
D3. Simplified Issuance Offer (SIO) 263
D4. Guaranteed Issuance Offer (GIO) 264
E. Group Underwriting 264
E1. Reason For Existence 264
E2. Group Stability 264
E3. Group Size 265
E4. Insured Company's Nature Of Business 265
E5. Employee Classes 265
E6. Level Of Participation 265
E7. Age & Gender Within The Group 265
E8. Expected Persistency 266
E9. Past Claims Experience 266
E10. Medical Inflation 267

E11. Medical Utilisation Rate & Trend 267
4. SOURCES OF UNDERWRITING INFORMATION 267
A. Proposal Form 267
A1. Sections Of A Proposal Form 268
B. The Agent's Statement 269
C. Medical Examinations/Tests 269
D. Attending Physician's Statement (APS) 270
E. Supplementary Questionnaires 270
5. HOW AN INSURANCE REPRESENTATIVE CAN HELP IN THE UNDERWRITING PROCESS 270
6. FINAL UNDERWRITING DECISION 271
A. Standard Risks 271
B. Sub-standard Risks 271
B1. Modifications Of Cover 271
B2. Postponement 272
B3. Decline 273
7. COMMENCEMENT OF RISK 273
8. CONCLUSION 273
APPENDIX 12A 274
APPENDIX 12B 275
APPENDIX 12C 278

1. INTRODUCTION

1.1 In this chapter, we will discuss the factors that underwriters look at when underwriting Health Insurance proposals on individual and group bases. We will also look at the various terms of acceptance that underwriters may impose on Health Insurance proposals. Let us begin by looking at what underwriting is all about.

2. WHAT IS UNDERWRITING?

2.1 Underwriting is the process, whereby an insurer assesses the risk and determines whether or not to accept an application and, if so, on what terms that it will offer coverage to the applicant or proposer. The main purpose of underwriting is to ensure that the premiums charged correspond closely with the risk that each proposer represents. While Life Insurance underwriting is concerned primarily with mortality (i.e. the incidence of death within a given population), Health Insurance underwriting is concerned primarily with morbidity which is the incidence of injury, illness or failure of health.

3. UNDERWRITING FACTORS THAT AFFECT THE RISK

3.1 The factors that affect a risk can be broadly classified as:

- medical; and
- non-medical

3.2 Let us begin by looking at the medical aspects of underwriting of a Health Insurance proposal, assuming that the proposer and the person/life to be insured (also known as the proposed insured in market practice) are the same person indicated in the proposal submission to the insurer.

A. Medical Factors

3.3 This requires a review of both the medical history and current physical conditions of the proposer, to determine on what basis coverage can be offered. Underwriters evaluate risks by considering the probable influence of current impairments and previous medical histories on future claims. For example, signs of cognitive (psychological) impairments indicate that the proposer is a poor or uninsurable risk for Long-Term Care Insurance.

A1. Medical History

3.4 The proposal form asked questions on the medical history of the proposer. Underwriter may require more information on the declared medical conditions. For example, if the proposer states that he is receiving treatment for high blood pressure, an attending physician's statement will be required for policies, such as Critical Illness Insurance and Disability Income Insurance, etc. In addition to obtaining general medical information, the underwriter will ask the attending physician about blood pressure readings, medication prescribed, and the

degree of control achieved. If a physical examination was not required before, the underwriter could now ask for one to get current blood pressure readings.

3.5 Insurers review histories of previous conditions to determine the:

- possibility of recurrence;
- effect of a medical history on the proposer's general health;
- complications likely to develop at a later date; and/or
- normal progression of any impairment.

3.6 Disabilities resulting from diseases of, say, the digestive system may also be more frequent or prolonged than will be anticipated without such a history.

3.7 Many acute disorders can be disregarded if recovery has been prompt and complete, and without evidence of any residual impairment. Examples include simple bone fractures or an appendectomy.

3.8 Latent complications, or the deterioration of an existing impairment are possible with many conditions. For example, overweight and elevated blood pressure, while normally not disabling in themselves, are considered indicators of a higher future incidence of cardiovascular impairment.

A2. Current Physical Conditions

3.9 The proposer's statements on a proposal form and medical examination results are the first indicators of present physical conditions. Additional tests and studies, e.g. urinalysis, blood studies, cognitive assessments and electrocardiograms (ECGs), may be required, depending on the age of the proposer and the amount of insurance coverage applied for.

B. Non-medical Aspects Of Underwriting

3.10 Non-medical factors can also have varying effects on the different classes of Health Insurance, as can be seen in the sections mentioned below:

B1. Financial Factor

3.11 The proposer's financial situation (i.e. income, assets and debts) is not a key consideration in underwriting most types of Health Insurance policies. In considering an application, this information allows an underwriter to gauge if the proposer has the ability to continue paying for the premium and keeping the policy throughout the term.

3.12 Financial information is important in underwriting individual Disability Income Insurance. This is because the underwriter must ensure that the benefit amount applied for is reasonable and not higher than 75% of his current income.

3.13 To determine whether the benefit (for Disability Income Insurance) is justifiable, the underwriter must consider the proposer's income, both earned and unearned (e.g. from investments). He must also take into account the proposer's net worth. A high net worth is significant, even if the proposer's assets are not producing substantial investment income at the time of underwriting. Assets can be shifted to income generating investments if the insured becomes disabled, and the resulting income combined with disability insurance benefits can lessen the insured's incentive to return to work.

B2. Occupational Factor

3.14 The proposer's occupation can have a strong influence on the risk that he presents. Occupational hazards fall into the following two main categories:

- accident hazards; and
- health hazards.

3.15 Some occupations, such as painters engaged to paint the exterior of tall buildings, have a higher risk of accidental injuries, thereby increasing the probability of hospitalisation. Occupations involving the handling of asbestos products have a higher risk of health hazard over time, as it can lead to asbestosis[1].

B3. Age Factor

3.16 Medical problems tend to increase with age. Hence, the underwriting guidelines call for more requirement on medical examinations/tests and attending physicians' statements for older proposers. The underwriter may also be investigating on the medical histories of older proposers more thoroughly, because of the increased possibility of related problems that may not be reflected in such proposal forms submitted.

B4. Residency Factor

3.17 Past, current and future residency can be important risk factors. Underwriter looks out for applicants who may travel to war zones, areas where there are health related risk or even politically unstable areas as part of the underwriting consideration.

B5. Additional Underwriting Considerations

(a) Avocation & Lifestyle Risks

Avocation and lifestyle risks are those which are associated with higher probabilities of contracting accidents or illnesses.

[1] Asbestosis is a disease caused by the inhalation of asbestos fibres and dust which can lead to respiratory failure and other complications. The incidence of carcinoma (cancer) of the lung is also higher for people exposed to asbestos dust.

Engagements in the following activities are considered to be lifestyle risks:

- drug abuse;
- multiple sexual partners;
- navigational recreational activity;
- hazardous occupations; and
- hazardous sports, such as motor racing, mountaineering, parachuting and scuba diving.

Insurers may require the completion of specially designed questionnaires, such as a supplementary lifestyle questionnaire for underwriting (see **Appendix 12A**).

(b) Habits

Both alcohol and drug uses by the proposer represent serious risks. Either activity can result in significant health problems or cause serious accidents while driving or during leisure activities. This is also known as the Proximate Cause.

C. Factors That Are Specifically Important For Each Type Of Health Insurance

3.18 Certain factors tend to be more important than others in the underwriting of each type of Health Insurance.

C1. Medical Expense Insurance

3.19 When assessing Medical Expense Insurance, the medical background or history and current physical condition of the proposer are the basic indicators of the probability of future problems that may result in medical expenses for hospitalisation and treatment. A proposer with a pre-existing condition when buying Medical Expense Insurance will usually have the condition excluded from coverage by the insurer. For example, the insurer will exclude all conditions relating to the heart for any proposer with hypertension (or high blood pressure).

C2. Disability Income Insurance

3.20 The size and stability of the proposer's earnings and his overall financial situation are important factors for the underwriting of Disability Income Insurance. Minor accident or illness may result in a disability for some people because of his nature of work, e.g. a throat infection may result in a singer having to cancel his show, and thus, disrupting his flow of earnings. To evaluate the occupational risks more accurately, underwriters have developed occupational risk classifications, as statistics show that persons in professional occupations (such as accountants) and those with relatively high incomes have fewer periods of disabilities, as well as disabilities of shorter duration than persons in other occupations. Details of the various types of occupational risks classifications used by underwriters are given in **Chapter 4** of this Study Guide. The chapter also discusses in detail the other underwriting factors for this class of insurance.

C3. Long-Term Care Insurance

3.21 The two key factors for the underwriting of Long-Term Care Insurance (LTC) cover is the detection of any early cognitive impairment and morbidity risk. Statistics show that cognitive impairment is the major source of LTC claims that can last a long time. This is why some insurers require the proposer to undergo some form of cognitive assessment during the underwriting stage. The second factor is assessing the morbidity risk of an individual. This means the chance of a person suffering any physical disability which will affect the individual's ability to perform his activities of daily living. Many conditions which may not be significant in the assessment of a mortality risk will be critical for a LTC risk. For example, any musculoskeletal condition will be a potential risk for LTC coverage.

C4. Critical Illness Insurance

3.22 For Critical Illness Insurance underwriting, besides the proposer's medical history and current physical conditions, the following two other factors are also important:

- smoking habit; and
- family history.

3.23 Smoking can increase the incidence of a person suffering from cardiovascular and cerebrovascular diseases, and cancer. Some diseases like diabetes mellitus, and breast and colon cancers have high prevalence among family members.

C5. Managed Healthcare

3.24 The key considerations for the underwriting of Managed Healthcare (MHC) are similar to those for Medical Expense Insurance cover.

3.25 However, when MHC covers are issued to groups, the age and gender of the group are strong factors in assessing the risk in the group. Older groups are associated with higher morbidity, while groups with a large proportion of females of child-bearing age tend to have higher costs, in view of healthcare and hospitalisation associated with pregnancies and deliveries.

D. Types Of Underwriting Methods For Health Insurance

3.26 There are four underwriting methods for Health Insurance cover:

- Full Medical Underwriting;
- Moratorium Underwriting also known as Point-of-Claim Underwriting.
- Simplified Issuance Offer (SIO)
- Guaranteed Issuance Offer (GIO)

D1. Full Medical Underwriting

3.27 Full medical underwriting is where the proposer completes a health declaration when he first applies for cover, in order to let the insurer know about his health and medical background or history. The insurer will review the health declaration details and decide the basis on which the insurer can accept him for cover. If necessary, the insurer may need to ask him or his attending physician for further information. The insurer may also ask him to undergo a medical examination.

3.28 If the proposer has a pre-existing condition that may need treatment in the future, it will usually be excluded from cover, along with any conditions related to it.

3.29 The insurer will provide written confirmation of any specific medical conditions that are excluded because of the proposer's personal medical history, as well as the terms of the policy. The proposer could request the insurer to review the exclusions in the future should he wish to do so.

3.30 **Advantage Of Full Medical Underwriting -** Although this method involves the proposer more time to complete his proposal form, when he (the insured) receives his policy document, he will have the certainty as to what is covered at the point of commencing the insurance cover, rather than at the time of making a claim.

D2. Moratorium Underwriting (Used for Medical Expense Insurance)

3.31 The proposer does not need to fill in a health declaration in his application, nor need to undergo a medical examination for this method. Instead, the insurer will declare a waiting period (usually two to five years) that will automatically exclude any pre-existing conditions for which he has received treatment and/or medication, or has been asked advice on, or has symptoms of (whether or not diagnosed) during the declared waiting period immediately before the commencement date of the Medical Expense Insurance cover.

3.32 However, if the proposer does not have any symptom, treatment, medication, or advice for those pre-existing conditions, and any directly related conditions during the waiting period, he will be covered when those conditions recur, subject to the terms and conditions of the policy, once the declared waiting period ends.

3.33 It is important to understand that long-term medical conditions (such as stroke, kidney failure, heart bypass and dementia), which are likely to continue to need regular or periodic treatment, medication or medical advice, will never be covered by the policy, even after a moratorium, or waiting period, has elapsed or passed, as it is unlikely they will meet the moratorium conditions. However, even if the proposer declares these conditions under a full medical underwriting method, these declared conditions will also be permanently excluded by the insurer.

3.34 The proposer should not delay in seeking medical advice or treatment for a pre-existing condition simply to obtain cover under the policy.

3.35 **Advantage Of Moratorium Underwriting -** The method allows policy to be issued quickly. The proposed insured will be asked to provide only basic information about himself. He will not be asked to disclose details of his medical history. However, he has to understand that, if he has any pre-existing medical condition, it will be excluded from cover. Also, if he can satisfy the moratorium criteria (two to five years as outlined in the above section) for a pre-existing condition, then treatment for that condition will automatically be covered if it later recurs, subject to the policy terms and conditions.

3.36 Full medical underwriting should always be the starting point, and insurance advisers should never use the moratorium underwriting for their own convenience. Moratorium underwriting should only be used where it affords a genuine advantage for the clients.

Example 12.1

The proposer has suffered from kidney stones recently. Will he be covered for any further treatment after the commencement date of his policy?

Under Full Medical Underwriting: No, he has to declare this information under his full medical declaration, and a personal medical exclusion will be applied to his policy. This means that he will not be covered for future problems associated with his kidney stones and any related conditions.

Under Moratorium Underwriting: No, as he has suffered from this condition before the commencement date of his policy, this condition will not be covered. He will be eligible for cover only if he does not have any symptom, treatment, medication or advice over a continuous period of time (two to five years, depending on the policy conditions) after the commencement date of his policy.

D3. Simplified Issuance Offer (SIO)

3.37 In Simplified Issuance Offer, the proposer is typically asked only a few questions and depending on the underwriting guidelines of the insurance company you are applying for coverage, the answers to those questions will determine whether the application is approved or not, as well as the cost of the policy. The proposer will not be sent for medical examination.

3.38 SIO are typically used in Critical Illness Plans where insurers market it via direct or online channel.

3.39 Pros and Cons of SIO – This method allows applicants to get coverage quickly as compared to days or weeks with Full Medical Underwriting method. However, premium is higher due to greater risk the insurer will assume.

D4. Guaranteed Issuance Offer (GIO)

3.40 Guaranteed Issuance Offer required no medical questions nor medical examination. The insurer guarantees to issue the policy so long as the applicant is eligible for cover and this is usually an age requirement. Eg GIO is only offered to someone below age 60. To minimise risk of anti-selection, GIO policies are capped at a limited coverage and pre-existing conditions are usually excluded permanently.

3.41 GIO is used in Hospital Income Plans or Single Critical Illness Plan where the products are sold via direct or online channel.

3.42 Pros and Cons of GIO – This method guarantees applicants to get coverage immediately regardless of health but they must be prepared to pay a higher premiums for the ease of getting cover.

E. Group Underwriting

3.43 The underwriting process for Group Insurance differs from that for individual policies. Group is underwritten as a whole, before considering the risks imposed by the individual members in the group. Underwriters select the eligibility of a group based on a number of factors which include:

E1. Reason For Existence

3.44 Underwriter needs to ensure that the reason for the existence of a group applying for the group coverage is for some purpose (e.g. operating a business as in the case of employers) other than for purchasing the insurance. This is to reduce any anti-selection from the group.

3.45 Group members must be actively at work on a full-time regular basis and have predictable incomes.

3.46 Examples of groups eligible for Group Insurance include:

- employer-employee groups;
- multiple-employer groups, such as trade associations and labour unions;
- members of professional associations or affinity groups, such as leisure clubs; and
- creditor-debtor groups which generally consist of credit granting institutions, such as banks and their debtors.

E2. Group Stability

3.47 Group stability is an important consideration. An unusually high turnover rate in the group can result in high administrative costs for insurers, as they need to add new members and delete leaving members from the programme. On the other hand, if a group that has a stable membership over a long period of time can also be riskier. The members in the group become older, without any new

and presumably younger members being added to the group, and hence, the group becomes a greater underwriting risk at each renewal because of higher average age.

3.48 An ideal group for insurers is one in which there is a steady flow of new members to replace those who leave the group, but not a massive influx or outflow of members.

E3. Group Size

3.49 Group size is important as it provides a better spread and diversification of the risk. It allows for more efficient administration and lower costs. However, the gender distribution, age profile and the sum assured of each insured member are also factors directly affecting the premiums.

E4. Insured Company's Nature Of Business

3.50 Certain lines of business tend to be more risky than others. A group from the oil rigging or timber logging industry is an example of a high-risk group. The economic prospects of the industry in which the business operates and the strength and financial condition of the business itself are also important factors, as they will affect the sustainability and growth potential of the group.

E5. Employee Classes

3.51 Employee classes are often based on conditions of employment, such as job title, salary amount or length of service. It has effects of over-representation. For example, over-representation by a highly paid class can result in higher-than-average medical claims, since people with higher incomes tend to use more expensive medical services (e.g. private clinics and private hospitals) than do people with lower incomes. Over-representation by a class in which the employees earn low incomes can result in a higher-than-desired rate of turnover.

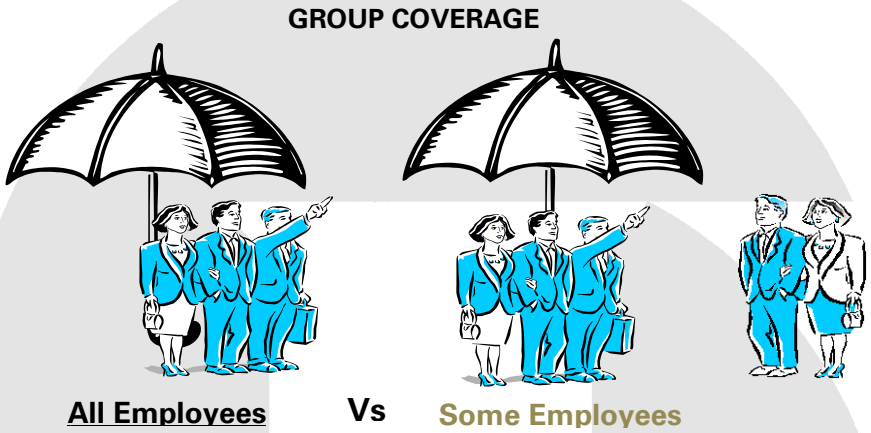
E6. Level Of Participation

3.52 Underwriters are particularly concerned about the level of participation in a contributory plan as members' participation in such a plan is on a voluntary basis. Insurers normally specify a minimum participation level requirement (e.g. between 70% and 90%) of eligible group members. This is to guard against anti-selection by spreading of risk, as well as to reduce administrative costs, across a wide range of expected mortality within such a group.

E7. Age & Gender Within The Group

3.53 Age is an important factor in underwriting, as it increases the mortality of the group to be insured. Gender in the form of the ratio of males to females is also an important consideration, as females have lower mortality rates (but higher morbidity rates) than males.

3.54 The underwriting requirements are very much dependent on the size of the group and the type of insurance applied for. For example, a group size of 20 members applying for a Group Medical Expense Insurance policy may not be required to complete individual Health Declaration forms. However, if this group applies for a Critical Illness Insurance policy, the underwriter will require every member to complete a Health Declaration form. For those whose sum assureds exceed the free cover limit[2], the underwriter will require them to go for medical examinations and/or other tests in accordance with the underwriting guidelines.



E8. Expected Persistency

3.55 New business cost (acquisition expenses) can be substantial (e.g. underwriting the proposal) to the insurer when acquiring a new group. The insurer will spread the acquisition expenses over an extended period, typically three to five years, so that the first year will be more competitive. For this reason, the insurer wants some assurance that the new business will remain in the books until these expenses are recovered. As such, the insurer will want to avoid any business that may be short-lived (e.g. special project group) or an employer that has a history of frequently switching insurers.

E9. Past Claims Experience

3.56 A group's claims history can be a good indicator of the likely future claims experience of this portfolio. For example, for a large group with an average S$100,000 past claims per year, an insurer can reasonably expect similar claims utilisation (assuming no change in the composition and profile of the group) and can charge premiums accordingly. This is why past claims experience is an important factor in group underwriting consideration.

[2] Free cover limit is the maximum coverage that an insurer is willing to provide to each member of a group without asking for declaration of health. Excess sum assured above the free cover limit will be underwritten before such coverage is granted.

E10. Medical Inflation

3.57 Medical inflation is the increase in the costs for medical services over a period of time. It may vary based on the types of services. For example, hospital costs may increase faster than physician charges.

3.58 Medical inflation will affect the claims experience of a group and is an important factor in group underwriting. It is measured by comparing historical data to more current cost data, over a period of time (e.g. 12 months).

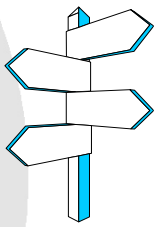
E11. Medical Utilisation Rate & Trend

3.59 Changes in utilisation can affect the trend. For example, when a group policy has been in force for some time, the average age may rise, thus increasing the frequency of claims in the group. Changes in medical practice, such as the use of new drugs, will also affect the cost of a plan. Hence, the medical utilisation rate and trend are important factors that underwriters will take into consideration, when assessing the risks posed by the group.

4. SOURCES OF UNDERWRITING INFORMATION

4.1 The underwriter relies on information obtained from various sources to make his decision. The primary source is the proposal form. Others include:

- Agent's Statement;
- Medical Examinations/Tests;
- Attending Physician's Statement (APS); and
- Supplementary Questionnaires.



4.2 The extent to which the underwriter uses these sources of information depends on the type and size of the policy applied for. A proposal for a S$500 (per month) Disability Income Insurance policy with benefits for two years on a person under the age of 30 years may require a review of only the most significant health history, as well as a confirmation of the person's salary that he is earning at the moment. On the other hand, a proposal from a 50-year-old person for a Disability Income Insurance policy for S$10,000 a month, with benefits to the age of 65 years, will require more careful scrutiny. More information, such as additional medical tests and a large sum assured financial questionnaire, will be required for underwriting.

A. Proposal Form

4.3 The proposal (application) form is the primary source of underwriting information for the insurer. It provides the basic information for the underwriter to make a decision, to provide the requisite coverage, or to modify it, to try to obtain more information, or to reject the proposal entirely.

4.4 After the policy is issued, the proposal will form a part of the insurance contract and is used as the basis when a claim is filed. If an insurer determines before the end of the contestable period that there has been a false statement or

incomplete disclosure of material information on the proposal, the insurer may reject the claim and rescind the contract. As such, every proposal form is required by the Insurance Act 1966, to include a warning statement, such as the following, to ensure that the duty of good faith is kept by the insured:

"Pursuant to Section 23(5) of the Insurance Act 1966, you are to disclose in this proposal form fully and faithfully, all the facts which you know or ought to know, otherwise, you may receive nothing from the policy."

A1. Sections Of A Proposal Form

4.5 Although the proposal form can vary for each of the Health Insurance products, it generally contains the information as described below:

(i) Identities Of The Contract Parties

The insurance contract is between the insurer and the proposer.

The header of the proposal form has the name of the insurer, its principal place of business and contact details, so the proposer knows to which insurer he is applying for an insurance policy. The questions contained in the "Particulars of Life To Be Insured (the proposed insured) and Particulars of Proposer" sections serve two purposes:

- They distinguish the proposer from the proposed insured. Although the proposed insured and the proposer are normally the same person, in a third-party insurance (for example, a mother applying for insurance for a child), they are different persons.

- They provide relevant information to the underwriting department to assess the risk factors, such as occupation, age and gender. The information determines the eligibility of the person applying for coverage, as well as the correct premium to be charged.

(ii) Particulars Of Policy Applied For

This section indicates the details of the policy that the proposer is applying for, such as the type of plan and sum insured.

(iii) Information On Past Applications & Existing Policies

This section is meant for the proposer to state the types of policies that he already has or has applied for, but was postponed or rejected. The proposer also needs to indicate whether he is purchasing this policy to replace an existing policy.

(iv) Personal Health Details & Habits Of The Proposed Insured

This section provides a detailed description of the proposed insured's medical history, current physical condition, habits in terms of drug taking, alcohol drinking, as well as family history.

(v) Declaration

The signatures of the proposer and proposed insured are very important, as they serve a number of purposes as follows:

- that the proposer/proposed insured has disclosed all material facts truthfully and faithfully in the proposal form;
- that the proposer/proposed insured has not withheld any material facts;
- that the proposer/proposed insured is aware that the benefits may be lost if material facts are not disclosed; and
- that the proposer/proposed insured agrees and authorises the insurer to release to any medical source or insurance office and vice versa, any information concerning him at any time, regardless of whether the proposal is eventually taken up.

4.6 The format of the proposal form and the depth of its questions vary among the insurers, depending on the types of products. Sample copies of the Individual Insurance proposal form and Group Insurance proposal form are in **Appendices 12B and 12C** respectively.

4.7 The proposer and proposed insured must personally sign the proposal form and counter-sign on any changes made to the proposal form, as the responsibility of proper disclosure of material facts in the proposal form lies with the proposer and proposed insured.

B. The Agent's Statement

4.8 Most insurers provide separate forms for confidential remarks by agents, such as how long and how well they know their proposers.

4.9 An agent may also be asked to indicate:

- knowledge of any information on the proposer that is not included in the proposal form, but which may have a bearing on risk selection; and
- the proposer's approximate net worth, annual earned income, and income from sources other than employment.

4.10 An insurance representative who lets the underwriter know of special circumstances of the sale, or a special problem not otherwise identified will gain the underwriter's confidence. Often the insurance representative's remarks may clarify a situation that is questionable or unclear, based on information from other sources.

C. Medical Examinations/Tests

4.11 Insurers require medical examinations/tests for certain types of Health Insurance, namely Disability Income Insurance, Critical Illness Insurance and Long-Term Care Insurance. A physician appointed by the medical director of the insurer usually completes these examinations and records the answers to the medical questions. The proposer needs to sign the medical examination form.

4.12 The examination provides information on the height and weight, pulse, blood pressure, and other important clinical/medical findings.

4.13 Other common tests that an insurer may request include:

- Electrocardiogram (ECG) test;
- Chest X-ray;
- Micro-urinalysis;
- Blood profile analysis;
- Human immunodeficiency virus (HIV) Antibody test; and
- Cognitive assessment for Long-Term Care Insurance.

4.14 Cost of the medical examination is borne by the insurer, unless the policy is subsequently not taken up.

D. Attending Physician's Statement (APS)

4.15 An APS is a standard pre-printed form for the attending physician to complete on his personal knowledge of the proposer, based on the proposer's medical records. This report is usually required, when the underwriter needs to have a better insight into the proposer's medical history, that is not available from the medical examination.

E. Supplementary Questionnaires

4.16 The proposed insured may have to complete special questionnaires for the insurer to gather additional information to classify a risk. The forms usually deal with medical histories, financial information and special hazards.

4.17 The typical medical questionnaires are for such specific health histories like blood pressure conditions, asthma, ulcers or diabetes. The financial questionnaires attempt to elicit information about net worth and unearned (passive) income, or develop information on an insurable interest in a special type of business insurance situation. Some insurers use the supplementary questionnaires designed to obtain and develop information on certain activities, such as aviation, scuba diving, and various forms of racing.

5. HOW AN INSURANCE REPRESENTATIVE CAN HELP IN THE UNDERWRITING PROCESS

5.1 Since the insurance representative has personal contact with the client, he is in the best position to select the client. In fact, he is considered to be the field underwriter.

5.2 He can help by firstly, establishing his client's motivation and needs to purchase the policy. Secondly, he should go through the questions in the proposal form, informing his client to declare all the information truthfully and faithfully, and to the best of his knowledge and belief.

5.3 If any of the answers in the proposal form is "Yes", he should extract as much details as possible from his client. For example, if his client has told him of seeing a doctor for diabetes, the insurance representative should find out from his client as much information as possible, such as the following:

- Name and address of the attending doctor.
- When was the onset of the diabetes?
- Is he on insulin treatment or oral medication?
- Frequency that he needs to go for his follow-up treatment.
- Is he careful with his diet, etc.?

5.4 By obtaining all such information, the insurance representative can help the underwriter to decide whether there is a need to call for an APS, or a completion of a questionnaire on diabetes. If, on the other hand, his client says that he has diabetes without detailed information being provided, the underwriter is likely to request for further underwriting information.

5.5 By ensuring that all questions in the proposal form are duly completed and signed by the proposer in the presence of the insurance representative, it enables the proposal form to be processed expeditiously. Knowing the underwriting guidelines, such as when medical examinations/tests and supplementary questionnaires are required, will also help to expedite the underwriting process.

6. FINAL UNDERWRITING DECISION

6.1 The underwriter may accept a Health Insurance proposal on any one of the terms of acceptance as described below:

A. Standard Risks

6.2 When a proposal is accepted as a standard risk, the policy is issued, based on the premium rate stated in the rate book or brochure. The policy will then be issued if the premium has been fully paid. 80% to 90% of all proposals received by the insurer are accepted at standard rates.

B. Sub-standard Risks

6.3 Sub-standard risks are people with medical or non-medical impairments which make them higher risks to the insurer. The insurer deals with a sub-standard risk, by modifying the cover that the proposer has applied for. The insurer can modify the cover as described overleaf.

B1. Modifications Of Cover

6.4 Coverage modification may be an exclusion, an extra premium charge, a change in benefits, reducing the benefit-paying period, increasing the deferred period, or a combination of some of these approaches.

(i) Specific Exclusions

Exclusions is used as a means of issuing coverage to persons who would otherwise have to be declined. When an exclusion is imposed, an endorsement is issued to state that the insurer will not pay for any claim arising out of the particular excluded risk, such as from a particular medical problem, e.g. back disorder or an unusually hazardous activity (e.g. motor car racing). The endorsement may be worded to exclude coverage for only a specific disorder, such as "hernia", or it may exclude an entire system or bodily area, such as "disease or disorder of the stomach or intestines." The actual wording is determined by the nature and severity of the person's medical history or impairment, as well as by the insurer's underwriting philosophy. Specific exclusions are commonly used in Medical Expense Insurance.

(ii) Extra Premiums

Depending on the types of Health Insurance products that are underwritten, the insurer may charge extra premiums. This is commonly used in the underwriting of Disability Income Insurance and Critical Illness Insurance. However, it is rarely used in Medical Expense Insurance.

(iii) Modification Of Benefits Offered

Another method of modification is to change the benefits to something other than what the proposer has requested. Examples of such modifications include a reduction in the amount of monthly benefit, a longer deferred period, or shorter benefit period on a Disability Income Insurance policy. Sometimes, modifications are used in conjunction with imposition of extra premiums or exclusions.

In fact, some insurers will automatically limit the benefit period on a Disability Income proposer who requires a large extra premium. For instance, an insurer may not issue a benefit period of more than five years to any risk requiring an extra premium of over 50%.

Benefits may also be reduced, or expense participation (deductible and co-insurance) increased, to counteract the possible over-utilisation of Medical Expense Insurance policies.

B2. Postponement

6.5 At times, a proposed insured may have just undergone a surgical operation or is going for a surgery. For such a case, the underwriter will normally postpone the proposal for a specified period of time (e.g. six months after the surgical operation). That is, the underwriter is not able to offer any terms at that point of time, but is prepared to reconsider the case at a later date.

B3. Decline

6.6 The most drastic underwriting action is to decline a proposal. This choice is used only for serious medical reasons, or because the proposed insured is clearly outside a particular insurer's parameters of acceptable risks for occupational or financial reasons. Most insurers have declination rates below 10%.

6.7 Hence, it is important for the insurance representative to inform his prospective client that he should apply for Health Insurance when he is healthy, to avoid the risk of being declined later when his health deteriorates or fails. Furthermore, Health Insurance premiums typically increase with age as one gets older.

7. COMMENCEMENT OF RISK

7.1 Whatever the terms of acceptance, the insurer will communicate the underwriting decision to the proposer in the form of a letter of acceptance. If the proposer agrees to the terms as stated in the letter of acceptance and pays the premium, the cover will be effected, and a policy will be issued to him.

8. CONCLUSION

8.1 As can be seen, underwriting is an important process, because it helps to sieve out undesirable risks, and ensures that the premium charged corresponds with the risks involved. In fact, underwriters are considered as gatekeepers. They help to protect the insurer against anti-selection risk. It is important that the insurance representative cum field underwriter clearly understands the underwriting process and the factors involved in underwriting, as this will be of good help to both the insurer and the client.

APPENDIX 12A

SUPPLEMENTARY LIFESTYLE QUESTIONNAIRE

Name of Life to be Insured _____ Proposal for Life Insurance Number _____

Name of Proposer (if other than Life to be Insured)_____

PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966 AND ANY REPLACEMENT THEREOF, YOU ARE TO DISCLOSE IN THIS SUPPLEMENTARY QUESTIONNAIRE, FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY ISSUED HEREUNDER MAY BE VOID.

Acquired Immune Deficiency Syndrome (AIDS) is a new but significant risk for life insurance, particularly as there is now no known cure. As with dangerous sports, occupations and fatal diseases, life insurers are concerned to identify those individuals who are at risk of contracting AIDS. This is to ensure equity for all new proposers and to protect the funds and bonuses of all existing policy owners. To date, AIDS has mainly affected certain groups of people, although not exclusively. The life insurance industry, therefore, needs to identify members of these risk groups to ensure that established life selection principles are maintained. (**This does not mean that all members of such high risk groups will be refused cover).**

This questionnaire will also be given to those who purchase large sum assured.

In order to fulfil this aim, we must, therefore ask you to complete this form and return it to us in the envelope provided. Your answers will be treated confidentially. When completing this form, please ensure that you answer each question fully and to the best of your knowledge.

We would ask you to read carefully the declaration at the bottom of this form. Failure to disclose facts pertinent to these questions could affect payment of benefits. If you have any doubts whether to disclose any information, you are strongly advised to do so.

1. Do you belong to, or have you ever belonged to, any of the following AIDS high-risk groups? If yes, please indicate accordingly. a. homosexuals b. bisexuals c. intravenous drug users d. haemophiliacs e. prostitutes	
2. Have you ever had sexual relationships with any of the AIDS high risk groups indicated in Question (1)? If so, indicate which and when was the most recent encounter.	
3. Have you ever been tested, received medical advice, counselling or treatment in connection with AIDS or an AIDS-related condition or on suspicion that you may have AIDS, or an AIDS-related condition or are carrying the Human immunodeficiency virus (HIV)? Please give details of the circumstances in which the test or advice was sought. (Routine testing for blood donation purposes may be ignored).	
4. Have you ever been tested, received medical advice or treatment in connection with any sexually transmitted disease including hepatitis? If yes: a. indicate the type of sexually transmitted disease which you have contracted in the past. b. state the number of occasions and dates exposed to sexually transmitted diseases. c. give name and address of doctors who attended to you on these occasions.	
5. Have you ever been rejected as a blood or organ donor? If yes, when, by whom and for what reasons?	

I/We declare that the answers I/we have given are, to the best of my knowledge, true and complete and that I have not withheld any material information that may influence the assessment or acceptance of this proposal.

I/We consent to the Company seeking information from any doctor who has attended to me, including any named in my answers to the questions above.

I/We agree that this form will constitute part of my/our Proposal for Life Insurance and that failure to disclose any material fact known to me/us may invalidate the contract.

_____ _____

Signature of Life to be Insured Signature of Proposer (if other than Life to be Insured)

Date: Date:

ABC Insurance Company (Singapore) Limited

21 Any Street, ABC Centre, Singapore 654321 Tel: (65) 6789 8181 Fax: (65) 6789 8282

APPENDIX 12B

ABC Insurance Company (Singapore) Limited
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

INDIVIDUAL HOSPITAL & SURGICAL INSURANCE PROPOSAL FORM

Agent's Code: ☐☐☐☐☐☐☐☐☐ Policy No: ☐☐☐☐☐☐☐☐☐

Agent's Name: ____

WARNING:
PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS PROPOSAL FORM, FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE NOTHING MAY BE PAYABLE UNDER THE POLICY. IF YOU ARE NOT ABLE TO ANSWER ANY OF THE QUESTIONS IN THIS PROPOSAL BECAUSE YOU DO NOT HAVE THE ANSWERS AND ARE ALSO NOT ABLE TO OBTAIN THE INFORMATION TO ANSWER THE QUESTION(S), PLEASE INDICATE ACCORDINGLY.

A. PARTICULARS OF PROPOSER (Proposer can be a company / firm / individual)

Full Name as shown on NRIC/Passport/BC*

Mr/Mrs/Mdm/Miss/Dr*

Sex: M ☐ F ☐

Address: Postal Code :

Tel. No. Home: Office: Ext:

Race: ☐ Chinese ☐ Malay ☐ Indian ☐ Caucasian ☐ Others :

Nationality: Birth:

*NRIC/Passport No. of Birth: / Month Day Year

Age Next Birthday: Marital Status : ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Present Employment Status: ☐ Employed ☐ Unemployed ☐ Self-employed

Name and Address of Company: ____

Position Held: ______________________ Exact Nature of Duties involved: ______________________

B. PLAN PROPOSED

PLAN: ☐ A ☐ B ☐ C ☐ D ☐ E

Period of Insurance: from ______________ to ______________ Total Premium: PP: GST:
(dd/mm/yyyy) (dd/mm/yyyy)

C. PARTICULARS OF PERSONS TO BE INSURED

Full Name as in *NRIC/Passport/B.C.	*NRIC/B.C./Passport No.	Sex	Date of Birth	ANB	Height (m)	Weight (Kg)	Occupation	Relationship to Proposer
1.								
2.								
3.								
4.								

D. ADDRESS OF PERSON(S) TO BE INSURED (To be completed if it differs from above)

*Please delete accordingly.

E. STATEMENT BY PROPOSER

		YES	NO
1.	What is the name and address of the regular doctor?		
2.	For what and when have you consulted him or any other doctor in the past? Please give name of doctor consulted.		
3.	Are there any persons listed in Section (C) above currently under observation or receiving any treatment or medicine?	☐	☐
4.	Have any of the persons listed in Section (C) above ever had or ever been that any of them suffered from or had been treated for any of the following:		
a.	Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system?	☐	☐
b.	High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitations or any heart disorder?	☐	☐
c.	Epilepsy, fits, dizziness, mental or nervous disorder?	☐	☐
d.	Diabetes, sugar or blood in urine, kidney disorder, kidney colic or stone or hernia?	☐	☐
e.	Disease of the eyes, ears, nose or throat?	☐	☐
f.	Arthritis, sciatica, rheumatism, back, spine, bone, joint, muscle or skin disorder?	☐	☐
g.	Ulcer or disorder of the stomach, intestines, haemorrhoids or rectal disorder?	☐	☐
h.	Gall bladder stone or liver disease or any type of hepatitis?	☐	☐
i.	Cancer, tumour or growth of any organ system?	☐	☐
j.	Anaemia, thyroid disorder (such as Goitre) or rheumatic fever?	☐	☐
k.	Sexually transmitted disease such as syphilis, gonorrhoea or herpes or non-specific urethritis?	☐	☐
l.	Any illness, disease or injury not mentioned above?	☐	☐
5.	Have any of the persons listed in Section (C) above ever received medical advice, treatment or had a blood test in connection with AIDS or AIDS related conditions?	☐	☐

If any of the above answers to question 3, 4 or 5 is "YES", please furnish the details below, indicating the question number (You may use a separate sheet of paper, if the space provided is insufficient).

Question No.	Name of persons to be insured	Details of medical condition	Date treated / hospitalised	Types of treatment	Name & address of attending doctor/hospital

F. DECLARATION

I/We declare that no material facts, that is, facts likely to influence the assessment and acceptance of this proposal have been withheld and to the best of my/our knowledge and belief the information furnished herein is true and complete and in the case of a life of another the information furnished herein shall be the basis of the contract of assurance. I/We authorise any medical source or insurance office to release to ABC Insurance Company (Singapore) Limited and similarly ABC Insurance Company (Singapore) Limited to release to any medical source or insurance office, any relevant information concerning me/us at any time, irrespective of whether the proposal is accepted by ABC Insurance Company (Singapore) Limited. A photographic copy of this authorisation shall be as valid as the original. I/We understand that any payment made at the time of signing this proposal or thereafter shall be held as a deposit placed with ABC Insurance Company (Singapore) Limited until acceptance of this proposal by ABC Insurance Company (Singapore) Limited subject to the terms and conditions contained in the receipt issued in respect of the said payment.

I/We agree that should I decide to cancel the Policy issued in respect of this proposal within 14 days after receipt of the Policy document, the amount refunded to me/us shall be the premium paid less expenses in underwriting the Policy.

However, should the proposal be declined, then I/we shall be entitled to a full refund of the amount paid as premium for this proposal.

I/We further understand that the assurance granted shall be subject to the conditions in and endorsed on the Policy issued.

If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.

_____	_____
Signature of Proposer & Company's Stamp (if applicable)	Signature of Witness
Date: _____	Name: _____
_____	NRIC No. _____
Signature of Life Insured	
Date: _____	Date: _____

APPENDIX 12C

ABC Insurance Company (Singapore) Limited
21 Any Street, ABC Centre, Singapore 654321
Tel: (65) 6789 8181 Fax: (65) 6789 8282

GROUP HOSPITAL & SURGICAL INSURANCE PROPOSAL AND HEALTH DECLARATION FORM

PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966 AND ANY REPLACEMENT THEREOF, YOU ARE TO DISCLOSE IN THIS PROPOSAL FORM, FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY

A. GENERAL INFORMATION

Name of Company _____ Nature of Business _____

Postal Address: _____

Telephone No.: _____ Fax No.: _____ Agent or Broker _____

B. ELIGIBILITY

(i) How many people do your Company employ? _____

(ii) Is cover to be applied to all Employees? Yes ☐ No ☐

(iii) If No, please define the class of employees for whom cover is applied, e.g. Management, Executives, Administration Clerical staff. _____

C. PLAN TO BE INSURED (Please tick the plan applicable)

PLAN A ☐ **PLAN B** ☐ **PLAN C** ☐

EFFECTIVE DATE **(Subject to satisfactory health underwriting by the Company)** : _____

OTHER OPTIONS

D. GROUP MAJOR MEDICAL – (OPTIONAL)

	PLAN A ☐	**PLAN B** ☐	**PLAN C** ☐
Overall limit per year	SS$50,000	SS$75,000	SS$100,000
Co-insurance	20%	20%	20%

E. GROUP OUT-PATIENT CANCER TREATMENT AND KIDNEY DIALYSIS – (OPTIONAL)

	PLAN A ☐	**PLAN B** ☐	**PLAN C** ☐
Outpatient Cancer Treatment per year	SS$10,000	SS$20,000	SS$50,000
Outpatient Kidney Dialysis per year	SS$10,000	SS$20,000	SS$50,000

F.

Name of Insured Employee:	**Spouse (if insured)**	**Child(ren)***if insured**
Sex:		
Occupation:		
Date of Birth:		
Height (Cm) & Weight (Kg):		
NRIC/Passport/BC No.:		
Nationality*:		
Martial Status:		
Country of Residence**:		

Notes:
* Foreign Nationalities – Please furnish proof of current work permit/employment pass.
** To be completed if you or any of the family members to be insured have any intention of residing outside Singapore for a period of more than 90 days. Acceptance/Terms and Conditions are subject to the Company's approval.
*** Proof of student status is required for insured child(ren) above 18 years old.

G. HEALTH STATEMENT – To be completed by each insured employee

	Employee Yes/No	Spouse Yes/No	1st Child Yes/No	2nd Child Yes/No	3rd Child Yes/No
1. Have you or any of the family members to be insured ever had any life, accident, hospitalisation or sickness insurance rejected or cancelled or issued on special terms or declined on renewal?					
2. Do you or any of the family members to be insured have life, accident hospitalisation or sickness insurance with this or any other company?					
3. Do you or any of the family members to be insured have any physical defect, deformity, impairment of hearing or vision, or loss of hand, foot or vision?					
4. Have you or any of the family members to be insured:					
(a) ever had a surgical operation?					
(b) ever been advised to have a surgical operation which has not yet been performed?					
5. Are you or any of your family members to be insured currently under any observation or receiving any treatment or medicine?					
6. Have you or any of the family members to be insured ever had or been told you had or been treated for the following disorder or disease:					
(a) Chronic cough, spitting of blood, asthma, hay fever, pleurisy, tuberculosis or any other disease of the respiratory system?					
(b) High or low blood pressure, heart disease, chest pain, heart attack, shortness of breath, palpitations or any heart disorder?					
(c) Apoplexy, paralysis, epilepsy, fits, dizziness, mental or nervous disorder?					
(d) Diabetes, sugar or blood in urine, kidney disorder, kidney colic or stone or hernia?					
(e) Arthritis, sciatica, rheumatism, back, spine, bone, joint, muscle or skin disorder?					
(f) Ulcer or disorder of the stomach, intestines, haemorrhoids or rectal disorder?					
(g) Gall bladder stone or liver disease or any type of hepatitis?					
(h) Cancer, tumour or growth of any organ system, thyroid disorder (such as Goitre) or anaemia?					
(i) Female reproductive system including lumps, but not limited to fibroids or cysts.					
(j) Sexually transmitted disease such as syphilis, gonorrhoea or herpes or non-specific urethritis?					
(k) Any illness or disease or injury not mentioned above?					

7. What are the complete details of any questions under 1 to 6 above answered "YES"?

Question No.	Name of Person	Details of Medical Condition	Date of First Consultation	Duration of Illness	Name & Address of Dr/Hospital

8. Name and address of your regular doctor (if any)?

9. Please state the type of policy and policy number to Question 2 (above) if your answer is "Yes".

I hereby declare that the foregoing statement and particulars are true and complete and I have not withheld any information that may influence the acceptance of this proposal, and I agree that this proposal and declaration shall be the basis of the contract between me and the insurer.
I declare that I and all the named family members to be insured are Singapore citizens or permanent residents or work permit holders or employment pass holders working in Singapore.
It is further understood and agreed that the proposal will be effective only if it has been accepted by the company and the applicable premium has been paid.
I hereby authorise any hospital, surgeon, medical practitioner, clinic or other medical or medically related facilities, insurer or other organisation or person to release to ABC Insurance Company (Singapore) Limited any such information with respect to any illness and to provide earlier medical history concerning me/us.

Date

Signature of Proposer

CHAPTER 12

HEALTH INSURANCE UNDERWRITING

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
What is underwriting?	• Underwriting is the process, whereby an insurer assesses the risk and determines whether or not to accept an application and, if so, on what terms that it will offer coverage to the applicant or proposer.
Medical factors	• Medical history. • Current physical condition.
Non-medical factors	• Financial factor. • Occupational factor. • Age factor. • Residency factor. • Additional underwriting considerations.
Underwriting factors that are specifically important for Medical Expense Insurance	• Medical background or history. • Current physical condition.
Underwriting factors that are specifically important for Disability Income Insurance	• Size and stability of the proposer's earnings. • Overall financial situation.
Underwriting factors that are specifically important for Long-Term Care Insurance	• Detection of any early cognitive impairment. • Morbidity risk.
Underwriting factors that are specifically important for Critical Illness Insurance	• Smoking habit. • Family history.
Underwriting factors that are specifically important for Managed Healthcare	• Similar to those for Medical Expense Insurance cover. • Age and gender of the group are strong factors in assessing the risk in the group.
Types of underwriting methods for Health Insurance	• Full Medical Underwriting. • Moratorium Underwriting also known as Point-of-Claim Underwriting. • Simplified Issuance Offer (SIO). • Guaranteed Issuance Offer (GIO).
Various underwriting factors for Group Insurance	• Reasons for existence. • Group stability. • Group size. • Insured company's nature of business. • Employee classes. • Level of participation. • Age & gender within the group. • Expected persistency. • Past claims experience. • Medical inflation. • Medical utilisation rate and trend.
Sources of underwriting information	• Proposal form. • Agent's Statement. • Medical Examinations/Tests. • Attending Physician's Statement (APS). • Supplementary Questionnaires.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
How an insurance representative can help in the underwriting process?	• "Field underwriter". • By obtaining all required information, the insurance representative can help the underwriter to decide whether there is a need to call for an APS, or a completion of a questionnaire on diabetes. • By ensuring that all questions in the proposal form are duly completed and signed by the proposer in the presence of the insurance representative, it enables the proposal form to be processed expeditiously. • Knowing the underwriting guidelines, such as when medical examinations/tests and supplementary questionnaires are required, will also help to expedite the underwriting process.
Various terms of acceptance for Health Insurance proposals	• Standard risks. • Sub-standard risks. » Modifications of cover. » Postponement. » Decline.
When does the risk commences?	When the proposer agrees to the terms as stated in the letter of acceptance and pays the premium, the cover will be effected, and a policy will be issued to him.

CHAPTER 13

NOTICE NO: MAS 120 – DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

CHAPTER OUTLINE

1. Introduction
2. Scope Of Notice No: MAS 120
3. Structure Of Notice No: MAS 120

Appendix 13A – Notice No: MAS 120

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- understand the objective of Notice No: MAS 120
- know the types of products covered by this Notice and their definitions
- understand and explain the mandatory requirements for:
  - the disclosure requirements for sales of:
    - A&H policies
    - life policies that contain A&H benefits
  - the advisory process requirements in respect of:
    - know-your-client
    - needs analysis
    - documentation and record keeping
    - switching
  - the additional disclosure requirements being adhered to by direct insurers
- know about the non-mandatory best practice standards on information disclosure, provision of advice, and monitoring of switching for long-term A&H policies under this Notice

Contents

CHAPTER OUTLINE 280
LEARNING OUTCOMES 280
1. INTRODUCTION 282
2. SCOPE OF NOTICE NO: MAS 120 282
3. STRUCTURE OF NOTICE NO: MAS 120 282
APPENDIX 13A 285

1. INTRODUCTION

1.1 The Monetary Authority of Singapore (MAS) first issued Notice No: MAS 120 – Disclosure And Advisory Process Requirements For Accident And Health (A&H) Insurance Products on 30 January 2004. The last amendment to MAS 120 was made on 1 June 2022.

2. SCOPE OF NOTICE NO: MAS 120

2.1 This Notice comprises both mandatory requirements and best practice standards on the disclosure of information and provision of advice to policy owners for A&H policies and life policies that provide A&H benefits. This Notice is issued in accordance with Sections 67, 72 and 154(4) of the Insurance Act 1966.

2.2 Generally, this Notice applies to all direct insurers, licensed or exempt financial advisers who provide advice and/or arranges A&H policies and life policies that provide A&H benefits. This Notice does not apply where:

(a) such policies are in respect of reinsurance of liabilities under insurance policies; and

(b) such policies provide that the A&H benefits are paid out only if the insured becomes totally and permanently disabled, as defined under that policy.

3. STRUCTURE OF NOTICE NO: MAS 120

3.1 This Notice comprises the following:

Part I – Mandatory Requirements made up of:

Division 1: General Requirements For A&H Policies – No direct insurer should use the word "Shield" when naming A&H policy, unless that policy is a Medisave-approved policy.

Division 1A: Disclosure Requirements For A&H Policies – This covers the following:

(a) General information about the A&H insurance intermediary (including its business name under which it conducts its insurance business, its business address and its telephone number) and status of an A&H insurance representative (including his name, the A&H insurance intermediary or intermediaries for which he acts);

(b) Remuneration of the A&H insurance intermediary;

(c) Conflict of interest;

(d) Disclosure when providing advice, including:
  (i) nature and objective of the policy;
  (ii) details of the insurer;
  (iii) contractual rights and obligations;
  (iv) benefits of the policy;

(v) risks of the policy;
(vi) provision on free-look period of the policy;
(vii) claim on termination;
(viii) warnings, exclusions and disclaimers;

(e) Provisions and explanations of any benefit illustration, product summary, and group policy under A&H policies;

(f) Marketing material; and

(g) Telemarking and direct marketing.

Division 2: Disclosure Requirements For Life Policies That Contain A&H Benefits – This specifies the regulatory requirements by an A&H insurance intermediary and an A&H insurance representative of a licensed or exempt financial adviser, when providing advice and/or arrange life policies containing A&H benefits.

Division 3: Additional Disclosure Requirements For Direct Insurers – This covers:
(a) meeting the industry standards on the preparation of a benefit illustration or a product summary in respect of a policy that the direct insurer underwrites;

(b) disclosure of relevant information in the respective documents for every Integrated Shield Plan (IP) or non-IP;

(c) required font size (Times New Roman 10-point or larger) for product summary, statement, conditional offer letter or termination letter with standardised relevant statement of disclosures for any individual Medical Expense Insurance policy, as well as any A&H policy not being Medisave-approved policy; and

(d) disclosing and explaining the policy terms, including any addition, amendment or variation to be made in writing to the policy owner, at least 30 days before taking effect.

Division 4: Requirements On Provision Of Advice Relating To A&H Policies – This specifies that an A&H insurance intermediary who provides health policies to policy owners must comply with the requirements relating to the following aspects:
(a) Reasonable basis for providing advice;
(b) "Know-Your-Client";
(c) Needs analysis;
(d) Documentation and record keeping; and
(e) Switching of A&H Insurance policies.

This Division shall not apply:
(i) in circumstances where no recommendation is made, or where only factual information is provided with respect to any health policy; or
(ii) to any advice provided in respect of any ElderShield policy.

Division 5: Requirements On Provision Of Advice Relating To Life Policies That Contain A&H Benefits – This requires any A&H insurance intermediary or A&H insurance representative who is licensed or exempt financial adviser to comply with requirements relating to recommendations and provisions of advice as set out in the Financial Advisers Act 2001 and its notices issued, including Notice No: MAS 120.

Division 6: Offences Relating To This Part – This specifies that any person who fails to comply with any requirement under any relevant paragraph of Notice No: MAS 120 shall be guilty of an offence punishable under Section 142(3) of the Insurance Act 1966.

Part II – Non-mandatory Best Practice Standards

(1) Information Disclosure & Provision Of Advice – This specifies that an A&H insurance intermediary is expected to meet disclosures of all product and marketing information given to policy owners.

(2) Monitoring Of Switching For Long-Term A&H Policies – This requires the A&H insurance intermediary should ensure that the policy owner declares in writing whether he had been advised by the A&H insurance representative to switch policy.

3.2 For details of this Notice and its compliance requirements, refer to **Appendix 13A** which has been adapted in full from the MAS Website.

APPENDIX 13A

Notice No : MAS 120
Issue Date : 30 January 2004

Last revised on 1 June 2022*

DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

Introduction

1. This Notice is issued pursuant to sections 67, 72 and 154(4) of the Insurance Act 1966 ["the Act"] and comprises both mandatory requirements and best practice standards on the disclosure of information and provision of advice to policy owners for accident and health policies and life policies that provide accident and health benefits.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

2. This Notice applies to —

(a) any direct insurer licensed under the Act;

(b) any licensed financial adviser or exempt financial adviser which provides any financial advisory service in respect of life policies;

(c) any representative of a licensed financial adviser or an exempt financial adviser who provides any financial advisory service in respect of life policies;

(d) any direct insurance broker or exempt direct insurance broker;

(e) any person acting for a direct insurance broker or an exempt direct insurance broker;

(f) any insurance agent operating under written agreement pursuant to section 64; or

(g) any insurance agent who is not required to comply with section 64

when he or she or it provides advice or arranges contracts of insurance or both, in respect of accident and health policies and life policies that provides accident and health benefits but does not apply where –

(i) such policies are in respect of reinsurance of liabilities under insurance policies; and

(ii) such policies provide that the accident and health benefits are paid out only if the insured becomes totally and permanently disabled, as defined under that policy.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

3. This Notice sets out the following in two parts:

(a) Part I — Mandatory Requirements

(i) Division 1: General requirements for accident and health policies

(ii) Division 1A: Disclosure requirements for accident and health policies;

(iii) Division 2: Disclosure requirements for life policies that contain accident and health benefits;

(iv) Division 3: Additional disclosure requirements for direct insurers;

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

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

(vii) Division 6: Offences relating to this Part;

(b) Part II — Non-mandatory Best Practice Standards.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

Definition

5. For the purpose of this Notice:

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

(a) a direct insurer;

(b) a licensed financial adviser;

(c) an exempt financial adviser;

(d) a direct insurance broker; or

(e) an exempt direct insurance broker,

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

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

(a) employed by or who acts as an insurance agent for, a direct insurer;
(b) employed by or who acts for, a direct insurance broker or an exempt direct insurance broker; or
(c) employed by or who acts as a representative of, a licensed financial adviser or exempt financial adviser,

and provides advice on or arranges contracts of insurance or both, in respect of accident and health policies and life policies that provides accident and

health benefits as an insurance intermediary, but does not include a person who is an A&H insurance intermediary;

"additional private insurance coverage" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

[Deleted by MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"Central Provident Fund Board" means the Central Provident Fund Board constituted under section 3 of the Central Provident Fund Act 1953;
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

[Deleted by MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

[Deleted by MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"exempt direct insurance broker" means a person exempt from registering as a direct insurance broker under section 92(1)(a) to (f) of the Act who has notified the Authority, in such manner as may be prescribed under section 154(1), of his or her commencement of insurance broking business;

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

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

"individual medical expense policy" means an accident and health policy, other than an integrated shield plan and a non-integrated shield plan—

(a) where the policy owner is an individual; and

(b) the main purpose of the policy is to reimburse an insured for the medical costs incurred by him in seeking inpatient medical treatment;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

"integrated shield plan" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"insured" includes an intending insured;

"medisave account" has the same meaning as section 2 of the MediShield Life Scheme Act 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"Medisave-approved policy" means any, integrated shield plan, non-integrated shield plan or supplementary disability insurance policy;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment No. 2) 2020, with effect from 1 October 2020]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"MediShield Life Component" has the same meaning as regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"MediShield Life Scheme" means the Scheme established under section 3 of the MediShield Life Scheme Act 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"Medisave Withdrawal Limits" means the respective withdrawal limits specified in regulation 5(1) of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"non-integrated shield plan" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations 2015;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

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

(a) in the event of an injury to, or disability of, the insured as a result of accident;
(b) on the death by accident of the insured; or
(c) on the occurrence of a combination of (a) and (b);

"policy owner" includes an intending policy owner;

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

"representative" has the same meaning as in section 2 of the Financial Advisers Act 2001["the FA Act"];

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"selected A&H insurance representative client" means a client of the A&H insurance intermediary who has purchased a Medisave-approved policy through an A&H insurance representative who has been assigned a balanced scorecard grade B or worse under the remuneration framework set out under section 47 of the FA Act consecutively for two calendar quarters immediately preceding the quarter in which the representative closed the sale of the relevant Medisave-approved policy on behalf of the A&H insurance intermediary;

[MAS Notice 120 (Amendment) 2020, with effect from 13 April 2020]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"selected client" means any client who meets any two of the following criteria–
(a) is 62 years of age or older;
(b) is not proficient in spoken or written English;
(c) has below GCE 'O' level or 'N' level certifications, or equivalent academic qualifications;

[MAS Notice 120 (Amendment) 2020, with effect from 13 April 2020]

"supplementary disability insurance policy" has the meaning given by regulation 2 of the CareShield Life and Long-Term Care (Supplement Scheme) Regulations 2020

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

"switching" includes terminating a policy and replacing it with another policy, and "switch" shall be construed accordingly;

"upgrading" means varying the terms of an existing policy or terminating an existing policy to purchase a new policy with the same insurer for the purpose of having better benefits than that under the existing policy, and "upgrade" shall be construed accordingly.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

Sections 67 and 72

7. For the purposes of section 67(1)(d) and (2)(e) of the Act, an A&H intermediary must also disclose the material information set out in paragraphs 12 to 18, 20 to 22, and 27(a) to (d).

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

8. For the purposes of section 72 of the Act, the standards to be maintained by an insurance intermediary in the conduct of business relating to disclosure and advisory process include those set out in paragraphs 19, 23 to 25, 27(e), 30, 34 to 46, and 48.

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

Representative of A&H Insurance Intermediary

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

Application to Direct Insurers

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Part I – Mandatory Requirements

Division 1: General Requirements for Accident and Health Policies

10A. No direct insurer shall use the word "Shield" in the name, description or title of any accident and health policy issued by it unless that policy is a Medisave-approved policy.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

10B. Notwithstanding paragraph 10A, a direct insurer may, prior to 1 November 2017, continue to use the word "Shield" in the name, description or title of any accident and health policy issued by it prior to 1 November 2015.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Division 1A: Disclosure Requirements for Accident and Health Policies

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

13. An A&H insurance representative shall disclose the following to the policy owner in writing:

(a) his name;
(b) the A&H insurance intermediary (or intermediaries) for which he acts.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

14. Where there is a change to such information referred to in paragraphs 12 and 13, an A&H insurance intermediary or an A&H insurance representative, as the case may be, shall inform a policy owner, in writing, of any change to such information in the next dealing right after the change, with the policy owner.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

15. An A&H insurance intermediary shall disclose in writing to a policy owner all remuneration, including any commission, fee and other benefit, that it has received or will be receiving for providing advice on, or arranging insurance contracts or both, in respect of any accident and health policy.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Conflict of Interest

16. An A&H insurance intermediary shall disclose, in writing, to its policy owners any actual or potential conflict of interest arising from any connection to or association

with any insurer, including any material information or facts that may compromise its objectivity in advice provided by the A&H insurance intermediary.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Disclosure when Providing Advice

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

(a) Nature and objective of the policy

The A&H insurance intermediary shall disclose and explain to the policy owner the nature and objective of the policy, including:

(i) whether the policy is a health policy or a personal accident policy; and

(ii) whether the policy seeks to reimburse health services costs incurred by the insured, provide continuous income during disability or sickness, provide lump sum benefits on the occurrence of specified events, or a combination of these.

(b) Details of the insurer

In addition to disclosing to the policy owner the insurer underwriting the policy and its relationship with that insurer required under section 67(1)(a) and (b) of the Act, an A&H insurance intermediary must disclose to the policy owner the business address of the insurer.

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

(c) Contractual rights and obligations

The A&H insurance intermediary shall disclose and explain to the policy owner—

(i) the party against which the policy owner may take action to enforce his rights with respect to the policy he has purchased;

(ii) that he is responsible for the accuracy and completeness of the information given to the insurer when applying for the policy and when making a claim under the policy;

(iii) that any mis-statement or non-disclosure of material facts may affect the validity of the policy; and

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

(d) Benefits of the policy
The A&H insurance intermediary shall disclose and explain to the policy owner the benefits of the policy, including—

(i) the conditions under which payment of policy moneys are made;

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

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

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

(v) any lien on the policy.

(e) Risks of the policy

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

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

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

(f) Provision on free-look period of the policy

The A&H insurance intermediary shall disclose and explain to the policy owner, where applicable —

(i) the time frame for the policy owner to reconsider his purchase of an accident and health policy ("free-look provision"); and

(ii) the terms and procedures for exercising the policy owner's rights under the free-look provision.

(g) Claim or termination

The A&H insurance intermediary shall disclose and explain to the policy owner the procedures for, and restrictions on, a claim under his accident and health policy and the procedures and charges for, and restrictions on, the termination of the policy.

(h) Warnings, exclusions and disclaimers

The A&H insurance intermediary shall disclose and explain to the policy owner all warnings, exclusions and disclaimers in relation to the product it has recommended to the policy owner.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

(a) information described in paragraph 17;

(b) duration of coverage; and

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

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

Marketing Material

23. An A&H insurance representative shall only use marketing materials which —

(a) with respect to an integrated shield plan, is approved by the insurer issuing the policy; and

(b) with respect to an accident and health policy, is approved by the A&H insurance intermediary for which an A&H insurance representative acts for.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Telemarketing and Direct Marketing

24. Where an A&H insurance intermediary engages in any marketing of accident and health policies which are not Medisave-approved policies over the telephone in a manner that is designed to solicit and close a sale, it shall—

(a) where no advice is provided, communicate to the call recipient a warning that—

(i) the call recipient may wish to seek advice from an A&H insurance intermediary before making a commitment to purchase the policy; and

(ii) in the event that the call recipient chooses not to seek advice from an A&H insurance intermediary, he should consider whether the policy in question is suitable for him; and

(b) maintain a record of all conversations made over the phone sufficient for the purpose of conducting audit checks where necessary.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

24A. An A&H insurance intermediary shall not close a sale of any Medisave-approved policy over the telephone where it has engaged in the marketing of the Medisave-approved policy over the telephone. Where an A&H insurance intermediary engages in the marketing of any Medisave-approved policy over the telephone in a manner that is designed to solicit a sale, it shall—

(a) communicate clearly to the call recipient that it is calling only to provide information and not to advise the call recipient on the Medisave-approved policy or sell that policy over the telephone;

(b) follow the script approved by the insurer issuing the policy, in providing any information relating to the policy; and

(c) maintain a record of all conversations made over the phone sufficient for the purpose of conducting audit checks where necessary.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Temporary Exemption

24B. Paragraph 24A of this Notice does not apply for the period from 13 April 2020 to 30 September 2022 (both dates inclusive).

[MAS Notice 120 (Amendment) 2020, with effect from 13 April 2020]
[MAS Notice 120 (Amendment No. 2) 2020, with effect from 1 October 2020]
[MAS Notice 120 (Amendment) 2021, with effect from 1 October 2021]

24BA. Where an A&H insurance intermediary engages in any marketing of any Medisave-approved policy over the telephone in a manner that is designed to solicit, but not close a sale of the Medisave-approved policy over the telephone, whether advice is provided on the Medisave-approved policy or not, during the period mentioned in paragraph 24B, it shall –

(a) follow the script approved by the insurer issuing the policy, in providing any information relating to the policy; and

(b) maintain a record of all conversations made over the phone sufficient for the purpose of conducting audit checks where necessary.

[MAS Notice 120 (Amendment) 2020, with effect from 13 April 2020]

24BB. Where an A&H insurance intermediary engages in any marketing of any Medisave-approved policy over the telephone in a manner that is designed to solicit and close a sale of the Medisave-approved policy over the telephone, whether advice is provided on the Medisave-approved policy or not, during the period mentioned in paragraph 24B, it shall—

(a) where no advice is provided by the A&H insurance intermediary on the policy, communicate clearly to the call recipient a warning that –

(i) the call recipient may wish to seek advice from an A&H insurance intermediary before making a commitment to purchase the policy; and

(ii) in the event that the call recipient chooses not to seek advice from an A&H insurance intermediary, the call recipient should consider whether the policy in question is suitable for him;

(b) follow the script approved by the insurer issuing the policy, in providing any information relating to the policy;

(c) conduct client call-back with every selected client or selected A&H insurance representative client whom the A&H insurance intermediary had closed the sale of any Medisave-approved policy with, within the time frame for the client to reconsider his purchase of that policy as set out in the terms of the policy in accordance with regulation 8 of the Insurance (General Provisions) Regulations; and

(d) maintain a record of all conversations made over the phone sufficient for the purpose of conducting audit checks where necessary.

[MAS Notice 120 (Amendment) 2020, with effect from 13 April 2020]

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

(a) the policy owner may wish to seek advice from an A&H insurance intermediary before purchasing the policy;

(b) in the event that the policy owner chooses not to seek advice from an A&H insurance intermediary, he should consider whether the type of policy in question is suitable for him; and

(c) in the event that the policy owner decides that the policy is not suitable after purchasing the policy, he may terminate the policy in accordance with the free-look provision, if any, and the insurer may recover from the policy owner any expense incurred by the insurer in underwriting the policy.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

(a) paragraph 17(a), (c)(iv), (d)(i), (d)(ii), (e), (f), (g) and (h);

(b) paragraph 20;

(c) paragraph 21(b) and (c);

(d) paragraph 22; and

(e) paragraph 24.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]
[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

Division 3: Additional Disclosure Requirements for Direct Insurers

28. When a direct insurer prepares a benefit illustration or a product summary for policies that it underwrites, it shall be prepared according to industry standards, if any.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

28A. For every integrated shield plan or non-integrated shield plan which a direct insurer issues, where the direct insurer provides the policy owner with any of the following documents, it shall disclose the following information in the respective documents:

(a) the information specified in Part A-1 of Appendix A in any product summary that the insurer issues for the policy;
(b) the information specified in Part A-2 of Appendix A in any proposal form that the insurer issues for the policy;
(c) the information specified in PartA-3 of Appendix A, in any acceptance letter that the insurer issues for the policy;
(d) the information specified in Part A-4 of Appendix A, in any conditional letter of offer that the insurer issues for the policy;
(e) the information specified in Part A-5 of Appendix A, in any premium notification letter that the insurer issues for the policy;
(f) the information specified in Part A-6 of Appendix A, in any termination letter that the insurer issues for the policy; and
(g) the information specified in Part A-7 of Appendix A, in any claims settlement letter that the insurer issues for the policy.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

28B. Where a direct insurer provides the policy owner who is an individual who is a citizen or permanent resident of Singapore with a conditional letter of offer or termination letter for any individual medical expense policy it issues, it shall include, in a font size Times New Roman 10-point or larger, in the conditional letter of offer or the termination letter, as the case may be, the statements as set out in Appendix B.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

28C. Where a direct insurer provides the policy owner with a product summary of any accident and health policy it issues which is not a Medisave-approved policy, it shall include, in a font size Times New Roman 10-point or larger, in the product summary, the statement as set out in Appendix C.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

28D. Where a direct insurer provides the policy owner with a product summary of any renewable short term accident and health policy it issues, it shall include, in a font size Times New Roman 10-point or larger, in the product summary, the statement as set out in Appendix D.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

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

(a) disclose the existing terms of the contract;

(b) disclose and explain the new terms of the contract;

(c) disclose and explain the manner in which the policy owner may accept the new terms or the circumstances under which the policy owner will be deemed to have accepted the new terms; and

(d) furnish the information under (a), (b), and (c) to the policy owner in writing at least 30 days before the variation, amendment or addition takes effect.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

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

31. For the purposes of paragraph 30, an A&H insurance intermediary does not have a reasonable basis for providing an advice to a person unless —

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

(b) the advice is based on the consideration and investigation referred to in sub-paragraph (a).

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

This Division does not apply –

33. in circumstances where no recommendation is made or where only factual information is provided with respect to any health policy.

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

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

(a) "Know-Your-Client";

(b) needs analysis; and

(c) documentation and record keeping.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

"Know-Your-Client"

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

(a) the objectives of the policy owner, including—

(i) the event, or events, which financial impact the insured is seeking protection from; and
(ii) the nature of benefits payment that the policy owner is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the policy owner or insured; and
(iii) the class of hospital ward that the insured is seeking to stay in;

(b) the employment status of the policy owner;

(c) the financial situation of the policy owner, including assets, liabilities, cash flow and income;

(d) the source and amount of the policy owner's regular income;

(e) the financial commitments of the policy owner;

(f) any existing health policy of the insured, including any policy moneys arising from any insurance scheme established and maintained by the Central Provident Fund Board;

(g) any medical conditions that the insured may have; and

(h) for any recommendation made in respect of a health policy that intends to include the policy owner's dependants as the insureds, the information listed in (a) to (e) for such dependants.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

(a) the objectives of the policy owner, including

(i) the financial impact of any event for which the policy owner is seeking protection for members of the group;

(ii) the mode of policy moneys payment that the insured is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the policy owner or insured; and

(iii) the class of hospital ward that the insured is seeking to stay in.

(b) the size and composition of the group, including a breakdown by gender, age, income, occupation;

(c) the claims history of the group; and

(d) any medical conditions that members of the group may have.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

37. An A&H insurance intermediary shall highlight the following in writing to its policy owner:

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Needs Analysis

38. An A&H insurance intermediary shall analyse the information provided by the policy owner and identify the type of policy that is suitable for the insured based on the information obtained from the policy owner.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

39. Where the A&H insurance intermediary is unable to identify a suitable policy, it shall inform the policy owner accordingly.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

41. Where a policy owner does not want to:

(a) provide any information requested by the A&H insurance intermediary in accordance with paragraph 35 or 36; or

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

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

42. Where a policy owner chooses not to receive any advice from an A&H insurance intermediary, the A&H insurance intermediary shall properly document the policy owner's decision.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Documentation and Record Keeping

43. An A&H insurance intermediary shall furnish to its policy owner a document containing the following when providing an advice in respect of a health policy to the policy owner—

(a) a summary of the information gathered by the A&H insurance intermediary pursuant to paragraph 35 or 36; and

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

and, where applicable, a statement that the policy owner does not want to—

(i) provide any information requested by the A&H insurance intermediary in accordance with paragraph 35 or 36;

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

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

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Switching of Accident and Health Insurance Policies

44. An A&H insurance intermediary shall not provide advice to a policy owner who is an individual to switch from one accident and health policy (referred to as "original policy") to another accident and health policy (referred to as "replacement policy") in a manner that would be detrimental to the insured. In considering whether a switch is detrimental, the Authority shall have regard to a number of factors, including—

(a) whether the policy owner suffers any penalty for terminating the original policy;

(b) whether the policy owner will incur any transaction cost without gaining any real benefit from such a switch;

(c) whether the replacement policy confers a lower level of benefit at a higher cost or same cost to the insured, or the same level of benefit at a higher cost; and

(d) whether the replacement policy is less suitable for the insured.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

46. An A&H insurance intermediary shall disclose, in writing, to a policy owner —

(a) any fee or charge the policy owner would have to bear; and

(b) the changes in level of benefits,

if he were to switch from one accident and health policy to another, in order to ensure that the policy owner is able to make an informed decision on whether to switch.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

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

48. In addition to these requirements, an A&H insurance intermediary or A&H insurance representative shall comply (with necessary modifications) with paragraphs 35(a), (f), (g), (h), 36 and 43 of this Notice when it provides advice in respect of life policies that contain accident and health benefits.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

Division 6: Offences relating to this Part

49. [Deleted by MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

50. [Deleted by MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

51. Any person who fails to comply with any requirement under any paragraph in Part I of this Notice shall be guilty of an offence punishable under section 142(3) of the Act.

[MAS Notice 120 (Amendment) 2022, with effect from 1 June 2022]

Part II – Non-mandatory Best Practice Standards

Information Disclosure and Provision of Advice

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

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

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

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

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

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

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

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

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

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

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

Monitoring of switching for long-term accident and health policies

54. To facilitate the monitoring of switching for long-term accident and health policies that may be detrimental to an insured's interests by an A&H insurance representative, the A&H insurance intermediary should ensure that the policy owner declares in writing whether he had been advised by the A&H insurance representative to switch policy. For the avoidance of doubt, such a declaration should also be made in the following situations:

(a) the switch is to another accident and health policy with different accident and health benefits as the policy that was terminated; and
(b) the policy that was terminated was purchased from another A&H insurance intermediary.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

55. If the policy owner declares that he had been advised by an A&H insurance representative to switch, the A&H insurance intermediary should ensure that the policy owner makes a declaration on –

(a) whether the representative has drawn his attention to the costs and possible disadvantages associated with the switch; and

(b) whether he wishes to proceed with the switch notwithstanding that the fees, charges or disadvantages that may arise from the switch could outweigh any potential benefits.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

56. Where the policy owner declares that the A&H insurance representative has recommended a switch, the A&H insurance intermediary should ensure that the supervisor of the A&H insurance representative reviews the switching recommendation, and indicates in writing, whether he agrees with the recommendation made and if not, the actions that have been taken to rectify the situation. In considering

whether a switch is appropriate, the supervisor should take into account the factors stated in paragraph 44.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

57. An A&H insurance intermediary should institute controls, processes and procedures to effectively monitor and track the switching of long-term accident and health plans, including but not limited to the following –

(a) tracking the volume of switches so as to identify any A&H insurance representatives with an unusually high volume of switching transactions;

(b) putting in place procedures to ensure that each switch recommended by an A&H insurance representative is reviewed by a supervisor from the A&H insurance intermediary for appropriateness; and

(c) implementing procedures and controls to identify any unusual trends in switching transactions.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

58. Where an A&H insurance intermediary detects a switch that is not declared by the policy owner, the A&H insurance intermediary should ensure that the supervisor of the A&H insurance representative reviews the switch and indicates in writing whether he agrees with the recommendation made, if any, and if not, the actions that have been taken to rectify the situation. In considering whether a recommended switch is appropriate, the supervisor should take into account the factors stated in paragraph 44.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

59. An A&H insurance intermediary should ensure that the back-end controls, processes and procedures implemented are commensurate with the A&H insurance intermediary's nature of business and risks.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

APPENDIX A: Information to be included in the respective documents for integrated shield plans and non-integrated shield plans

A-1: Information to be disclosed in the product summary

Comparison of Benefits

1. The insurer shall –

(a) disclose that an integrated shield plan comprises a MediShield Life Component and the additional private insurance coverage;

(b) disclose that the final payout, in the event of hospitalisation or medical treatment, will comprise both the MediShield Life Component payout and the integrated shield plan payout, where applicable; and

(c) provide a comparison of the benefits provided by the MediShield Life Scheme and the integrated shield plan.

Breakdown of standard premium rates

2. The insurer shall provide a breakdown of the premiums payable for all age bands on the basis that the insured does not have any pre-existing condition at the time that the product summary is prepared in respect of --

(a) a citizen or permanent resident of Singapore insured under an integrated shield plan; and

(b) a foreigner insured under a non-integrated shield plan.

The insurer shall also include information on the applicable Medisave Withdrawal Limits and cash outlay. Where the plan is an integrated shield plan, the insurer shall ensure that the breakdown of premiums payable shows separately the premiums payable for the MediShield Life Component and the additional private insurance coverage.

Risks and limitations of switching or upgrading

3. The insurer shall highlight the risks and limitations of—

(a) switching the integrated shield plan issued by the insurer to that issued by another insurer; and

(b) upgrading the integrated shield plan.

Option to downgrade an existing integrated shield plan

4. The insurer shall highlight that, where the policy owner has concerns on affordability, the policy owner has the option to switch to another integrated shield plan with a lower coverage but more affordable plan or, terminate his integrated shield plan. Where the insured is a citizen or permanent resident of Singapore, the insurer shall inform the policy owner that the insured will continue to be covered by the MediShield Life Scheme, even if the policy owner terminates the insured's existing integrated shield plan.

A-2: Information to be disclosed in the proposal form

Monies in Medisave account

5. The insurer shall ensure that the policy owner declares, before he purchases any integrated shield plan issued by the insurer, that he has received advice from his A&H insurance representative to consider the policy owner's long-term financial commitment to pay the premiums for an integrated shield plan and, that the policy owner should have sufficient monies in his Medisave account or sufficient means to pay the MediShield Life Scheme premiums on an ongoing basis.

Risks and limitations of switching or upgrading

6. Where the policy owner has indicated to the insurer that he intends to switch or upgrade the policy owner's existing integrated shield plan, the insurer shall ensure that the policy owner declares that the policy owner's A&H insurance representative has highlighted to the policy owner the risks and limitations of —

(a) switching the integrated shield plan issued by the insurer to that issued by another insurer; or

(b) upgrading the integrated shield plan.

A-3: Information to be disclosed in the acceptance letter

Risks and limitations of switching or upgrading

7. Where the policy owner has indicated to the insurer that he intends to switch or upgrade the policy owner's existing integrated shield plan, the insurer shall highlight to the policy owner the risks and limitations of—

(a) switching the integrated shield plan issued by the insurer to that issued by another insurer; or

(b) upgrading the integrated shield plan.

Start of policy coverage

8. Where the inception date of the policy is after the issuance of the acceptance letter, the insurer shall state that –

(a) the policy commences on the inception date of the policy and not on the date of the acceptance letter;

(b) the policy inception date will be reflected in the policy schedule, which will be sent to the policy owner after the issuance of the policy; and

(c) where the inception date of the policy is dependent on the successful deduction of monies from the policy owner's medisave account, the insurer shall also state that the policy schedule will be sent to the policy owner upon the successful deduction of monies from the policy owner's medisave account.

A-4: Information to be disclosed in the conditional letter of offer
Breakdown of premiums payable for insured

9. The insurer shall, in respect of any integrated shield plan--

(a) provide a breakdown of the premiums payable for the MediShield Life Component and the additional private insurance coverage;

(b) a further breakdown of the premiums payable for the MediShield Life Component to reflect any applicable government subsidy, any premium rebate and any additional premiums for serious pre-existing conditions;

(c) provide a further breakdown of the premiums for additional private insurance coverage to reflect any rebates or any loading imposed by the insurer; and

(d) indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

10. The insurer shall, in respect of any non-integrated shield plan, provide a breakdown of the premiums payable to reflect any rebates or any loading imposed by the insurer. The insurer shall indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

Medisave Withdrawal Limits
11. The insurer shall provide information on the Medisave Withdrawal Limits applicable for –

(a) the MediShield Life Component of an integrated shield plan;

(b) the additional private insurance coverage of an integrated shield plan, in the case where the insured is a citizen or permanent resident of Singapore; or

(c) the non-integrated shield plan, in the case where the insured is a foreigner.

Risk-loading factor and standard premium rates
12. Where an insurer offers a policy which provides benefits for any medical conditions that would otherwise be excluded, for additional premiums, the insurer shall indicate the risk-loading factor to be applied to the premiums on the basis that the policy owner does not have any pre-existing condition.

13. The insurer shall provide a breakdown of the premiums payable for all age bands on the basis that the policy owner does not have any pre-existing condition at the time that the product summary is prepared in respect of –

(a) a citizen or permanent resident of Singapore insured under an integrated shield plan; and

(b) a foreigner insured under a non-integrated shield plan.

The insurer shall also include information on the applicable Medisave Withdrawal Limits and cash outlay. Where the plan is an integrated shield plan, the insurer shall ensure that the breakdown of premiums payable shows separately the premiums payable for the MediShield Life Component and the additional private insurance coverage.

Risks and limitations of switching or upgrading

14. Where the policy owner has indicated to the insurer that he intends to switch or upgrade the policy owner's existing integrated shield plan, the insurer shall highlight to the policy owner the risks and limitations of—

(a) switching the integrated shield plan issued by the insurer to that issued by another insurer; or

(b) upgrading the integrated shield plan.

MediShield Life coverage

15. Where the insured is a citizen or permanent resident of Singapore, the insurer shall disclose that –

(a) the integrated shield plan comprises a MediShield Life Component; and

(b) if the policy owner does not purchase the integrated shield plan, the MediShield Life Scheme will continue to provide lifetime cover to the insured, without excluding any existing medical condition.

Start of policy coverage

16. Where the inception date of the policy is after the issuance of the acceptance letter, the insurer shall state that –

(a) the policy commences on the inception date of the policy and not on the date of the acceptance letter;

(b) the policy inception date will be reflected in the policy schedule, which will be sent to the policy owner after the issuance of the policy; and

(c) where the inception date of the policy is dependent on the successful deduction of monies from the policy owner's medisave account, the insurer shall also state that the policy schedule will be sent to the policy owner upon the successful deduction of monies from the policy owner's medisave account.

A-5: Information to be disclosed in the premium notification letter

MediShield Life coverage

17. Where the insured is a citizen or permanent resident of Singapore, the insurer shall disclose that –

(a) the integrated shield plan comprises a MediShield Life Component; and

(b) if the policy owner does not purchase the integrated shield plan, the MediShield Life Scheme will continue to provide lifetime cover to the insured, without excluding any existing medical conditions.

Option to downgrade an existing integrated shield plan

18. The insurer shall highlight that, where the policy owner has concerns on affordability, the policy owner has the option to switch to another integrated shield plan with a lower coverage but more affordable plan or, terminate his integrated shield plan. Where the insured is a citizen or permanent resident of Singapore, the insurer shall inform the policy owner that the insured will continue to be covered by the MediShield Life Scheme, even if the policy owner terminates the insured's existing integrated shield plan.

List of policies due for renewal

19. The premium notification letter shall include a list of the policies issued by the insurer that are purchased by the policy owner, at least one month before the date of renewal of each policy. The insurer shall, in respect of any integrated shield plan –

(a) provide a breakdown of the premiums payable for the MediShield Life Component and the additional private insurance coverage;

(b) provide a further breakdown of the premiums payable for the MediShield Life Component to reflect any applicable government subsidy;

(c) indicate where there are exclusions imposed on the insured in the policy; and

(d) indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

The insurer shall, in respect of any non-integrated shield plan –

(a) indicate where there are exclusions imposed on the insured in the policy; and

(b) indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

Breakdown of premiums payable for insured

20. The insurer shall, in respect of any integrated shield plan—

(a) provide a breakdown of the premiums payable for the MediShield Life Component and the additional private insurance coverage;

(b) a further breakdown of the premiums payable for the MediShield Life Component to reflect any applicable government subsidy, any premium rebate and any additional premiums for serious pre-existing conditions;

(c) provide a further breakdown of the premiums for additional private insurance coverage to reflect any rebates or any loading imposed by the insurer; and

(d) indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

21. The insurer shall, in respect of any non-integrated shield plan, provide a breakdown of the premiums payable to reflect any rebates or any loading imposed by the insurer. The insurer shall indicate the respective amounts payable from the policy owner's medisave account and cash outlay, where applicable.

Medisave Withdrawal Limits

22. The insurer shall provide information on the Medisave Withdrawal Limits applicable for-

(a) the MediShield Life Component of an integrated shield plan;

(b) the additional private insurance coverage of an integrated shield plan, in the case where the insured is a citizen or permanent resident of Singapore; or

(c) the non-integrated shield plan, in the case where the insured is a foreigner.

Breakdown of standard premium rates

23. The insurer shall provide a breakdown of the premiums payable for all age bands on the basis that the policy owner does not have any pre-existing condition at the time that the product summary is prepared in respect of –

(a) a citizen or permanent resident of Singapore insured under an integrated shield plan; and

(b) a foreigner insured under a non-integrated shield plan.

The insurer shall also include information on the applicable Medisave Withdrawal Limits and cash outlay. Where the plan is an integrated shield plan, the insurer shall ensure that the breakdown of premiums payable shows separately the premiums payable for the MediShield Life Component and the additional private insurance coverage.

A-6: Information to be disclosed in the termination letter

Risks and limitations of switching or upgrading

24. The insurer shall highlight the risks and limitations of—

(a) switching the integrated shield plan issued by the insurer to that issued by another insurer; or

(b) upgrading the integrated shield plan.

MediShield Life coverage

25. Where the insured is a citizen or permanent resident of Singapore and is not terminating this policy in order to switch to another integrated shield plan, the insurer shall inform the policy owner that the insured will continue to be covered by the MediShield Life Scheme, without excluding any existing medical condition, even if the policy owner terminates the insured's existing integrated shield plan.

Reinstatement period

26. For cases where a policy owner terminates a policy with the intention to switch, the insurer shall highlight to the policy owner that the policy owner may reinstate the policy within 30 days of the date of notice of termination without the need for the insured to provide a health declaration.

A-7: Information to be disclosed in the claims settlement letter

Breakdown of claims paid out

27. In the event of a claims payment, the insurer shall provide the policy owner with a breakdown of the claims to be paid out under each of the following, where applicable –

(a) the MediShield Life Component;

(b) the additional private insurance coverage; and

(c) integrated shield plan rider, if any.

[MAS Notice 120 (Amendment) 2015, with effect from 1 November 2015]

APPENDIX B: Standardised Disclosures for all Individual Medical Expense Policies

Statement to be included in the Conditional Letter of Offer for the policy

If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.

Statement to be included in the Termination Letter for the policy

If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatments in Singapore even though you have terminated the policy. The cover is provided regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

APPENDIX C: Standardised Disclosures for all accident and health policies which are not Medisave-approved policies

Statement to be included in the product summary of the policy

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

APPENDIX D: Standardised Disclosures for renewable Short-term Accident and Health Policies

Statement to be included in the product summary of the policy

This is a short-term accident and health policy[1] and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you ____[2] notice in writing.
*If you have any existing medical condition at the policy renewal date, you may not be covered under the renewed policy for such a medical condition. If such a medical condition is covered under the renewed policy, you may need to pay additional premiums.

[1]The insurer shall use in the above statement the same term that is used in the product summary to refer to the short-term accident and health policy.
[2]The insurer shall set out the relevant notice period, whether in days, weeks or months.
* The insurer shall include this statement only if it imposes exclusions or require additional premiums to cover existing medical conditions under the short-term accident and health policy at renewal.

[MAS Notice 120 (Amendment) 2015, with effect from 30 June 2016]

***Endnotes of History of Amendments**

1. MAS Notice 120 (Amendment) 2015, dated 30 October 2015 with effect from 1 November 2015, except paragraphs 2(z) and 4 which are effective from 30 June 2016.
2. MAS Notice 120 (Amendment) 2020 with effect from 13 April 2020.
3. MAS Notice 120 (Amendment No. 2) 2020 with effect from 1 October 2020.
4. MAS Notice 120 (Amendment) 2021 with effect from 1 October 2021.
5. MAS Notice 120 (Amendment) 2022 with effect from 1 June 2022.

Source: MAS Website

CHAPTER 13

NOTICE NO: MAS 120 – DISCLOSURE AND ADVISORY PROCESS REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE PRODUCTS

Please refer to the full notice for more details as not all information is detailed here.

- *Except for the Notices which were extracted in full from the MAS website, amendments were only made to the title of the Acts in the relevant paragraphs of the study text.*
- *As the respective notices are still pending release from MAS, they will be updated once MAS has published them.*

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Objective of Notice No: MAS 120	• Comprises both mandatory requirements and best practice standards on the disclosure of information and provision of advice to policy owners for A&H policies and life policies that provide A&H benefits.
General Requirements For A&H Policies	• No direct insurer should use the word "Shield" when naming A&H policy, unless that policy is a Medisave-approved policy.
Types of products covered by this Notice and their definitions	• "ElderShield policy" means a policy purchased under the ElderShield Scheme as defined in regulation 2 of the Central Provident Fund (Withdrawals for ElderShield Scheme) Regulations. • "ElderShield Supplement policy" means a policy purchased under the ElderShield Supplement Scheme as defined under regulation 2 of the Central Provident Fund (Withdrawals for ElderShield Scheme) Regulations. • "Health policy" means an accident and health policy that is not a personal accident policy. • "Individual medical expense policy" means an accident and health policy, other than an integrated shield plan and a non-integrated shield plan. • "Medisave-approved policy" means any CareShield Life Supplement policy, ElderShield policy, ElderShield Supplement policy, integrated shield plan or non-integrated shield plan. • "MediShield Life Component" has the same meaning as regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations. • "MediShield Life Scheme" means the Scheme established under section 3 of the MediShield Life Scheme Act 2015 (No. 4 of 2015). • "Non-integrated shield plan" has the same meaning as in regulation 2 of the MediShield Life Scheme (Private Medical Insurance Scheme) Regulations. • "Personal accident policy" means an accident and health policy where accident and health benefits are paid out only— a. in the event of an injury to, or disability of, the insured as a result of accident; b. on the death by accident of the insured; or c. on the occurrence of a combination of (a) and (b).

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Disclosure requirements for sales of: • **A&H policies**	• General information about the A&H insurance intermediary (including its business name under which it conducts its insurance business, its business address and its telephone number) and status of an A&H insurance representative (including his name, the A&H insurance intermediary or intermediaries for which he acts). • Remuneration of the A&H insurance intermediary. • Conflict of interest. • Disclosure when providing advice, including: » Nature and objective of the policy; » Details of the insurer; » Contractual rights and obligations. » Benefits of the policy. » Risks of the policy. » Provision on free-look period of the policy. » Claim on termination. » Warnings, exclusions and disclaimers. » Provisions and explanations of any benefit illustration, product summary, and group policy under A&H policies. • Marketing material. • Telemarking and direct marketing.
Disclosure requirements for sales of: • **Life policies that contain A&H benefits**	• Regulatory requirements by an A&H insurance intermediary and an A&H insurance representative of a licensed or exempt financial adviser, when providing advice and/or arrange life policies containing A&H benefits. • Please refer to the respective paragraphs of the Notice: » Paragraph 17(a), (c)(iv), (d)(i), (d)(ii), (e), (f), (g) and (h); » Paragraph 20; » Paragraph 21(b) and (c); » Paragraph 22; and » Paragraph 24.
Advisory process requirements in respect of: • **Know-your-client (Individual)**	• Objectives of the policy owner, including— » the event, or events, which financial impact the insured is seeking protection from; and » the nature of benefits payment that the policy owner is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the policy owner or insured; and » the class of hospital ward that the insured is seeking to stay in; • Employment status of the policy owner; • Financial situation of the policy owner, including assets, liabilities, cash flow and income; • Source and amount of the policy owner's regular income; • Financial commitments of the policy owner; • Any existing health policy of the insured, including any policy moneys arising from any insurance scheme established and maintained by the Central Provident Fund Board; • Any medical conditions that the insured may have; and • For any recommendation made in respect of a health policy that intends to include the policy owner's dependants as the insureds and the required information for such dependants.
Advisory process requirements in respect of: • **Know-your-client (Group)**	• Objectives of the policy owner, including » the financial impact of any event for which the policy owner is seeking protection for members of the group; » the mode of policy moneys payment that the insured is seeking, whether it is a lump sum payment or in periodical payments, and whether it relates to cost actually incurred by the policy owner or insured; and » the class of hospital ward that the insured is seeking to stay in. • Size and composition of the group, including a breakdown by gender, age, income, occupation; • Claims history of the group; and • Any medical conditions that members of the group may have.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Advisory process requirements in respect of: • **Needs analysis**	• Analyse the information provided by the policy owner and identify the type of policy that is suitable for the insured based on the information obtained from the policy owner. • If unable to identify a suitable policy, it shall inform the policy owner accordingly. • Explain to its policy owner the basis for its advice and the basis shall be documented. • Where a policy owner does not want to provide any information or accept the advice of the A&H insurance intermediary and chooses to purchase another health policy which is not advised by the A&H insurance intermediary, » A&H insurance intermediary may proceed with the policy owner's request, but it shall document the decision of the policy owner and inform the policy owner that it is the policy owner's responsibility to ensure the suitability of the type of policy selected.
Advisory process requirements in respect of: • **Documentation and record keeping**	• Furnish the policy owner a document containing the following when providing an advice in respect of a health policy to the policy owner » Know-your-client (Individual); or » Know-your-client (Group). • Any advice provided to the policy owner by the A&H insurance intermediary and the basis for the advice. • Where applicable, a statement that the policy owner does not want to: » Provide any information requested by the A&H insurance intermediary under Know-your-client; » Accept the advice of the A&H insurance intermediary and has chosen to purchase another health policy which is not that advised by the A&H insurance intermediary; or » Receive any advice from the A&H insurance intermediary
Advisory process requirements in respect of: • **Switching**	• An A&H insurance intermediary shall not provide advice to a policy owner who is an individual to switch from one accident and health policy (referred to as "original policy") to another accident and health policy (referred to as "replacement policy") in a manner that would be detrimental to the insured. In considering whether a switch is detrimental, the Authority shall have regard to a number of factors, including— » Whether the policy owner suffers any penalty for terminating the original policy; » Whether the policy owner will incur any transaction cost without gaining any real benefit from such a switch; » Whether the replacement policy confers a lower level of benefit at a higher cost or same cost to the insured, or the same level of benefit at a higher cost; and » Whether the replacement policy is less suitable for the insured. • An A&H insurance intermediary shall disclose, in writing, to a policy owner: » Any fee or charge the policy owner would have to bear; and » The changes in level of benefits.
Additional disclosure requirements being adhered to by direct insurers	• Meeting the industry standards on the preparation of a benefit illustration or a product summary in respect of a policy that the direct insurer underwrites. • Disclosure of relevant information in the respective documents for every Integrated Shield Plan (IP) or non-IP. • Required font size (Times New Roman 10-point or larger) for product summary, statement, conditional offer letter or termination letter with standardised relevant statement of disclosures for any individual Medical Expense Insurance policy, as well as any A&H policy not being Medisave-approved policy. • Disclosing and explaining the policy terms, including any addition, amendment or variation to be made in writing to the policy owner, at least 30 days before taking effect.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Non-mandatory best practice standards on information disclosure, provision of advice	• Information disclosed to policy owners in any advertisement or publicity material in any media should be presented in plain language, and in a manner that is easy for the policy owner to understand. • Jargon or technical terms used should be clearly explained to policy owners. • Information disclosed to policy owners should not be limited to seeking compliance with requirements the Act and this Notice, but should accord with industry best practices. In addition, the information provided should be sufficient to help policy owners make an informed decision. • Warning and important information such as the nature and objective of the product, risks of the product, fees and charges, and contractual rights and obligations of policy owners and the insurer, should be prominently presented and clearly explained. • Information disclosed to policy owners should not be ambiguous in language or presentation. • Information relating to accident and health insurance products should be disclosed in an objective and unbiased manner. • Where an opinion is expressed, there should be a reasonable basis for expressing the opinion and it should be unambiguously stated that it is a statement of opinion. • Documents to be given to policy owners should be kept up-to-date.
Non-mandatory best practice standards on monitoring of switching for long-term A&H policies	• An A&H insurance intermediary should institute controls, processes and procedures to effectively monitor and track the switching of long-term accident and health plans, including but not limited to the following – » Tracking the volume of switches so as to identify any A&H insurance representatives with an unusually high volume of switching transactions; » Putting in place procedures to ensure that each switch recommended by an A&H insurance representative is reviewed by a supervisor from the A&H insurance intermediary for appropriateness; and » Implementing procedures and controls to identify any unusual trends in switching transactions.

CHAPTER 14
FINANCIAL NEEDS ANALYSIS

CHAPTER OUTLINE

1. Introduction
2. Needs Selling Versus Product Selling
3. What Is Fact-Finding?
4. Identifying & Quantifying Needs
5. Product Recommendations
6. Presenting Your Recommendations
7. Periodic Client Review

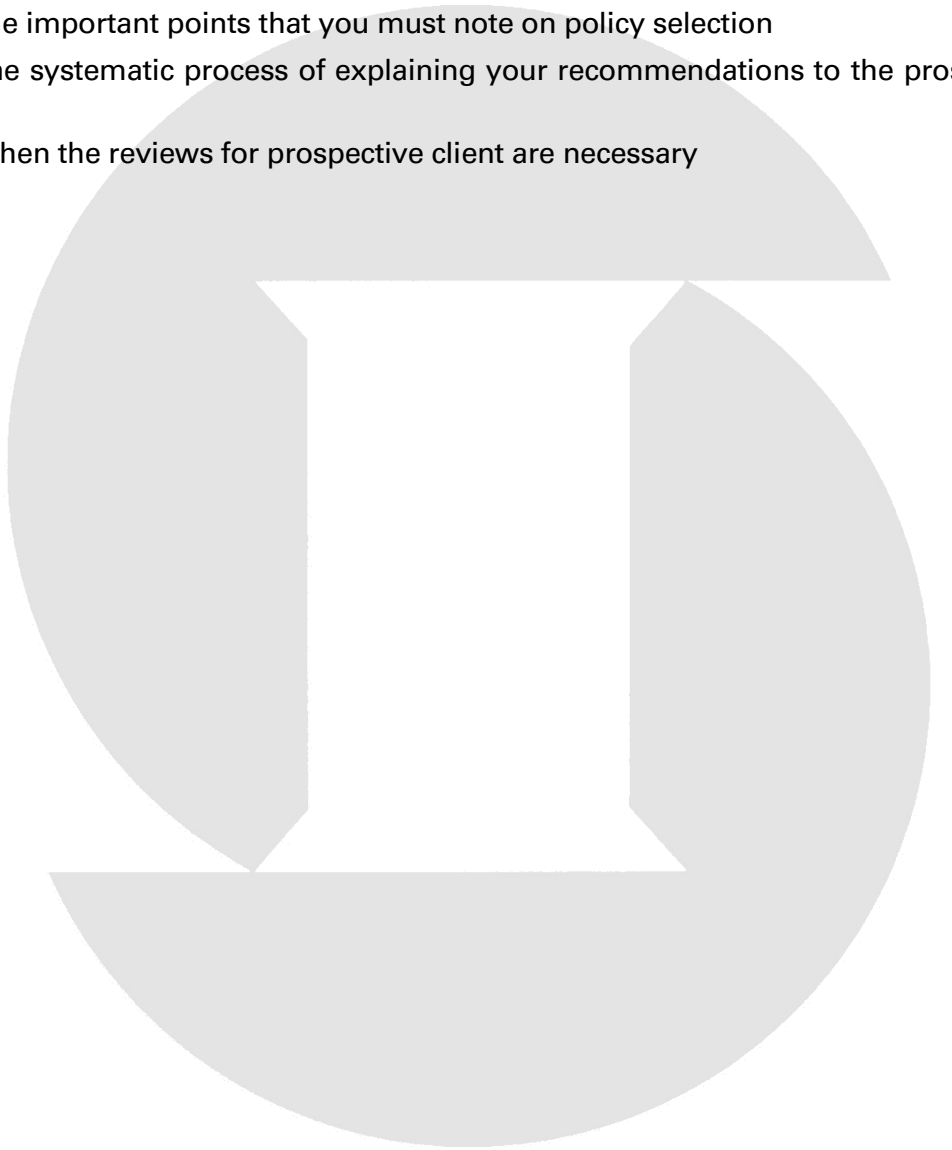
Appendix 14A – Top 10 Conditions Of Hospitalisation
Appendix 14B – Hospital Bill Size By Conditions/Procedures

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- know how needs selling differs from product selling
- explain what fact-finding is
- understand the purposes served by the various sections of the Fact-Find Document
- know the answers to the quantification of needs questions which must be taken into consideration, when going through the prospective client's Fact-Find Document to identify his needs
- understand the importance of an emergency fund
- know at which stage of the prospective client's life cycle, where the need to protect one's earnings against disability and ill health, is critical
- know what to do if the prospective client has the following existing policies:
  - Disability Income Insurance
  - Life Insurance with Total & Permanent Disability Benefit
  - Medical Expense Insurance
  - Critical Illness Insurance
  - Personal Accident Insurance
  - Long-Term Care Insurance
  - Managed Healthcare Insurance
  - Hospital Cash Insurance
  - Life Insurance Policy & Work Injury Compensation Insurance
- know how to quantify the following:
  - disability income protection needs

  - medical and ancillary costs
  - hospital cash income needs
  - Critical Illness Insurance
- list the two basic principles that you should be aware of, before making any product recommendation
- know the types of product knowledge that you must possess
- understand why is affordability an important factor when you are selecting a suitable product to recommend to the prospective client
- know the important points that you must note on policy selection
- know the systematic process of explaining your recommendations to the prospective client
- know when the reviews for prospective client are necessary



Contents

CHAPTER OUTLINE 313
LEARNING OUTCOMES 313
1. INTRODUCTION 316
2. NEEDS SELLING VERSUS PRODUCT SELLING 316
3. WHAT IS FACT-FINDING? 317
A. Common Sections Of The Fact-Find Document 317
4. IDENTIFYING & QUANTIFYING NEEDS 322
A. Identifying Needs 322
A1. Emergency Fund 322
A2. Employment Status & Occupation 323
A3. Life Stages 323
A4. Dependants 323
A5. Existing Insurance Policies 323
A6. Need For Health Insurance 326
B. Quantifying Needs 326
B1. Disability Income Protection Needs 326
B2. Medical Costs 328
B3. Hospital Cash Insurance 329
B4. Critical Illness Insurance 330
5. PRODUCT RECOMMENDATIONS 331
A. Product Suitability 331
A1. Good Product Knowledge 331
B. Affordability 332
C. Important Points To Note On Policy Selection 332
6. PRESENTING YOUR RECOMMENDATIONS 333
7. PERIODIC CLIENT REVIEW 334
APPENDIX 14A 335
APPENDIX 14B 336

1. INTRODUCTION

1.1 In this chapter, we will bring you through the needs analysis process, namely fact-finding, identifying and quantifying needs, product recommendations, presenting the recommendations and review. You are reminded to keep yourself abreast of the LIA and GIA Guidelines On Disclosure Requirements and Needs-Based Sales Process for A&H Insurance Products. Let us begin by looking at the differences between needs selling and product selling.

2. NEEDS SELLING VERSUS PRODUCT SELLING

2.1 Needs selling differs from product selling in the following ways:

TYPES	NEEDS SELLING	PRODUCT SELLING
(a) Service Orientation	You help to discover the prospective client's needs and advise on the most suitable product, and how much to buy. You spend more time on the prospective client's situation than you do on your product. You are not pushing a product, you are providing a service through a proper needs-based advisory process.	You assume that the prospective client needs your product and that you go straight into it. However, making such assumptions can give the prospective client the impression that your main concern is just to sell your product and close a sale.
(b) Pressure To Buy	You help the prospective client to uncover his needs and recommend suitable solutions for him. His concerns are already there before your arrival, and will remain after you go, unless the prospective client takes action. You are not there to pressure him to buy your products, but to offer solutions to his needs.	You create pressure to buy and the prospective client may not know why he needs the product. People will resist pressure, even if they like your product.
(c) Long-Term Relationships	The focus is on the prospective client's situation, rather than the product. You show that: ▪ you care his particular situation, rather than about selling your products;	Your relationship with the prospective client depends on how well he likes your product. Just as you would like to shop around before deciding on a purchase, so would the prospective client.

TYPES	NEEDS SELLING	PRODUCT SELLING
	▪ you have the knowledge to help him to identify his needs and can be trusted to help him to find relevant solutions. Based on your understanding of the prospective client, you propose solutions that meet his budget and needs. You return to review his needs periodically, hence, establishing an ongoing relationship with him.	The prospective client may become product conscious, and expect you to always provide the best-priced solution. Even if you make the sale, the next sale to your new client is not necessarily going to be easier than the first one.

2.2 In short, needs selling is more desirable than product selling because it is:

- service-oriented;
- not pressure selling; and
- relationship based.

2.3 In order to carry out needs selling, you need to know the prospective client (a requirement under the Notice No: MAS 120). This can be achieved by way of completing a fact-find using a Fact-Find Document. There is also Group Fact Find, but we will not be touching on the details in this chapter.

3. WHAT IS FACT-FINDING?

3.1 Fact-finding is the process of obtaining answers to a series of questions about a prospective client's personal circumstances, finance and ambitions, etc. for the future. This information will enable you to have a better understanding of the prospective client's objectives, needs and personal profile which will enable you to have a proper basis to recommend suitable Accident and Health (A&H) Insurance products to the prospective client.

A. Common Sections Of The Fact-Find Document

3.2 You should note that the format of the Fact-Find Document may vary from one insurer to another.

3.3 Each section of the Fact-Find Document serves a different purpose.

(a) Important Notice to Client

This section provides general information on the financial adviser and representative and serves two purposes:

- Firstly, it gives the prospective client information on who the insurance representative is, which insurers he represents and what product classes he can provide advice on.

- Secondly, it highlights to the prospective client the importance of providing accurate information on the Fact-Find Document. This is because a policy purchased with partial completion or inaccurate completion of a Fact-Find Document may be inappropriate to his needs.

(b) Application Type

The prospective client can choose one of three types of disclosure he wish to share with the adviser.

Application Type 1. "I/We wish to disclose all information requested for in this Form." This is meant for those who wish to complete the fact find in full, so as to receive recommendations on product suitability.

The prospective client has to complete and sign "Know Your Client" and "Our Advice and Reasons Why" Forms.

Application Type 2. "I/We wish to receive product advice only." This is meant for people who do not wish to, or are unable to provide all information requested in the form. It is suitable for those who wish to receive recommendation on product suitability.

The prospective client has to complete Section 2 – "Our Advice and Reasons Why", sign Section 3 – Acknowledgement.

Application Type 3. "I/We do not wish to receive any advice from my/our adviser." This is only suitable for people who already know which Medical Insurance product and amount of coverage that they want to purchase. For example, a prospective client wants to purchase "lump sum Health Insurance plan [1] ". The representative takes the prospective client's instructions and assists the prospective client in his completion of the proposal form, as well as understanding of the benefit illustration.

At the end of this section, the prospective client has to sign and confirm on the chosen application type before moving on to the other parts of the fact-find form.

(c) Personal Information: Information on personal details like the name, salutation, identity card/passport number, date of birth, marital status and gender, serves the following purposes:

- it is essential for administrative purposes on the part of the company;

- it provides you with a preliminary assessment of the types of products that will likely be needed. For example, if the prospective client is a

[1] It refers to a specific Health Insurance plan that is without sub-limits and it is payable on a lump sum basis.

single working individual, he may need a Disability Income Insurance policy to protect his earnings in the event of his disability; and

- information pertaining to age is essential for underwriting and premium determination.

As you can see, the information is important and you need to ensure that the prospective client completes the section correctly.

(d) **Information on employment details** asks for the prospective client's current occupation, as well as the monthly income range. The prospective client's current occupation will provide you with the following information:

- whether the prospective client is eligible for Disability Income Insurance (DII). DII is not issued to any unemployed person, nor anyone who does not have a stable job (e.g. an odd job labourer);

- enables you to determine the deferred period for a DII policy. A self-employed person will need the insurance cover as soon as possible, whereas for an employee, he may be able to afford a longer deferred period, as he may continue to receive his pay from his company for a period of time (e.g. six months) while he is disabled;

- enables you to know whether the prospective client is exposed to any occupational hazards (e.g. radiographers may be exposed to ionising radiation) and accidents (e.g. construction workers have a high chance of getting injured at the worksite). If so, you have to ask for more information to assist the underwriter in assessing the risk.

The monthly income range will enable you to know roughly whether the prospective client can afford to purchase any insurance policy from you. Do not stop using the fact-find just because you think that the prospective client is not likely to be able to afford the premium.

If the prospective client has a need for one of the A&H Insurance policies, but is not able to afford the premium, what you can do is to look at his expenses to see if you can help him to review and prioritise his expenses, so as to release the necessary funds to purchase the policy that he needs. If the prospective client really cannot afford to purchase any policy at this time, what you can do is to point out the needs that you have uncovered for him. Inform him that you can meet up with him again when his financial situation improves, and highlight the importance of being financially protected.

(e) **Information on details of spouse and dependants** is necessary for the following purposes:

- identification in the event of a claim;
- premium determination;
- any occupational hazards (in respect of the spouse);
- eligibility to be covered as a dependant (this is because A&H Insurance policies that provide coverage for any dependant has an age limit to qualify as a dependant); and
- determine whether there is a need to provide A&H Insurance cover for the dependants.

Note that even if family coverage is not required, it will be good to find out about the spouse and details of the dependants. This is because a prospective client who has dependants has an even greater need for Health Insurance protection, especially the need to cover for loss of income resulting from illness or sickness. You may also check whether the other categories of people, besides those who are married, have any dependants. This is because they may have aged parents or handicapped siblings to take care of, and the dependants will have an effect on the prospective client's needs.

By understanding more about the prospective client, you will obtain useful information, when you are analysing the prospective client's needs to provide more accurate advice. However, do note that this is not compulsory, unless the prospective client is intending to apply for family coverage. Some prospective clients may not wish to disclose such information.

The Fact-Find Document may also ask for additional information on the prospective client's language proficiency, educational level and accompaniment. The information is useful to establish if the prospective client is considered vulnerable. For example, a prospective client who is not proficient in written and spoken English and/or possess primary school education may be considered as vulnerable, and the supervisor of the insurance representative will make a call-back to the prospective client, to ensure that he has understood the recommendations and products for which he has applied.

(f) **Existing Health Insurance Policies/Existing Insurance Portfolio**: This information will indicate how far the prospective clients' existing plan(s) will go towards meeting their needs in the event of ill health or disability. In other words, they serve as a starting or reference point for any further A&H Insurance recommendations.

Note that the policy or policies that you are recommending should complement those that the prospective client already has. You should avoid asking the prospective client to replace his existing policies with new ones or cause him to be over-insured, especially for those A&H policies (e.g. Medical Expense Insurance) that are subject to the Co-ordination of Benefit Clause.

As most prospective clients do not really know what policies they have purchased, it is good that you ask for the policy documents to extract the information that you need.

(g) **Personal Priorities and Objectives**: This information will enable you to tell what the prospective client's priorities are with regard to the type of A&H policies that he may need. However, it does not mean that you must follow strictly what the prospective client has indicated. As a professional insurance representative, you should consider the overall profile of the client and help him to re-prioritise the needs that he has specified.

(h) **Health Condition**: If this information is required to be completed in the Fact-Find Document, it will help to determine whether the prospective client is insurable and, if so, on what terms.

If the prospective client answered "Yes" to this question, find out the following information from him, so that you can help to expedite the underwriting process:

- the medical term of the illness (if the client knows. If not, ask him to give a description of it);
- the date of onset of the medical condition;
- the type of medical treatment received;
- is he still undergoing medical treatment?
- is there any hospitalisation? If so, to find out when is the hospitalisation, and what type of medical treatment is being received;
- is there any recurrence?
- whether he has fully recovered and if so, when? and
- does he have any medical report on his condition? If so, you must obtain a copy from him for submission to the underwriter. You will need to inform the prospective client that the information will form part of the insurer's risk assessment process. Note that you must not keep any copy of the report, and that you must treat the information with strict confidentiality.

(i) **Replacement of Policy**: If the prospective client's answer is "Yes", you have to:

- explain to the prospective client the consequences of replacing policies, by highlighting the following disadvantages to him:
  - that he may not be insurable at standard terms, if there is any deterioration in his health, or if he has changed to a risky occupation, etc.;
  - that he may have to pay a higher premium; and
  - that the terms and conditions may be less advantageous or beneficial, especially if there are any changes to his health.

(j) **Customer's Financials:** The Life Insurance Fact-Find Document has a section to gather information, such as customer's investment profile, cash flow and budget, as well as assets and liabilities. Information gathered here serves to ascertain the affordability of the recommendation and plans, and facilitates the planning of financial needs.

(k) **Representative's Declaration:** Before you sign this section, reiterate to the prospective client that you will treat the information given in the Fact-Find Document with strict confidentiality, and that you will use it only for the purpose of determining suitable insurance products for him, and not for any other purposes, bearing in mind the requirements under the Personal Data Protection Act 2012. This will help to establish trust between you and the prospective client.

3.4 Having completed the Fact-Find Document, you will then move on to the next step to help the prospective client, to identify and quantify his needs.

4. IDENTIFYING & QUANTIFYING NEEDS

A. Identifying Needs

4.1 You begin by analysing the information which you have gathered during the fact-find stage. You should ask yourself the following questions as you go through the Fact-Find Document:

- Does he have an emergency fund in place?
- What is his employment status and occupation?
- Which life stage is he in?
- Does he have any dependants?
- Does he or his dependants (if any) have any Individual Life or Health Insurance, or Group Medical Insurance (such as Group Critical Illness Insurance, Group Hospital & Surgical Insurance) in place?
- Does he or his dependants have a need for Life or Health Insurance?
- Can he afford to purchase any insurance policy that you are going to propose to him?
- Has he stated his priorities correctly?

A1. Emergency Fund

4.2 An emergency fund is useful to guard against the breadwinner's loss of a job or a short-term disability that interrupts the financial flow of income to the family. It also provides for certain expenses not covered by insurance, such as the costs of a child's tuition.

4.3 If the prospective client does not have an emergency fund in place, it may affect his ability to service any policies that he may purchase from you.

A2. Employment Status & Occupation

4.4 See information on employment details under **Section 3.3(d)** of this chapter.

A3. Life Stages

4.5 Most people will go through the following life stages:

- childhood;
- young unmarried;
- young married;
- married with young children;
- married with older children;
- pre-retirement; and
- retirement.

4.6 During his active employment years, it is crucial to ensure that one protects his earnings against disability resulting from injury or long-term sickness.

4.7 The need for protection against ill health applies to everyone at any stage in his life. For older people, they will have a greater need for Critical Illness Insurance, Medical Expense Insurance and Long-Term Care Insurance, as there is a higher chance of them falling sick or getting injured.

A4. Dependants

4.8 If the prospective client has dependants, provision should be made for their medical expenses to avoid any financial burden, in case any of the dependants contracts a major illness or becomes disabled.

A5. Existing Insurance Policies

4.9 If the prospective client and his dependants have any Life and Health Insurance, you need to compare the benefits under his existing policy with his current needs, to see if the prospective client is sufficiently covered. Let us look at how this can be done.

(i) Disability Income Insurance

For a prospective client who already has a Disability Income Insurance policy, compare the level of cover with his current income level to see if the cover is sufficient. Check if the policy covers up to the target retirement age, the length of the deferred period, and whether the prospective client's employer provides him with any disability income benefit. Remind the prospective client not to over-insure because of the Limitation Clause under the Disability Income Insurance policy.

(ii) Life Insurance with Total & Permanent Disability Benefit

The prospective client (or his spouse) who may not be actively employed (e.g. housewife) can consider to get protection for disability with the TPD

benefits under Life Insurance. You can check for any TPD benefits that the prospective client already has by reviewing the existing life insurance policies.

(iii) Medical Expense Insurance

If the prospective client has a Medical Expense Insurance policy, including the Medisave-approved Integrated Plan, you need to find out the exact coverage, such as the hospital and ward entitlement of the plan, the annual and lifetime limits, and the policy co-insurance and deductible, if any. Also look at the expiry age and the renewability condition. You must ensure that the prospective client will be adequately covered in his preferred hospital and ward type in the event of hospitalisation, and that he will enjoy the coverage for as long as possible and will not risk losing his coverage at a time when he needs it most.

In addition, you also need to keep in mind the Co-ordination of Benefit Clause. **Example 14.1** gives an illustration of how this Clause works.

Example 14.1: Illustration Of The Working Of The Co-ordination Of Benefit Clause

Allison has been recently hospitalised for eight (8) days for an operation to remove her womb. Her total hospital bill comes out to be S$22,400. She has received S$11,000 reimbursement under her company's Group Medical Expense Insurance policy and is now waiting for the reimbursement from her own Private Medical Insurance (PMI).

Details of her hospital bills and PMI (no deductible nor co-insurance) are as follows:

Description	Hospital Bills	Limits Under PMI	Amount Covered Under PMI
Room & Board	S$300 x 8 = S$2,400	S$250 per day	S$250 x 8 = S$2,000
Surgery	S$20,000	S$10,000	S$10,000
Total	S$22,400		S$12,000

Applying the Co-ordination of Benefit Clause, since the Group Medical Expense Insurance policy has already paid her S$11,000, the amount which she can claim from her PMI will be the minimum of the:

- balance bill i.e. S$22,400 - S$11,000 = S$11,400 or
- amount covered under PMI i.e. S$12,000

In this instance, she will claim S$11,400 from her PMI, even though the above table shows a slighter higher amount. Hence, the total amount which she will receive from all her health policies is S$22,400 which does not exceed the actual hospital expenses incurred.

***Note: The above example is only an illustration and that the sub-benefits of the group medical expenses are more or less in sync to her PMI.**

With the illustration in **Example 14.1**, you will appreciate the importance of knowing the prospective client's current insurance benefits, his personal expectation of the types of medical care, and his ability to pay

the premiums. Over-purchase of Medical Insurance is not necessary, but under-insurance risk is equally disastrous.

(iv) Critical Illness Insurance

For Critical Illness Insurance, review whether it is a stand-alone policy or a rider attached to an ILP, Term, Endowment or Whole Life Insurance policy. It is good to ensure that the prospective client will have the Critical Illness Insurance cover even in his old age. For example, if the prospective client has an Endowment type of Critical Illness Insurance policy, his CI Insurance cover will terminate once the policy matures. Usually, this will happen at a time when he needs the cover most. Also find out the percentage of the sum insured that will be payable in the event that your client suffers a critical illness, since you know that this policy can be issued as a 100% or 50% acceleration (Note: Accelerated Benefits accelerate the lump sum benefit of the basic plan upon diagnosis of a covered critical illness as defined in the policy).

For CI with less than 100% Acceleration, you may wish to recommend him to add on the Critical Illness Waiver of Premium rider to the policy, For clients with life policies, they may also wish to consider adding the CI Waiver of Premium rider. In doing so, future premiums can be waived in the event of a critical illness, so that any premium payable for the balance coverage will be waived and the coverage can continue should he be diagnosed to be suffering from a critical illness. In this way, the balance of the sum assured can then be preserved for his dependants upon his death.

You should also take note of the maximum aggregate sum assured that each client is entitled to, if the insurer that you are selling for has such a practice.

(v) Personal Accident Insurance

For this class of policy, you need to find out the extent of its coverage, including the details of its exclusions and limitations. This will enable you to assess whether the prospective client is adequately covered.

(vi) Long-Term Care Insurance

Review the benefits that are payable and the benefit trigger point, the definitions used for the Activities of Daily Living (ADLs) and the number of ADLs needed before the benefits are payable. In addition, you need to find out if it is a reimbursement type of benefit, where the payment is based on the actual amount of expenses incurred.

(vii) Managed Healthcare Insurance

Find out the exact amounts of deductible and co-insurance that the prospective client has to bear. In addition, do bear in mind the Co-ordination of Benefit Clause.

(viii) Hospital Cash Insurance

Hospital Cash Insurance pays on top of all other Health Insurance plans. You need to find out the daily benefit and the maximum number of days that the benefit is payable.

(ix) Life Insurance & Work Injury Compensation Insurance

Find out if the prospective client is covered under the statutory Work Injury Compensation Insurance policy and whether he has any Life Insurance policy.

Work Injury Compensation Insurance policy pays in the event of any accident resulting in hospitalisation, permanent incapacity and/or death while arising out of and in the course of employment and its payment will affect how the other policies (with Co-ordination of Benefit Clause) pay. The total and permanent disability benefit under the Life Insurance policy can be used to help the prospective client, to overcome his financial difficulties in the event that he is totally and permanently disabled.

A6. Need For Health Insurance

4.10 Having gone through the list of questions in the Fact-Find Document, you are now in a position to tell whether the prospective client has a need for Health Insurance and, if so, whether he can afford it. If the client does not have any need for more Health Insurance coverage, you should not persuade him to purchase any such policy. Instead, you should do a review with him when his circumstances change (e.g. having a newborn child). On the other hand, if the prospective client does have a need for Health Insurance, and he has the means to pay for it, the next step that you have to carry out is to quantify the prospective client's Health Insurance needs.

B. Quantifying Needs

4.11 Needs quantification is not mandatory, but an industry "best practice". For the purpose of quantifying Health Insurance needs, we will focus on the Protection and Accident & Health sections of the Form. Here is how the quantification of the prospective client's needs is done.

B1. Disability Income Protection Needs

4.12 Disability Income Protection Needs is also known as Maintenance Costs. This is the amount that is required to meet the ongoing maintenance of the prospective client and his dependants, i.e. their daily living expenses.

4.13 There are commonly three methods (as described below) to quantify this.

Method 1

Using the monthly salary, 75% of it is his income protection need in the event of his disability.

Disability Income Protection = 75% x monthly income	:	S$X
Less		
Existing disability benefit per month	:	(S$X)
Estimated level of disability income protection needed	:	S$XX

Method 2

This method uses monthly expenses instead of income to determine the coverage needed.

Total monthly expenses	:	S$X
Less		
Existing disability benefit per month	:	(S$X)
Estimated level of income protection needed	:	S$XX

Monthly expenses should include the amount that the prospective client spends on himself, as well as on his family. This is because when a person is disabled, the usual expenses will continue, and on top of that, the prospective client also has to take care of his medical expenses. This method provides the minimum amount that is required to sustain the prospective client's living expenses in the event of a disability. **Example 14.2** shows you how to compute the amount of income protection needed in the event of a disability using **Method 2**.

Example 14.2: Computing The Amount Of Disability Income Protection Needs

Ben, aged 35 years, has indicated in his Fact-Find Document that his family's living expenses (inclusive of that of his own) is S$3,000 per month. He has also indicated that he wishes to have an income in the event that he is disabled and is not able to work. So far, he does not have any insurance coverage other than the Central Provident Fund (CPF) Board's Dependants' Protection Scheme (DPS)[2], Home Protection Scheme and IncomeShield Plan MA, as well as his employer's Group Term Life Insurance of S$100,000 sum assured, and Hospital and Surgical Insurance coverage of up to S$50,000 without any sub-limits. The amount of disability income protection that he needs is:

Total monthly expenses	:	S$3,000
Less		
Existing disability benefit per month	:	S$ 0
Existing hospital cash benefit per month	:	S$ 0
Estimated level of income protection needed	:	S$3,000

[2] DPS is a low cost term-life, opt-out insurance scheme that provides a basic coverage of up to S$46,000 to the family of insured in the event of his death or total and permanent disablement.

Method 3

There may be circumstances under which the prospective client may not want, is not able to afford a Disability Income Insurance (DII) policy or simply does not have an income to be eligible for a DII policy. For such a prospective client, you can help to provide him with total and permanent disability benefits usually incorporated into a Life Insurance policy.

This method provides a lump sum benefit should a person become totally and permanently disabled.

Example 14.3 illustrates how you can compute the amount of total and permanent disability benefits which the prospective client will need.

Example 14.3: Computing The Amount Of Total And Permanent Disability (TPD) Benefit

Following **Example 14.2**, the amount of TPD benefit that Ben needs per year is as follows:

Yearly income needed = family's average living expenses x 12
= S$3,000 x 12
= S$36,000

Assuming that the annual inflation rate and expected rate of return from investments remain constant at 2% and 4% respectively, the expected rate of return from funds (adjusted for inflation) = 4% - 2% =2%

If the number of years that the income is needed is 25 (to be determined by the client), then the estimated funds required to provide income is:
=S$36,000 x 19.9139 (refer to **Table A2** at the end of this Study Guide)
=S$716,900

Less
Funds available + Existing Insurance*
= S$(46,000 + 100,000)
= S$146,000

Additional amount of total and permanent disability benefit required
= S$(716,900 – 146,000)
= S$570,900

*only consider those existing insurance policies which have a TPD benefit. Group Term Life and DPS both have TPD benefits.

4.14 Having learnt how to determine the maintenance cost, let us now learn how to determine the medical costs.

B2. Medical Costs

4.15 Medical costs refer to the immediate hospital and medical expenses associated with an injury or illness resulting in the prospective client being hospitalised for treatment or surgery.

4.16 To quantify medical cost needs, you need to discuss and make some assumptions with the prospective clients as follows:

- the most common conditions for a person to be hospitalised;
- the cost of treatment for any one particular illness, such as a heart condition;
- The hospital type and ward the client would opt for in the event of hospitalization;
- The need to provide coverage for medical cost from the first dollar or can he accept a co-payment;
- The continuous affordability of medical insurance premiums when he is no longer working

4.17 The data are available from the Ministry of Health (MOH) Website at: www.moh.gov.sg. Examples of the two sets of data are given in **Appendices 14A** and **14B**. As they change over time, it is advisable for you to refer to the MOH Website every time when you need information on such data.

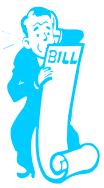
4.18 In addition, the following factors should be considered and discussed with the prospective client, with appropriate adjustments made, if necessary:

- as Group Insurance is not portable, that is the prospective client may lose his Group Insurance coverage when he leaves the organisation later, he may wish to consider removing his Group Insurance coverage from any computation;
- the prospective client may be concerned with the treatment cost of more than one medical condition in a year.

B3. <u>Hospital Cash Insurance</u>

4.19 The way to compute the amount of Hospital Cash Insurance required is as follows:

Total monthly expenses	S$ X
Less	
Existing hospital cash benefit per month	(S$ X)
Estimated level of income protection needed	S$XX



Assuming Eugene's monthly expenses is S$2,500; the amount of Hospital Cash Income required is as follows:

Monthly expenses	S$ 2,500
Less	
Existing hospital cash benefit per month	(S$ 0)
Estimated level of income protection needed	S$ 2,500

Therefore, the amount of Hospital Cash income required is:
= S$2,500 ÷ 30 days
= <u>S$83.33 per day</u>

B4. Critical Illness Insurance

4.20 Besides taking care of hospitalisation expenses and disability income, the prospective client may also want a lump sum payment for his rehabilitation expenses, to defray expenses not covered by other Health Insurance policies, and to maintain his family living expenses, as well as to handle any emergency expenses, if he contracts a dread disease or critical illness. A Critical Illness (CI) Insurance policy is suitable for these purposes. You will need to calculate the amount of CI Insurance cover that is required.

4.21 The calculation is really more of an art than a science, since there are many uncertainties. Some factors to consider for the prospective client are described below:

(a) Which dread disease is he most susceptible to? His family medical history may shed some light on this answer. Therefore, medical costs can be approximated.

(b) His family's needs and expenses.

(c) His family's level of dependence on him.

(d) Does he already have sufficient Medical Expense Insurance and/or Disability Income Insurance?

(e) His desired level of medical treatment, e.g. private or public hospital.

(f) Whether he wants to buy an Additional Benefit Type or Acceleration Benefit Type of CI Insurance. If he decides on the Additional Benefit Type, then he must be informed that the coverage will normally cease at the age of 65 years, unlike the Acceleration Benefit Type. Since the Acceleration Benefit Type is usually attached to a Whole Life Insurance policy, this type of benefit will last the whole of life.

(g) Does he want a benefit on early diagnosis of a critical illness, does he want to be able to make multiple critical illness claims, does he want to cover other conditions such as diabetes or mental illness?

(h) His preference and comfort level. Some prospective clients will require only S$50,000 CI Insurance cover, while others will feel that even S$500,000 cover is insufficient.

4.22 After an agreement has been reached with him as to the CI Insurance cover required, you will be able to calculate the shortfall in cover by deducting away the current CI Insurance cover that he already has.

4.23 Having seen how a prospective client's needs for Health Insurance are quantified, we now move on to see how to go about recommending the most suitable products to meet the prospective client's needs.

5. PRODUCT RECOMMENDATIONS

5.1 There are three basic principles that you should be aware of, before you start making any product recommendations to the prospective client. They are:

- recommend products only if he needs them; and
- recommend products which are only the most suitable for him, given his existing circumstances.
- if he needs a product that the company you represent does not carry, let him know, so that he can find alternatives.

A. Product Suitability

5.2 In order for you to determine if a product is suitable for the prospective client, you need to have a good understanding of the products available.

A1. Good Product Knowledge

5.3 You should be familiar with the following aspects of your company's products:

- What is the product range?
- What does the product serve to do? For example, reimbursement of expenses or replacement of income?
- What are the eligibility criteria for making a claim under the policy?
- Does the policy have any waiting period? If so, find out the duration and effective date of the waiting period.
- Is the policy guaranteed renewable, optionally renewable, conditionally renewable or cancellable?
- What are the exclusions and limitations under the policy?
- Does the policy have any special features, such as the survival period under a Critical Illness Insurance policy, and the requirement to inform the insurer of any change in occupation under a Disability Income Insurance policy?
- Is the policy subject to any Co-ordination of Benefit Clause?
- Does the policy have any deductible or co-insurance feature?
- Is there any per day, per year or per lifetime limit under the policy? How much are the limits?
- When and how are the benefits payable? For example, a Hospital Cash (Income) policy pays a flat amount for each day of hospitalisation capped at a certain number of days.
- What are the distribution costs, charges and expenses levied on the products?
- What is the duration of cover under the policy?
- What are the premiums and the frequency modes for premium payments, and are they subject to changes?
- Is there a grace period allowed for the payment of premium due and, if so, what is the time frame?

- What is the implication of non-payment of premium?
- What are the medical and non-medical limits (i.e. the underwriting guidelines on when a medical test is required for the assessment of an application) of the products?
- Which types of policies have non-forfeiture options?
- Is there any geographical limit imposed on the policy?

B. Affordability

5.4 Affordability is an important factor when selecting the most suitable product to recommend to the prospective client. Most policies require regular premiums to be paid. Being able to afford the initial premium does not mean that he will be able to sustain the regular payments. For policies paid with Medisave, you have ensured that his Medisave is enough to support continuity of the policy, either with his current balance or his future regular contribution to his Medisave Account. A prospective client who cannot afford the premiums in the longer term will allow his policy to lapse. The insurer, the insurance representative and the prospective client do not benefit from early policy lapses. From the prospective client's standpoint, he loses the coverage. The insurance representative loses the prospective client's goodwill and the commission payable under the policy. The insurer has to absorb the high initial cost of underwriting the policy.

C. Important Points To Note On Policy Selection

5.5 When deciding on which policy is most suitable for the prospective client, you will have to consider all the factors which we have gone through in this chapter. In addition, it is important that you should also consider the points as listed in **Table 14.1** below.

Table 14.1: Important Points To Note On Policy Selection

- Ensure that the new recommended policy provides cover only for his coverage shortfall to minimise over-insurance.
- Ensure that the prospective client has the longest coverage possible, as Health Insurance is needed most when one is old.
- Ensure that the prospective client can afford the premium in the long term.
- Ensure that the prospective client is not over-insured.
- Ensure that the policy insures the right life (e.g. if the husband is the sole breadwinner, then you should ensure that he is properly covered first, before you recommend any products to his dependants).
- Ensure that the prospective client with dependants has sufficient death protection in place.
- Recommend a rider if it can help to save premiums (provided that the expiry age of the rider will not be shortened by the term of the basic policy).
- For Critical Illness (CI) Insurance, take note of the two types of cover - Additional Benefit Type and Acceleration Benefit Type. Discuss the

following with the client - expiry age, premium difference, whether he should take up a CI rider if he has existing life policies.

- Consider to attach the CI Waiver of Premium rider for the client who has other life insurance protection.
- For the prospective client who is covered under his employer-sponsored Medical Expense Insurance (MEI) and has a need for additional MEI cover, ensure that the proposed plan complement the one provided by the employer. For example, most employer-sponsored MEI policies provide cover from the first dollar onwards, but the coverage is low. In such a case, you can propose a Major MEI to your client.
- Always check for alternative policies to the one that you are recommending to give the prospective client more choices. This gives the prospective client more flexibility in terms of the premiums and benefits that meet his needs.

6. PRESENTING YOUR RECOMMENDATIONS

6.1 To ensure that the prospective client understands the products recommended and the reasons for your recommendations, you should explain the features and benefits of the recommended products, and how these fit into his situation.

6.2 Before meeting the prospective client to go through your recommendation, plan how you would like to present to him. It is advisable that you follow a systematic process.

6.3 An example below shows a systematic process to explain your recommendations to the prospective client in a sequential order.

1. State the purpose of the product (i.e. the need which is actually being met by this product).
2. Give a description of the nature of the product.
3. Brief the prospective client on the benefits and limitations of the product.
4. Give a detailed explanation on the options within the product.
5. Give a summary of the reasons why the product is being recommended.
6. Explain the benefit illustration and highlight the guaranteed and non-guaranteed benefits (if applicable).
7. Disclose any distribution costs, charges and expenses under the policy.

6.4 During the meeting, communicate clearly and simply. Avoid using technical jargon. If the prospective client accepts your recommendations, you have to ensure that all relevant forms required by your principal (insurer) are properly completed. In the case where the prospective client decides not to take up any of your recommendations, you may seek to clarify his reasons for not accepting your recommendations. However, you should not insist if the prospective client refuses to explain. Thank the prospective client for his time before leaving.

7. PERIODIC CLIENT REVIEW

7.1 The process of identifying and satisfying your client's needs does not stop with the implementation of the initial recommendations. Your client's personal circumstances are likely to change and new needs may surface over time. Such changes may affect the initial product recommendations, as they may no longer be adequate. Regular reviews will ensure that your existing client continues to receive quality service from you, and also reinforces your relationship with your existing client.

7.2 The question of when and how often the existing client's position should be reviewed depends on some extent of the initial advice provided by you, and also on the existing client's own wishes for a review. Generally, you should do a review with your existing client under the following circumstances:

- a change in the client's personal circumstances, such as the birth of a child;
- external developments, such as changes in the CPF ruling which can have an impact on the client's financial position and/or the appropriateness of products already held;
- the original products purchased by the client are not adequate to cover all his needs; and
- the launching of new products in the financial services market.

7.3 Regular reviews benefit both you and your client. As a professional insurance representative, you should ensure that the products recommended meet with the client's current needs. You should also seek to arrange regular meetings with him to address his future needs.

7.4 The long-term needs of the client should be a principal concern, and your relationship with him should also be an ongoing one.

Do not recommend any further Health Insurance policies to the prospective client if he has adequate medical cover, as he may not be able to claim under all the insurance policies.

APPENDIX 14A

Top 10 Conditions of Hospitalisation

		2016	2017	2018
Total No. of Discharges ('000)		**569.2**	**593.8**	**611.9**
% of Total Discharges				
1.	Accident, poisoning & violence	8.3	8.4	8.6
2.	Cancer	5.9	5.9	5.8
3.	Pneumonia	3.2	3.3	3.2
4.	Ischaemic heart diseases	3.1	3.2	3.1
5.	Intestinal infectious diseases	2.8	2.6	2.7
6.	Other heart diseases	2.5	2.5	2.5
7.	Infections of the skin and subcutaneous tissue	2.1	2.1	2.3
8.	Diabetes mellitus	1.7	1.8	2.1
9.	Cerebrovascular diseases (including stroke)	1.8	1.9	2.0
10.	Accute upper respiratory infections	1.9	2.1	1.9

Source: MOH Website – "Top 10 Conditions of Hospitalisation"

https://www.moh.gov.sg/resources-statistics/singapore-health-facts/top-10-conditions-of-hospitalisation

APPENDIX 14B

HOSPITAL BILL SIZE BY CONDITIONS/PROCEDURES

Heart Coronary Disease, Coronary Artery Bypass Graft(Open)

Private Hospital

Inpatient	25% of patients are charged below:	50% of patients are charged below:	75% of patients are charged below:
Total Bill Amount	**$67.272**	**$75,398**	**$88,942**
Operation Fee	$43,195	$50,874	$57,724
i. Surgeon Fee	$24,557	$27,820	$30,495
ii. Anaesthetist Fee	$3,500	$4,815	$5,350
iii. *Facility Fee*	$15,611	$19,093	$24,158
Implant	n/a	n/a	n/a
Other Fee	$20,451	$25,533	$33,216

Public Hospital (Ward A)

Ward A	25% of patients are charged below:	50% of patients are charged below:	75% of patients are charged below:
Total Bill Amount	**$36,091**	**$38,485**	**$42,876**
Operation Fee	$16,877	$18,019	$19,012
Implant	n/a	n/a	n/a
Other Fee	$17,931	$20,576	$23,183

Public Hospital (Ward B2)

Ward B2	25% of patients are charged below:	50% of patients are charged below:	75% of patients are charged below:
Total Bill Amount	**$7,266**	**$8,006**	**$9,016**
Operation Fee	$1,287	$1,287	$2,061
Implant	$0	$0	$9
Other Fee	$5,724	$6,387	$7,556

Source : https://www.moh.gov.sg/cost-financing/fee-benchmarks-and-bill-amount-information/Details/SD812H--1

CHAPTER 14

FINANCIAL NEEDS ANALYSIS

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Needs selling versus product selling	Needs selling is more desirable than product selling because it is: • Service-oriented. • Not pressure selling. • Relationship based.
What is fact-finding?	• Fact-finding is the process of obtaining answers to a series of questions about a prospective client's personal circumstances, finance and ambitions, etc. for the future.
Purposes served by the various sections of the Fact-Find Document	• Important notice to client » Gives the prospective client information on who the insurance representative is, which insurers he represents and what product classes he can provide advice on. » Highlights to the prospective client the importance of providing accurate information on the Fact-Find Document. • Application type » Types of disclosure. » Application type 1,2 or 3. • Personal information » Essential for administrative purposes on the part of the company. » Preliminary assessment of the types of products that will likely be needed. » Information pertaining to age is essential for underwriting and premium determination. • Information on employment details » Eligibility for Disability Income Insurance (DII). » Determine the deferred period for a DII policy. » Know whether the prospective client is exposed to any occupational hazards. » Affordability. • Information on details of spouse and dependants » Identification in the event of a claim; » Premium determination; » Any occupational hazards (in respect of the spouse); » Eligibility to be covered as a dependant (this is because A&H Insurance policies that provide coverage for any dependant has an age limit to qualify as a dependant); and » Determine whether there is a need to provide A&H Insurance cover for the dependants. • Existing health insurance policies / existing insurance portfolio » Indicate how far the prospective clients' existing plan(s) will go towards meeting their needs in the event of ill health or disability. • Personal Priorities and Objectives » Enable the representative to tell what the prospective client's priorities are with regard to the type of A&H policies that he may need.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Purposes served by the various sections of the Fact-Find Document	• Health condition » Help to determine whether the prospective client is insurable and, if so, on what terms. • Replacement of policy » If prospective client's answer is "yes", the representative is required to explain to the prospective client the consequences of replacing policies. • Customer's financials » Ascertain the affordability of the recommendation and plans, and facilitates the planning of financial needs. • Representative's declaration » Declaration on treating the information given in the Fact-Find Document with strict confidentiality and use it only for the purpose of determining suitable insurance products, and not for any other purposes, bearing in mind the requirements under the Personal Data Protection Act 2012 » Establish trust between the representative and the prospective client.
Sample questions to be taken into consideration when going through the prospective client's Fact-Find Document to identify his needs	• Does he have an emergency fund in place? • What is his employment status and occupation? • Which life stage is he in? • Does he have any dependants? • Does he or his dependants (if any) have any Individual Life or Health Insurance, or Group Medical Insurance (such as Group Critical Illness Insurance, Group Hospital & Surgical Insurance) in place? • Does he or his dependants have a need for Life or Health Insurance? • Can he afford to purchase any insurance policy that you are going to propose to him? • Has he stated his priorities correctly?
Importance of an emergency fund	Guard against the breadwinner's loss of a job or a short-term disability that interrupts the financial flow of income to the family.
Which stage of the prospective client's life cycle versus where the need to protect one's earnings against disability and ill health, is critical	• During active employment years, it is crucial to ensure that one protects his earnings against disability resulting from injury or long-term sickness. • Need for protection against ill health applies to everyone at any stage in his life. • For older people, they will have a greater need for Critical Illness Insurance, Medical Expense Insurance and Long-Term Care Insurance, as there is a higher chance of them falling sick or getting injured. • If there are dependants, provision should be made for their medical expenses to avoid any financial burden, in case any of the dependants contracts a major illness or becomes disabled.
Know what to do if the prospective client has a: • **Disability Income Insurance**	• Compare the level of cover with his current income level to see if the cover is sufficient. • Check if the policy covers up to the target retirement age, the length of the deferred period, and whether the prospective client's employer provides him with any disability income benefit. • Remind the prospective client not to over-insure because of the Limitation Clause under the Disability Income Insurance policy.
Know what to do if the prospective client has a: • **Life Insurance with Total & Permanent Disability Benefit**	Check for any TPD benefits that the prospective client already has by reviewing the existing life insurance policies.
Know what to do if the prospective client has a: • **Medical Expense Insurance**	• Find out the exact coverage, such as the hospital and ward entitlement of the plan, the annual and lifetime limits, and the policy co-insurance and deductible, if any. • Look at the expiry age and the renewability condition. • Ensure that the prospective client will be adequately covered in his preferred hospital and ward type in the event of hospitalisation, and that he will enjoy the coverage for as long as possible and will not risk losing his coverage at a time when he needs it most. • Keep in mind the Co-ordination of Benefit Clause.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Know what to do if the prospective client has a: • **Critical Illness Insurance**	• Review whether it is a stand-alone policy or a rider attached to an ILP, Term, Endowment or Whole Life Insurance policy. • Take note of the maximum aggregate sum assured that each client is entitled to, if the insurer has such a practice.
Know what to do if the prospective client has a: • **Personal Accident Insurance**	Find out the extent of its coverage, including the details of its exclusions and limitations to assess whether the prospective client is adequately covered.
Know what to do if the prospective client has a:: • **Long-Term Care Insurance**	• Review the benefits that are payable and the benefit trigger point, the definitions used for the Activities of Daily Living (ADLs) and the number of ADLs needed before the benefits are payable. • Find out if it is a reimbursement type of benefit, where the payment is based on the actual amount of expenses incurred.
Know what to do if the prospective client has a: • **Managed Healthcare Insurance**	• Exact amounts of deductible and co-insurance that the prospective client has to bear. • Bear in mind the Co-ordination of Benefit Clause.
Know what to do if the prospective client has a: • **Hospital Cash Insurance**	Find out the daily benefit and the maximum number of days that the benefit is payable.
Know what to do if the prospective client has a: • **Life Insurance Policy & Work Injury Compensation Insurance**	Find out if the prospective client is covered under the statutory Work Injury Compensation Insurance policy and whether he has any Life Insurance policy.
Quantify disability income protection needs	• Method 1 » Using the monthly salary, 75% of it is his income protection need in the event of his disability. • Method 2 » This method uses monthly expenses instead of income to determine the coverage needed. • Method 3 » This method provides a lump sum benefit should a person become totally and permanently disabled.
Quantify medical and ancillary costs	To quantify medical cost needs, the representative needs to discuss and make some assumptions with the prospective clients as follows: • The most common conditions for a person to be hospitalised; • The cost of treatment for any one particular illness, such as a heart condition; • The hospital type and ward the client would opt for in the event of hospitalisation; • The need to provide coverage for medical cost from the first dollar or can he accept a co-payment; • The continuous affordability of medical insurance premiums when he is no longer working.
Quantify hospital cash income needs	Estimated level of protection needed = Total monthly expense Less Existing hospital cash benefit per month

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Quantify Critical Illness Insurance	Calculation is really more of an art than a science, since there are many uncertainties. Some factors to consider for the prospective client are described below: • Which dread disease is he most susceptible to? His family medical history may shed some light on this answer. Therefore, medical costs can be approximated. • His family's needs and expenses. • His family's level of dependence on him. • Does he already have sufficient Medical Expense Insurance and/or Disability Income Insurance? • His desired level of medical treatment, e.g. private or public hospital. • Whether he wants to buy an Additional Benefit Type or Acceleration Benefit Type of CI Insurance. If he decides on the Additional Benefit Type, then he must be informed that the coverage will normally cease at the age of 65 years, unlike the Acceleration Benefit Type. Since the Acceleration Benefit Type is usually attached to a Whole Life Insurance policy, this type of benefit will last the whole of life. • Does he want a benefit on early diagnosis of a critical illness, does he want to be able to make multiple critical illness claims, does he want to cover other conditions such as diabetes or mental illness? • His preference and comfort level. Some prospective clients will require only S$50,000 CI Insurance cover, while others will feel that even S$500,000 cover is insufficient.
Basic principles before making any product recommendation	• Recommend products only if the prospective client needs them. • Recommend products which are only the most suitable for the prospective client, given his existing circumstances. • If prospective client needs a product that the company you represent does not carry, let him know, so that he can find alternatives.
Sample questions to ask for better understanding of the product	• What is the product range? • What does the product serve to do? For example, reimbursement of expenses or replacement of income? • What are the eligibility criteria for making a claim under the policy? • Does the policy have any waiting period? If so, find out the duration and effective date of the waiting period. • Is the policy guaranteed renewable, optionally renewable, conditionally renewable or cancellable? • What are the exclusions and limitations under the policy? • Does the policy have any special features, such as the survival period under a Critical Illness Insurance policy, and the requirement to inform the insurer of any change in occupation under a Disability Income Insurance policy? • Is the policy subject to any Co-ordination of Benefit Clause? • Does the policy have any deductible or co-insurance feature? • Is there any per day, per year or per lifetime limit under the policy? How much are the limits? • When and how are the benefits payable? For example, a Hospital Cash (Income) policy pays a flat amount for each day of hospitalisation capped at a certain number of days. • What are the distribution costs, charges and expenses levied on the products? • What is the duration of cover under the policy? • What are the premiums and the frequency modes for premium payments, and are they subject to changes? • Is there a grace period allowed for the payment of premium due and, if so, what is the time frame? • What is the implication of non-payment of premium? • What are the medical and non-medical limits (i.e. the underwriting guidelines on when a medical test is required for the assessment of an application) of the products? • Which types of policies have non-forfeiture options? • Is there any geographical limit imposed on the policy?

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Why is affordability an important factor when selecting a suitable product to recommend to the prospective client?	• Affordability is an important factor when selecting the most suitable product to recommend to the prospective client. • Most policies require regular premiums to be paid. Being able to afford the initial premium does not mean that he will be able to sustain the regular payments. • The insurer, the insurance representative and the prospective client do not benefit from early policy lapses. » The prospective client loses the coverage. » The insurance representative loses the prospective client's goodwill and the commission payable under the policy. » The insurer has to absorb the high initial cost of underwriting the policy.
Important points on policy selection	• Ensure that the new recommended policy provides cover only for his coverage shortfall to minimise over-insurance. • Ensure that the prospective client has the longest coverage possible. • Ensure that the prospective client can afford the premium in the long term. • Ensure that the prospective client is not over-insured. • Ensure that the policy insures the right life. • Ensure that the prospective client with dependants has sufficient death protection in place. • Recommend a rider if it can help to save premiums. • For Critical Illness (CI) Insurance, take note of the two types of cover - Additional Benefit Type and Acceleration Benefit Type. • Discuss the following with the client - expiry age, premium difference, whether he should take up a CI rider if he has existing life policies. • Consider to attach the CI Waiver of Premium rider for the client who has other life insurance protection. • For the prospective client who is covered under his employer-sponsored Medical Expense Insurance (MEI) and has a need for additional MEI cover, ensure that the proposed plan complement the one provided by the employer. • Always check for alternative policies to the one that you are recommending.
Example of a systematic process of explaining recommendations to the prospective client	• State the purpose of the product (i.e. the need which is actually being met by this product). • Give a description of the nature of the product. • Brief the prospective client on the benefits and limitations of the product. • Give a detailed explanation on the options within the product. • Give a summary of the reasons why the product is being recommended. • Explain the benefit illustration and highlight the guaranteed and non-guaranteed benefits (if applicable). • Disclose any distribution costs, charges and expenses under the policy.
When the reviews for prospective client are necessary?	• A change in the client's personal circumstances, such as the birth of a child. • External developments, such as changes in the CPF ruling which can have an impact on the client's financial position and/or the appropriateness of products already held. • Original products purchased by the client are not adequate to cover all his need. • Launching of new products in the financial services market.

CHAPTER 15
CASE STUDIES

CHAPTER OUTLINE

1. Introduction
2. Case Study 1 – Individual Health Insurance
3. Case Study 2 – Group Health Insurance

Appendices 15A & 15B – Mr Tang's Existing Health Insurance Policies

LEARNING OUTCOMES

After studying this chapter, you should be able to:

- know how to apply the principles that you have learnt from the previous chapters to carry out a proper needs-based sales advisory process through looking at two case scenarios

Contents

CHAPTER OUTLINE 337
LEARNING OUTCOMES 337
1. INTRODUCTION 339
2. CASE STUDY 1 – INDIVIDUAL HEALTH INSURANCE 339
A. Maintenance Costs 340
B. Medical Costs 341
3. CASE STUDY 2 – GROUP HEALTH INSURANCE 347
APPENDIX 15A 350
APPENDIX 15B 351

1. INTRODUCTION

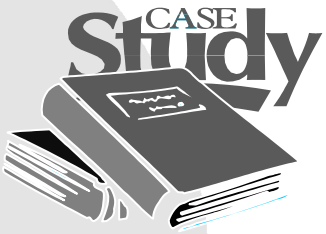
1.1 In this chapter, we bring you through two case studies to show you how the whole needs-based sales process may be carried out.

1.2 Note that the case studies given in this chapter are meant only to provide you with an illustration of how needs-based selling is done for Health Insurance. The circumstances can differ across time and across individuals, as well as corporations. Hence, the examples given here cannot be used as a comprehensive guide for every situation. You should also keep abreast of the LIA and GIA Guidelines On Disclosure Requirements and Needs-Based Sales Process for A&H Insurance Products.

1.3 Let us begin by looking at a case study on an individual client.

2. CASE STUDY 1 – INDIVIDUAL HEALTH INSURANCE

2.1 Angela has done a fact-find with Tommy Tang, her new client who is a Singapore Citizen. Below is a summary of the data that she has extracted from the Fact-Find Document:



Mr Tang : 38 years old
Mrs Tang : 37 years old, housewife
Son : 5 years old
Daughter : 1 year old

2.2 Existing Health Insurance Policies:

- Group Hospital & Surgical (H & S) Insurance (Plan A) (See **Appendix 15A**)

2.3 Angela has also obtained the following information from Tommy:

- Mr and Mrs Tang have sufficient cover for death protection.
- His family's average monthly expenditure is S$3,000 and his income is S$4,000.
- He has not set aside any funds for protection planning, other than his savings which is intended to meet any emergency needs, such as hospitalisation.
- He likes to have a Critical Illness Insurance policy of S$200,000 for himself and S$100,000 for his wife.
- He thinks that he will need maintenance cost for 21 years for his wife in the event of his disability, as the youngest child should be independent by then.
- The estimated expenses required for the children in the event of Mrs Tang's disability are S$1,500 per month.
- He and his family would stay in the A ward of a public hospital should they be hospitalised.
- His budget for Health Insurance cover is S$700 per month.

2.4 Having gathered the necessary information, Angela then proceeds to analyse the insurance needs of Tommy and his family members.

A. Maintenance Costs

2.5 The most suitable policy for maintenance cost is Disability Income Insurance.

2.6 Tommy does not have a Disability Income Insurance policy. He has indicated in his Fact-Find Document that he has an urgent need for cover for loss of income resulting from accident or sickness, as he is the sole breadwinner in his family.

2.7 As such, Angela proposes a Disability Income Insurance policy with benefit at 75% of Tommy's monthly salary, i.e. S$3,000. This will ensure that the family is adequately provided for in the event of Tommy's disability. The deferred period will be six months, as the employer will continue to pay Tommy's salary up to six months in the event that he is disabled. Mrs Tang, a housewife, is not eligible for Disability Income Insurance. In her case, there are two possible ways to provide her with protection against disability, i.e. through the Total and Permanent Disability (TPD) Benefit under the Life Insurance policies, or through a Personal Accident Insurance policy.

2.8 The amount of TPD cover which she requires is as follows:

Maintenance Costs Required On Mrs Tang's Disablement

Yearly income needed	: S$1,500 (current monthly expenditure) x 12 = S$18,000
Number of years income is needed	: 21 years
Expected annual rate of return from funds (adjusted for inflation)	: 3% (assume that rate of return is 5%, and inflation rate is 2%)
Estimated funds required to provide income	: S$18,000 x 15.8775 (refer to **Table A2** at end of this Study Guide) = S$285,795
Less Funds available Existing Insurance	: S$0
Funds required	: S$285,795

2.9 Having determined the maintenance costs for the Tangs, Angela then goes on to determine whether the Tangs' current Medical Expense Insurance policies are sufficient to meet their needs.

B. Medical Costs

2.10 The policies that may be used to meet medical costs are:

- Medical Expense Insurance;
- Managed Healthcare Insurance;
- Long-Term Care Insurance;
- Critical Illness Insurance;
- Hospital Cash Insurance; and
- Personal Accident policy with medical expense benefit.

2.11 According to the fact-find results, Tommy only has Medical Expense Insurance coverage under his employer's insurance. Angela informed Tommy that Group H&S is not portable and that he may lose it later or the coverage may change if he moves into a different job or retire. They agreed to consider Group H&S as a temporary (not lifetime) benefit instead. She then proceeds to determine the coverage he requires for Medical Expense Insurance policies to meet the Tangs' needs in the event of hospitalisation.

2.12 These were steps taken by Angela to review and recommend a suitable Medical Expense Insurance:

- Confirm his preference of stay in the event of hospitalisation then discuss the top 10 conditions of hospitalisation with Tommy to give him an indication of the total hospital bill amount of a medical condition he wish to know.
- Briefly compute what his Group H&S would have covered him in that medical condition to provide a view if it can cover a portion of co-insurance and deductible of a hospitalisation for as long as the GHS is valid.
- Present a medical expense insurance plan that will provide cover for Public Ward A hospitalisation, showing the current and future annual premiums of the proposed plan. Tommy should be informed that the premium rate is non-guaranteed and in view of medical inflation, it is likely that premiums seen in current premium table will change and get even more expensive in the future. This is to give a practical view of the future affordability of premium on the chosen plan.

2.13 **Step 1**

Tommy has indicated preference to stay in Ward A of Public Hospital, and having gone through the top 10 conditions of hospitalisation, Tommy wanted to know the average cost of Heart Bypass. Angela has found out from the MOH Website that for a heart coronary disease (coronary artery bypass graft) in an A ward in public hospital, the total bill amount is in the range of S$36,091 and S$42,876[1] and average length of stay for this condition is 10 days. This gave Tommy an indication of the average total amount required today for a Heart Bypass surgery.

[1] Source: MOH Website – www.moh.gov.sg

2.14 **Step 2**
Angela computes the amount payable under Tommy's existing Group H&S should he be hospitalised for Heart Bypass Surgery.

Amount payable under Group H & S policy[2]

Inpatient Benefit[3] (S$360 x 10 days)	S$ 3,600
Surgical Benefit	S$15,000
Total Amount Payable	S$18,600

2.15 Subject to the Co-ordination of Benefits Clause and policy terms and conditions, the benefits payable under Group H&S can be used to cover part of co-insurance and deductible of the average bill size of the medical condition. Hence it may not be necessary to have first dollar cover for his individual medical expense insurance. This way, he can save some premiums to fund for future premiums. However, Angela highlighted to Tommy that once he lose the Group H&S, his co-payments for any hospitalisation has to be out-of-pocket. Tommy acknowledged this and agreed to go with a plan that has deductible and co-insurance in order to lower the premiums.

2.16 **Step 3**
Next, Angela presented the recommended plan and premium table to Tommy for his consideration.

2.17 The discussion with Tommy on affordability should not just be on current, but also on future sustainability to pay premiums, whether with Medisave or cash.

[2] Please refer to **Appendix 15A** for coverage details of Tommy's Group H & S policy.
[3] Please refer to **Appendix 15B** for average length of stay for Heart Surgery.

Table of Premium Rates

Enhanced IncomeShield Yearly Premium Rate for insured person who is a Singapore Citizen or Permanent Resident

Age Next birthday^	MediShield Life Premiums (Fully Payable by MediSave)~	Additional Withdrawal Limits (AWLs)	Additional private insurance coverage							
			Enhanced IncomeShield							
			Preferred		Advantage		Basic – SG		Basic – PR	
			Premiums	Cash Outlay	Premiums	Cash outlay	Premiums	Cash outlay	Premiums	Cash outlay
1 to 18	$130	$300	$205	-	$69	-	S49	-	$56	-
19 to 20	$130		$252	-	$87	-	$73	-	$78	-
21 to 30	$195		$255	-	$71	-	$57	-	$62	-
31 to 35	$310		$375	$75	$104	-	$71	-	$81	-
36 to 40	$310		$392	$92	$128	-	$81	-	$99	-
41 to 45	$435	$600	$648	$48	$212	-	$123	-	$151	-
46 to 50	$435		$766	$166	$224	-	$140	-	$170	-
51 to 55	$630		$888	$288	$343	-	$154	-	$185	-
56 to 60	$630		$1,162	$562	$379	-	$166	-	$198	-
61 to 65	$755		$1,592	$992	$603	$3	$308	-	$367	-
66 to 70	$815		$2,250	$1,650	$912	$312	$477	-	$578	-
71 to 73	$885	$900	$3,113	$2,213	$1,299	$399	$725	-	$871	-
74 to 75	$975		$3,553	$2,653	$1,544	$644	$859	-	$1,031	$131
76 to 78	$1,130		$3,994	$3,094	$1,877	$977	$1,026	$126	$1,238	$338
79 to 80	$1,175		$4,506	$3,606	$2,169	$1,269	$1,162	$262	$1,398	$498
81 to 83	$1,250		$4,726	$3,826	$2,242	$1,342	$1,275	$375	$1,508	$608
84 to 85	$1,430		$5,270	$4,370	$2,561	$1,661	$1,502	$602	$1,775	$875
86 to 88	$1,500		$5,890	$4,990	$2,849	$1,949	$1,656	$756	$2,169	$1,269
89 to 90	$1,500		$6,455	$5,555	$3,152	$2,252	$1,929	$1,029	$2,491	$1,591
91 to 93	$1,530		$6,414	$5,714	$3,487	$2,587	$2,308	$1,408	$2,939	$2,039
94 to 95	$1,530		$7,143	$6,243	$3,878	$2,978	$2,573	$1,673	$3,250	$2,350
96 to 98	$1,530		$7,641	$6,741	$4,249	$3,349	$2,836	$1,936	$3,560	$2,660
99 to 100	$1,530		$8,117	$7,217	$4,609	$3,709	$3,108	$2,208	$3,881	$2,981
Over 100	$1,530		$8,289	$7,389	$4,985	$4,085	$3,395	$2,495	$4,221	$3,321

SG: Singapore Citizen PR: Singapore Permanent Resident

^ The last entry age is 75, based on the insured's age next birthday.

~ Your MediShield Life premiums may differ depending on your premium subsidies, premium rebates and whether you need to pay for the Additional Premiums. The net MediShield Life premium payable after accounting for these is fully payable by MediSave.

This refers to the cash outlay if you are paying by MediSave (assuming you have sufficient monies in your MediSave account). If you are not paying by MediSave, your total cash outlay will be equal to MediShield Life Premiums + Premiums for Additional private insurance coverage. For example, for an insured aged 30 (at next birthday) buying Enhanced IncomeShield Preferred plan, the total premium = $195 +$255 = $450

Source: https://www.income.com.sg/health-insurance/enhanced-incomeshield/citizen-pr-premium-table

2.18 The Tangs also require Critical Illness Insurance cover, as the medical expenses incurred in the event of a critical illness may not be fully covered by Tommy's policies. They will also need Long-Term Care Insurance cover (under ElderShield) if they can afford the premium, as the cover is not insured by his two existing policies.

2.19 As the Tangs already have policies for protection against premature death, Angela proposed a 100% Acceleration Benefit type of Critical Illness Insurance policy packaged with a Whole Life Insurance policy, so that they can have the cover for life. This policy will also take care of Mrs Tang's TPD needs. To summarise, the package for Mr and Mrs Tang is shown in **Table 15.1** below:

Table 15.1: Summary Of Insurance Package For Mr & Mrs Tang

Mr Tang (Tommy)

Type Of Plan & Sum Assured	Monthly Premium
Enhance Income Shield Advantage Plan	$438/year and Fully funded by Medisave
100% Acceleration Benefit Type of Critical Illness Insurance policy packaged with Whole Life Insurance policy - S$200,000	S$480.80
Disability Income Insurance of S$3,000 with six months' deferred period up to the age of 65 years	S$38.45
Total Monthly Premium with cash	S$519.25

Mrs Tang

Type Of Plan & Sum Assured	Monthly Premium
Enhance Income Shield Advantage Plan	$438/year and Fully funded by Medisave
100% Acceleration Benefit Type of Critical Illness Insurance policy packaged with Whole Life Insurance policy - S$100,000	S$160.00
Personal Accident (PA) Insurance policy - S$50,000	S$5.00
Total Monthly Premium with cash	S$165.00

Two Children

Type Of Plan & Sum Assured	Monthly Premium
Enhance Income Shield Advantage Plan	$199/year per child and Fully funded by Medisave

2.20 The total premium payable with cash works out to be S$684.25 (i.e. S$519.25 + S$165.00) and is within Tommy's budget. As there is no excess premium for the Long-Term Care Insurance cover, Angela has decided not to propose it at this moment.

2.21 Having decided on the types of policies that are suitable to Tommy, Angela next proceeds to complete the "Representative Recommendations" section of the Fact-Find Document.

REPRESENTATIVE'S RECOMMENDATIONS	
Please note that the information that you provide will be the basis on which advice will be given. Please also note that any inaccurate or incomplete information provided may affect the suitability of the recommendations presented to you.	
Client's Objective(s) Client's concern, investment objectives, shortfall amount ($), time horizon, investment risk profile, where applicable	He likes to have a Critical Illness Insurance policy of S$200,000 for himself and S$100,000 for his wife.
Plan(s) Recommendation Full name of plan and rider, duration, sum assured ($), premium ($)/frequency, fund name(s), investment amount and respective risk classification, where applicable **Reason(s) for Recommendations** ▪ State how the plan meets the Client's need(s). ▪ State and explain features and benefits relating to the product sold. **Risk / Limitation(s) of Plan** ▪ State any possible risks relating to the product sold. ▪ State possible disadvantage(s) based on circumstances of the Client.	▪ **Medical Expense Insurance** Proposed Enhanced IncomeShield Advantage Plan for the entire family which are fully payable with Medisave. This plan provides cover for up to Public Hospital Ward A in the event of hospitalisation. There is co-insurance and deductible on this policy to make the premium affordable. ▪ **Critical Illness Insurance Policy Tommy** **Proposed a 100% Acceleration Benefit Type of Critical Illness Insurance cover packaged with a Whole Life Insurance policy – sum assured of S$200,000 as specified by Tommy.** This policy is suitable for Tommy's budget. It will provide him with death, disability and critical illness coverage. It serves to supplement the Whole Life Insurance policy in providing for the family, in the event of his early demise.

REPRESENTATIVE'S RECOMMENDATIONS	
Reason(s) for Deviation(s) Reasons for any deviation from client's profile, objectives and/or representative's recommendations (where applicable) ▪ Premiums are more than Client's budget ▪ Funds recommended (e.g. ILP sub-fund, par fund) are of a higher risk than client's risk preference Client's choice of product/funds differs from representative's recommended plan/funds	Besides, it provides life cover for him. In other words, it ensures that he is covered in his old age. **Mrs Tang** Proposed a 100% Acceleration Benefit Type of Critical Illness Insurance cover packaged with a Whole Life Insurance policy – sum assured of S$100,000 as specified by Mr Tang. This policy will give Mrs Tang the additional TPD cover that she needs. It will also provide her with life cover, thus ensuring that she will be covered in her old age when her need is the greatest.
	▪ **<u>Disability Expense Protection</u>** **Tommy** Proposed a Disability Income Insurance policy of S$3,000 (75% of salary) with a six months' deferred period up to the age of 65 years This policy is considered suitable for Tommy, because it will provide his family with a monthly income in the event that he is totally or partially disabled. **Mrs Tang** Has not proposed Disability Income Insurance policy, as she is not working and, hence, not eligible. Has proposed a PA Insurance policy of S$50,000 to make up the shortfall for TPD cover after she takes up the S$100,000 Critical Illness Insurance policy. This policy is recommended, as it will provide her with cover for death, TPD and medical expenses at a very low cost. This means to say that this policy may also help to take care of the shortfall in Medical Expense Insurance cover.

2.22 Having finalised the insurance package to be recommended to the client, Angela then arranges to meet up with his client, and presents the package to him.

2.23 Note that it is worthwhile to repeat that the case study illustrates a possible set of recommendations among others. As a result, certain plausible suggestions have not been discussed, such as Outpatient cover, or extending the client's coverage to include accidental loss of limbs, or medical expenses arising from accidents.

2.24 As an insurance representative, you should also be thoroughly aware of "Your Guide To Health Insurance", as well as the "Evaluating My Health Insurance Coverage" sheet issued by LIA in conjunction with the MoneySENSE national financial education programme. You can view and download them from the LIA Website at: www.lia.org.sg

2.25 You should bring these documents to the attention of your prospective client and discuss them with him.

3. CASE STUDY 2 – GROUP HEALTH INSURANCE

3.1 We will now look at another case study focusing on a prospective client's need for Group Health Insurance. Apex Services Company Private Limited has approached you for quotations on Group Term Life and Health Insurance policies to cover its employees as part of its employee benefit package. As the Company wants the policies to be tailored to their needs, you will have to get the Company to complete the Group Insurance Fact-Finding (GIFF) Form. Note that the format of the Form may vary for different insurers.

3.2 Before proceeding further, you need to find out whether the Company (i.e. the prospective client) meets your insurer's underwriting requirements in terms of group size and group stability, etc.

3.3 Once you have established that the prospective client is eligible for the group coverage, you may then proceed to explain to your prospective client the following:

- the types of policies available and the benefits offered;
- the advantages of joining the Portable Medical Benefits Scheme or Transferable Medical Insurance Scheme, as well as how these schemes work; and
- the differences between compulsory and voluntary participation, as well as their advantages.

3.4 In addition, you will need to help your prospective client to determine the amount of sum assured for each category of employees. If your prospective client has an existing plan, they may wish to stick to the same amount of benefit, or make some minor adjustments to it. For a prospective client buying the Group Term Life Insurance for the first time, it is your responsibility to help the prospective client to determine the sum assured. There are two common methods which can be used, i.e.:

- according to rank; or
- number of times of the employee's basic salary.

3.5 The first method is easier to manage, as it goes according to the rank of the employee. However, it does not take into account the length of service of the staff concerned.

3.6 For example, a new staff joining as an executive will get the same amount of benefit, as one who has been with the company for two years, although his pay may be lower than the more experienced staff. The second method, on the other hand, takes into account the length of service, as the salary of a more experienced staff is likely to be higher than that of a new staff. Hence, this method may be more equitable as compared to the former method. You may also ask for the client's budget, as this will also help to determine the sum assured to be covered.

3.7 For instance, in this case, your prospective client has told you that the Company prefers to go by the ranking method. Based on the budget given, you can then design a plan, such as the one below:

Category	Sum Assured Per Person	
	Term Assurance	Living Assurance
Senior Management	S$200,000	S$100,000
Managers/Executives	S$100,000	S$ 50,000
Assistant Executives	S$ 50,000	S$ 25,000
Clerks	S$ 20,000	S$ 10,000

3.8 By attaching the 50% Acceleration Critical Illness Insurance cover as a rider to the Group Term Life Insurance policy, it will help your prospective client to provide the benefit at an affordable amount (if there is a constraint in the amount that the Company can spend).

3.9 For the Group Hospital & Surgical Insurance policy, you can also plan according to the ranking method as follows:

Category	Plan
Senior Management	Plan 1 – Room & Board SS$250
Managers/Executives	Plan 2 – Room & Board SS$150
Others	Plan 3 – Room & Board SS$100

3.10 Next, obtain the Company's past three years of claims history. The claims history is very important, as this will determine the premium to be charged.

3.11 Note also that your prospective client must duly complete and sign the GIFF Form. It is important that you sign this Form too. The insurer is not allowed to give any quotation, unless this Form has been duly completed and signed.

3.12 Having completed the GIFF Form, submit it to the insurer to work out a quotation for your presentation to the prospective client.

3.13 The sales quotation will include the coverage, underwriting guidelines, premium chargeable, exclusions and waiting periods, etc. You have to go through the quotation and highlight the important points that your prospective

client needs to be aware of, e.g. exclusions, limitations, restricted provisions and conditions, as well as no free-look period applicable to any Group Insurance policy.

3.14 Once your prospective client accepts the quotation, you need to assist in the completion of the proposal and health declaration forms, if necessary, and submit them together with the premium payment to the insurer. You need to arrange for the medical examination, if any of the employees' coverage falls outside the free cover limit.

APPENDIX 15A

ABC INSURANCE COMPANY (SINGAPORE) LIMITED

Group Hospital & Surgical Insurance

Schedule Of Benefits (Maximum Per Any One Disability)	Plan A (S$)	Plan B (S$)	Plan C (S$)
Daily Room & Board (Max. 120 days)	360	280	220
Intensive Care Unit (Max. 30 days)	1,035	840	600
Other Hospital Services (Including Implants)	4,500	4,000	3,500
Surgical Benefit	15,000	15,000	10,000
In-Hospital Doctor's Consultation (Max. 120 Days)	100	90	75
Emergency Out-Patient Treatment (Accident)	2,500	2,000	1,750
Pre - & Post-Hospitalisation Specialists' Consultation, Diagnostic X-ray & Laboratory Test	1,700	1,500	1,400
Hospitalisation in Singapore Government Hospital or Singapore Government Restructured Hospital (Overall Maximum Limit Per Disability)	17,250	14,000	10,000
Death Benefit	3,000	3,000	3,000
Outpatient Kidney Dialysis/Cancer Treatment	10,000	10,000	10,000

APPENDIX 15B

<table>
<tr><th rowspan="2">Benefits</th><th colspan="3">Enhanced IncomeShield
(Payout includes MediShield Life payout)</th></tr>
<tr><th>Preferred</th><th>Advantage</th><th>Basic</th></tr>
<tr><td>Ward entitlement</td><td>Standard room in private hospital or private medical institution</td><td>Restructured hospital for ward class A and below</td><td>Restructured hospital for ward class B1 and below</td></tr>
<tr><td>Inpatient hospital treatment</td><td colspan="3">Limits of compensation</td></tr>
<tr><td>Daily ward and treatment charges (each day)
- Normal ward
- Intensive care unit ward</td><td colspan="3" rowspan="5">As charged</td></tr>
<tr><td>Surgical benefits (including day surgery)</td></tr>
<tr><td>Organ transplant benefit (including stem-cell transplant)</td></tr>
<tr><td>Surgical implants</td></tr>
<tr><td>Radiosurgery</td></tr>
<tr><td>Accident inpatient dental treatment</td><td colspan="3">As charged</td></tr>
<tr><td>Pre-hospitalisation treatment</td><td>Not provided by our panel: up to 100 days before admission
Provided by our panel: Up to 180 days before admission[12]</td><td colspan="2">As charged
Up to 100 days before admission</td></tr>
<tr><td>Post-hospitalisation treatment</td><td>As charged
Not provided by our panel: up to 100 days after discharge
Provided by our panel: Up to 365 days after discharge</td><td colspan="2">As charged
Up to 100 days after discharge</td></tr>
<tr><td>Community hospital (Rehabilitative)</td><td colspan="3" rowspan="2">As charged
(up to 90 days for each admission)</td></tr>
<tr><td>Community hospital (Sub-acute)</td></tr>
<tr><td>Inpatient palliative care service (General)</td><td colspan="3" rowspan="2">As charged</td></tr>
<tr><td>Inpatient palliative care service (Specialised)</td></tr>
</table>

Benefits	Enhanced IncomeShield (Payout includes MediShield Life payout)		
	Preferred	Advantage	Basic
Outpatient hospital treatment	**Limits of compensation**		
Radiotherapy for cancer - External (except Hemi-body) - Brachytherapy - Hemi-body - Stereotactic	As charged		
Chemotherapy for cancer			
Immunotherapy for cancer			
Kidney dialysis			
Erythropoietin for chronic kidney failure			
Immunosuppressants for organ transplant			
Long-term parenteral nutrition			
Special benefits	**Limits on special benefits**		
Breast Reconstruction after Mastectomy	As charged		
Congenital abnormalities benefit	As charged (with 12 months' waiting period)		
Pregnancy and delivery-related complications benefit	As charged (with 10 months' waiting period)		
Living organ donor (insured) transplant benefit – insured as the living donor donating an organ	As charged, up to $60,000 (each transplant with 24 months' waiting period for the person receiving the organ)	As charged, up to $40,000 (each transplant with 24 months' waiting period for the person receiving the organ)	As charged, up to $20,000 (each transplant with 24 months' waiting period for the person receiving the organ)
Living organ donor (non-insured) transplant benefit (each transplant) – insured as the recipient of organ	As charged, up to $60,000	Covered up to MediShield Life benefits only	
Cell, tissue and gene therapy benefit (each policy year)	As charged, up to $250,000		As charged, up to $150,000
Proton beam therapy (each policy year)	As charged, up to $100,000		As charged, up to $70,000
Continuation of autologous bone marrow transplant treatment for multiple myeloma (each policy year)	As charged, up to $25,000		As charged, up to $10,000
Inpatient psychiatric treatment benefit (each policy year)	As charged, up to $7,000		As charged, up to $5,000

Benefits	Enhanced IncomeShield (Payout includes MediShield Life payout)		
	Preferred	Advantage	Basic
Special benefits	**Limits on special benefits**		
Prosthesis benefit (each policy year)	As charged, up to $10,000	As charged, up to $6,000	
Emergency overseas treatment	As charged but limited to costs of Singapore private hospitals	As charged but limited to costs of ward class A in Singapore restructured hospitals	As charged but limited to costs of ward class B1 in Singapore restructured hospitals
Waiver of pro-ration factor for outpatient kidney dialysis	Does not apply	Waive pro-ration factor for applicable treatment provided by our preferred partner	
Final expenses benefit (waiver of co-insurance and deductible)	$5,000		$3,000
Pro-ration factor	**SG/PR/FR**		
Inpatient			
– Restructured hospital - Ward class C, B2 or B2+ - Ward class B1 - Ward class A	Does not apply	Does not apply Does not apply Does not apply	Does not apply Does not apply 85%
– Private hospital or private medical institution or emergency overseas treatment		65%	50%
– Community hospital - Ward class C, B2 or B2+ - Ward class B1 - Ward class A		Does not apply Does not apply Does not apply	Does not apply Does not apply 85%
Day surgery or short-stay ward			
– Restructured hospital subsidised	Does not apply	Does not apply	Does not apply
– Restructured hospital non-subsidised		Does not apply	Does not apply
– Private hospital or private medical institution or emergency overseas treatment		65%	50%

Benefits	Enhanced IncomeShield (Payout includes MediShield Life payout)		
	Preferred	Advantage	Basic
Outpatient hospital treatment			
– Restructured hospital subsidised	Does not apply	Does not apply	Does not apply
– Restructured hospital non-subsidised		Does not apply	Does not apply
– Private hospital or private medical institution		65%	50%

SG: Singapore Citizen | PR: Singapore Permanent Resident | FR: Foreigner

Benefits	Preferred	Advantage	Basic
Deductible for each policy year for an insured aged 80 years or below next birthday			
Inpatient			
– Restructured hospital			
- Ward class C	$1,500	$1,500	$1,500
- Ward class B2 or B2+	$2,000	$2,000	$2,000
- Ward class B1	$2,500	$2,500	$2,500
- Ward class A	$3,500	$3,500	$2,500
– Private hospital or private medical institution or emergency overseas treatment	$3,500	$3,500	$2,500
– Community hospital			
- Ward class C	$1,500	$1,500	$1,500
- Ward class B2 or B2+	$2,000	$2,000	$2,000
- Ward class B1	$2,500	$2,500	$2,500
- Ward class A	$3,500	$3,500	$2,500
Day surgery or short-stay ward			
– Subsidised	$2,000	$2,000	$2,000
– Non-subsidised	$3,500	$3,500	$2,500
Deductible for each policy year for an insured aged over 80 years at next birthday			
Inpatient			
– Restructured hospital			
- Ward class C	$2,250	$2,250	$2,250
- Ward class B2 or B2+	$3,000	$3,000	$3,000
- Ward class B1	$3,750	$3,750	$3,750
- Ward class A	$5,250	$5,250	$3,750
– Private hospital or private medical institution or emergency overseas treatment	$5,250	$5,250	$3,750
– Community hospital			
- Ward class C	$2,250	$2,250	$2,250
- Ward class B2 or B2+	$3,000	$3,000	$3,000
- Ward class B1	$3,750	$3,750	$3,750

Benefits	Preferred	Advantage	Basic
- Ward class A	$5,250	$5,250	$3,750
Day surgery or short-stay ward			
– Subsidised	$3,000	$3,000	$3,000
– Non-subsidised	$5,250	$5,250	$3,750

Co-insurance	10%		
Limit in each policy year	$1,500,000	$500,000	$250,000
Limit in each lifetime	Unlimited		
Last entry age (age next birthday)	75		
Maximum coverage age	Lifetime		

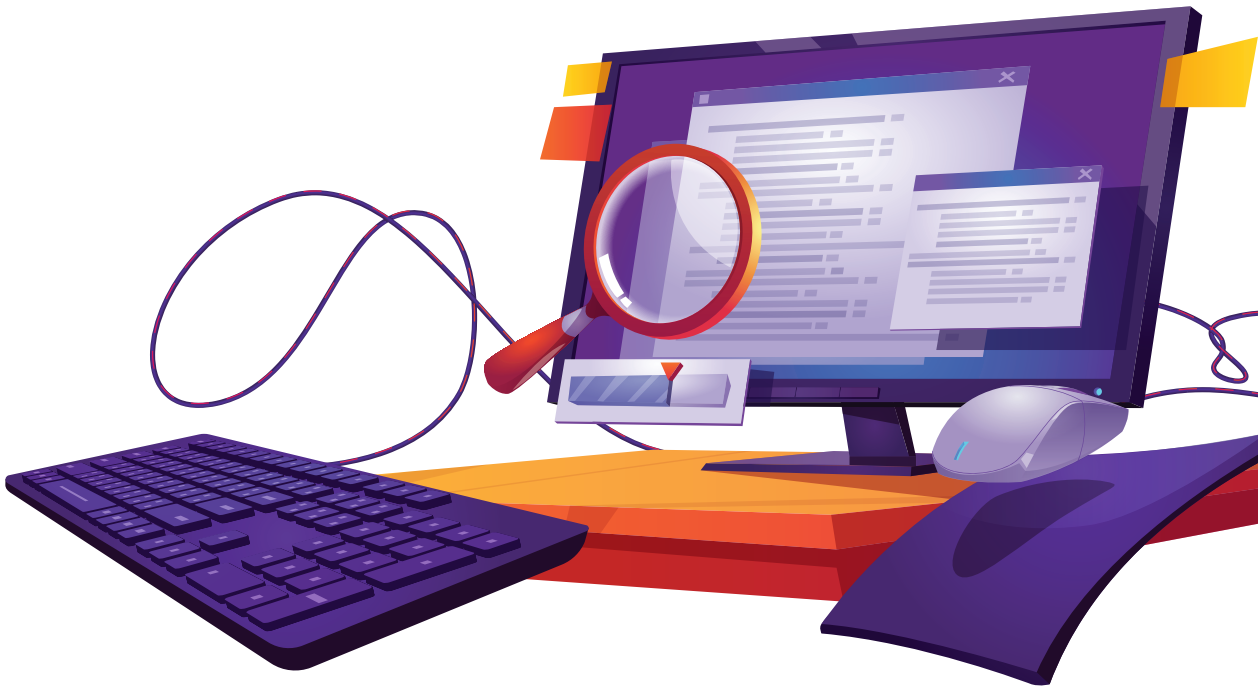
Source: https://www.income.com.sg/kcassets/78476c34-20c6-4a95-a9e5-6a5a14dc6ab3/Enhanced%20IncomeShield%20Brochure_Website.pdf

CHAPTER 15

CASE STUDIES

Below are just some of the pointers to take for Individual Health Insurance and Group Health Insurance. This chapter requires candidates to apply the principles learnt from the previous chapters to carry out a proper needs-based sales advisory process.

IMPORTANT CONCEPTS	DEFINITIONS/EXPLANATIONS
Case Study 1 **Individual Health Insurance**	• Information collected from client. • Complete fact find form. • What policy is suitable for maintenance cost? 1. Review and recommend. • What policy is suitable for medical costs? 1. Review and recommend. • Representative's Recommendations • Disclosures and documentations.
Case Study 2 **Group Health Insurance**	• Assess if the prospective client meets the insurer's underwriting requirements in terms of group size and group stability, etc. • Explain to the prospective client the following: 1. The types of policies available and the benefits offered; 2. The advantages of joining the Portable Medical Benefits Scheme or Transferable Medical Insurance Scheme, as well as how these schemes work; and 3. The differences between compulsory and voluntary participation, as well as their advantages. • Determine the amount of sum assured for each category of employees. • Complete GIFF form. • Sales quotations and documentations.



TABLES

Table A1 FUTURE VALUE OF ANNUITY FACTORS

Table A2 PRESENT VALUE OF AN ANNUITY DUE OF ONE DOLLAR

Time Value Of Money Tables

TABLE A1
FUTURE VALUE OF ANNUITY FACTORS
FVA Factor = [(1+i)^n−1] / i where i = rate and n = periods

i =	0.5%	1%	1.5%	2%	2.5%	3%	3.5%	4%	4.5%	5%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	2.0050	2.0100	2.0150	2.0200	2.0250	2.0300	2.0350	2.0400	2.0450	2.0500
3	3.0150	3.0301	3.0452	3.0604	3.0756	3.0909	3.1062	3.1216	3.1370	3.1525
4	4.0301	4.0604	4.0909	4.1216	4.1525	4.1836	4.2149	4.2465	4.2782	4.3101
5	5.0503	5.1010	5.1523	5.2040	5.2563	5.3091	5.3625	5.4163	5.4707	5.5256
6	6.0755	6.1520	6.2296	6.3081	6.3877	6.4684	6.5502	6.6330	6.7169	6.8019
7	7.1059	7.2135	7.3230	7.4343	7.5474	7.6625	7.7794	7.8983	8.0192	8.1420
8	8.1414	8.2857	8.4328	8.5830	8.7361	8.8923	9.0517	9.2142	9.3800	9.5491
9	9.1821	9.3685	9.5593	9.7546	9.9545	10.1591	10.3685	10.5828	10.8021	11.0266
10	10.2280	10.4622	10.7027	10.9497	11.2034	11.4639	11.7314	12.0061	12.2882	12.5779
11	11.2792	11.5668	11.8633	12.1687	12.4835	12.8078	13.1420	13.4864	13.8412	14.2068
12	12.3356	12.6825	13.0412	13.4121	13.7956	14.1920	14.6020	15.0258	15.4640	15.9171
13	13.3972	13.8093	14.2368	14.6803	15.1404	15.6178	16.1130	16.6268	17.1599	17.7130
14	14.4642	14.9474	15.4504	15.9739	16.5190	17.0863	17.6770	18.2919	18.9321	19.5986
15	15.5365	16.0969	16.6821	17.2934	17.9319	18.5989	19.2957	20.0236	20.7841	21.5786
16	16.6142	17.2579	17.9324	18.6393	19.3802	20.1569	20.9710	21.8245	22.7193	23.6575
17	17.6973	18.4304	19.2014	20.0121	20.8647	21.7616	22.7050	23.6975	24.7417	25.8404
18	18.7858	19.6147	20.4894	21.4123	22.3863	23.4144	24.4997	25.6454	26.8551	28.1324
19	19.8797	20.8109	21.7967	22.8406	23.9460	25.1169	26.3572	27.6712	29.0636	30.5390
20	20.9791	22.0190	23.1237	24.2974	25.5447	26.8704	28.2797	29.7781	31.3714	33.0660
21	22.0840	23.2392	24.4705	25.7833	27.1833	28.6765	30.2695	31.9692	33.7831	35.7193
22	23.1944	24.4716	25.8376	27.2990	28.8629	30.5368	32.3289	34.2480	36.3034	38.5052
23	24.3104	25.7163	27.2251	28.8450	30.5844	32.4529	34.4604	36.6179	38.9370	41.4305
24	25.4320	26.9735	28.6335	30.4219	32.3490	34.4265	36.6665	39.0826	41.6892	44.5020
25	26.5591	28.2432	30.0630	32.0303	34.1578	36.4593	38.9499	41.6459	44.5652	47.7271
26	27.6919	29.5256	31.5140	33.6709	36.0117	38.5530	41.3131	44.3117	47.5706	51.1135
27	28.8304	30.8209	32.9867	35.3443	37.9120	40.7096	43.7591	47.0842	50.7113	54.6691
28	29.9745	32.1291	34.4815	37.0512	39.8598	42.9309	46.2906	49.9676	53.9933	58.4026
29	31.1244	33.4504	35.9987	38.7922	41.8563	45.2189	48.9108	52.9663	57.4230	62.3227
30	32.2800	34.7849	37.5387	40.5681	43.9027	47.5754	51.6227	56.0849	61.0071	66.4388
35	38.1454	41.6603	45.5921	49.9945	54.9282	60.4621	66.6740	73.6522	81.4966	90.3203
40	44.1588	48.8864	54.2679	60.4020	67.4026	75.4013	84.5503	95.0255	107.030	120.800
45	50.3242	56.4811	63.6142	71.8927	81.5161	92.7199	105.782	121.029	138.850	159.700
50	56.6452	64.4632	73.6828	84.5794	97.4843	112.797	130.998	152.667	178.503	209.348

Time Value Of Money Tables

TABLE A1 (CONTINUED)
FUTURE VALUE OF ANNUITY FACTORS
FVA Factor = [(1+i)^n−1] / i where i = rate and n = periods

i =	5.5%	6%	6.5%	7%	7.5%	8%	8.5%	9%	9.5%	10%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	2.0550	2.0600	2.0650	2.0700	2.0750	2.0800	2.0850	2.0900	2.0950	2.1000
3	3.1680	3.1836	3.1992	3.2149	3.2306	3.2464	3.2622	3.2781	3.2940	3.3100
4	4.3423	4.3746	4.4072	4.4399	4.4729	4.5061	4.5395	4.5731	4.6070	4.6410
5	5.5811	5.6371	5.6936	5.7507	5.8084	5.8666	5.9254	5.9847	6.0446	6.1051
6	6.8881	6.9753	7.0637	7.1533	7.2440	7.3359	7.4290	7.5233	7.6189	7.7156
7	8.2669	8.3938	8.5229	8.6540	8.7873	8.9228	9.0605	9.2004	9.3426	9.4872
8	9.7216	9.8975	10.0769	10.2598	10.4464	10.6366	10.8306	11.0285	11.2302	11.4359
9	11.2563	11.4913	11.7319	11.9780	12.2298	12.4876	12.7512	13.0210	13.2971	13.5795
10	12.8754	13.1808	13.4944	13.8164	14.1471	14.4866	14.8351	15.1929	15.5603	15.9374
11	14.5835	14.9716	15.3716	15.7836	16.2081	16.6455	17.0961	17.5603	18.0385	18.5312
12	16.3856	16.8699	17.3707	17.8885	18.4237	18.9771	19.5492	20.1407	20.7522	21.3843
13	18.2868	18.8821	19.4998	20.1406	20.8055	21.4953	22.2109	22.9534	23.7236	24.5227
14	20.2926	21.0151	21.7673	22.5505	23.3659	24.2149	25.0989	26.0192	26.9774	27.9750
15	22.4087	23.2760	24.1822	25.1290	26.1184	27.1521	28.2323	29.3609	30.5402	31.7725
16	24.6411	25.6725	26.7540	27.8881	29.0772	30.3243	31.6320	33.0034	34.4416	35.9497
17	26.9964	28.2129	29.4930	30.8402	32.2580	33.7502	35.3207	36.9737	38.7135	40.5447
18	29.4812	30.9057	32.4101	33.9990	35.6774	37.4502	39.3230	41.3013	43.3913	45.5992
19	32.1027	33.7600	35.5167	37.3790	39.3532	41.4463	43.6654	46.0185	48.5135	51.1591
20	34.8683	36.7856	38.8253	40.9955	43.3047	45.7620	48.3770	51.1601	54.1222	57.2750
21	37.7861	39.9927	42.3490	44.8652	47.5525	50.4229	53.4891	56.7645	60.2638	64.0025
22	40.8643	43.3923	46.1016	49.0057	52.1190	55.4568	59.0356	62.8733	66.9889	71.4027
23	44.1118	46.9958	50.0982	53.4361	57.0279	60.8933	65.0537	69.5319	74.3529	79.5430
24	47.5380	50.8156	54.3546	58.1767	62.3050	66.7648	71.5832	76.7898	82.4164	88.4973
25	51.1526	54.8645	58.8877	63.2490	67.9779	73.1059	78.6678	84.7009	91.2459	98.3741
26	54.9660	59.1564	63.7154	68.6765	74.0762	79.9544	86.3456	93.3240	100.914	109.182
27	58.9891	63.7058	68.8569	74.4838	80.6319	87.3508	94.6947	102.723	111.501	121.100
28	63.2335	68.5281	74.3326	80.6977	87.6793	95.3388	103.744	112.968	123.094	134.210
29	67.7114	73.6398	80.1642	87.3465	95.2553	103.966	113.562	124.135	135.788	148.631
30	72.4355	79.0582	86.3749	94.4608	103.399	113.283	124.215	136.308	149.688	164.494
35	100.251	111.435	124.035	138.237	154.252	172.317	192.702	215.711	241.688	271.024
40	136.606	154.762	175.632	199.635	227.257	259.057	295.683	337.882	386.520	442.593
45	184.119	212.744	246.325	285.749	332.065	386.506	450.530	525.859	614.519	718.905
50	246.217	290.336	343.180	406.529	482.530	573.770	683.368	815.084	973.445	1163.91

Time Value Of Money Tables

TABLE A1 (CONTINUED)
FUTURE VALUE OF ANNUITY FACTORS
FVA Factor = [(1+i)^n−1] / i where i = rate and n = periods

i =	10.5%	11%	11.5%	12%	12.5%	13%	13.5%	14%	14.5%	15%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	2.1050	2.1100	2.1150	2.1200	2.1250	2.1300	2.1350	2.1400	2.1450	2.1500
3	3.3260	3.3421	3.3582	3.3744	3.3906	3.4069	3.4232	3.4396	3.4560	3.4725
4	4.6753	4.7097	4.7444	4.7793	4.8145	4.8498	4.8854	4.9211	4.9571	4.9934
5	6.1662	6.2278	6.2900	6.3528	6.4163	6.4803	6.5449	6.6101	6.6759	6.7424
6	7.8136	7.9129	8.0134	8.1152	8.2183	8.3227	8.4284	8.5355	8.6439	8.7537
7	9.6340	9.7833	9.9349	10.0890	10.2456	10.4047	10.5663	10.7305	10.8973	11.0668
8	11.6456	11.8594	12.0774	12.2997	12.5263	12.7573	12.9927	13.2328	13.4774	13.7268
9	13.8684	14.1640	14.4663	14.7757	15.0921	15.4157	15.7468	16.0853	16.4317	16.7858
10	16.3246	16.7220	17.1300	17.5487	17.9786	18.4197	18.8726	19.3373	19.8142	20.3037
11	19.0387	19.5614	20.0999	20.6546	21.2259	21.8143	22.4204	23.0445	23.6873	24.3493
12	22.0377	22.7132	23.4114	24.1331	24.8791	25.6502	26.4471	27.2707	28.1220	29.0017
13	25.3517	26.2116	27.1037	28.0291	28.9890	29.9847	31.0175	32.0887	33.1997	34.3519
14	29.0136	30.0949	31.2207	32.3926	33.6126	34.8827	36.2048	37.5811	39.0136	40.5047
15	33.0600	34.4054	35.8110	37.2797	38.8142	40.4175	42.0925	43.8424	45.6706	47.5804
16	37.5313	39.1899	40.9293	42.7533	44.6660	46.6717	48.7750	50.9804	53.2928	55.7175
17	42.4721	44.5008	46.6362	48.8837	51.2493	53.7391	56.3596	59.1176	62.0203	66.0751
18	47.9317	50.3959	52.9993	55.7497	58.6554	61.7251	64.9681	68.3941	72.0132	75.8364
19	53.9645	56.9395	60.0942	63.4397	66.9873	70.7494	74.7388	78.9692	83.4551	88.2118
20	60.6308	64.2028	68.0051	72.0524	76.3608	80.9468	85.8286	91.0249	96.5561	102.444
21	67.9970	72.2651	76.8257	81.6987	86.9058	92.4699	98.4154	104.768	111.557	118.810
22	76.1367	81.2143	86.6606	92.5026	98.7691	105.491	112.701	120.436	128.732	137.632
23	85.1311	91.1479	97.6266	104.603	112.115	120.205	128.916	138.297	148.399	159.276
24	95.0699	102.174	109.854	118.155	127.130	136.831	147.320	158.659	170.917	184.168
25	106.052	114.413	123.487	133.334	144.021	155.620	168.208	181.871	196.699	212.793
26	118.188	127.999	138.688	150.334	163.023	176.850	191.916	208.333	226.221	245.712
27	131.597	143.079	155.637	169.374	184.401	200.841	218.825	238.499	260.023	283.569
28	146.415	159.817	174.535	190.699	208.452	227.950	249.366	272.889	298.726	327.104
29	162.789	178.397	195.607	214.583	235.508	258.583	284.031	312.094	343.041	377.170
30	180.881	199.021	219.101	241.333	265.946	293.199	323.375	356.787	393.782	434.745
35	304.159	341.590	383.879	431.663	485.660	546.681	615.640	693.573	781.644	881.170
40	507.252	581.826	667.850	767.091	881.592	1013.70	1166.14	1342.03	1544.96	1779.09
45	841.836	986.639	1157.23	1358.23	1595.07	1874.16	2203.04	2590.56	3047.17	3585.13
50	1393.05	1668.77	2000.61	2400.02	2880.79	3459.51	4156.10	4994.52	6003.54	7217.72

Time Value Of Money Tables

TABLE A1 (CONTINUED)
FUTURE VALUE OF ANNUITY FACTORS
FVA Factor = [(1+i)^n−1] / i where i = rate and n = periods

i =	16%	17%	18%	19%	20%	22%	24%	26%	28%	30%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	2.1600	2.1700	2.1800	2.1900	2.2000	2.2200	2.2400	2.2600	2.2800	2.3000
3	3.5056	3.5389	3.5724	3.6061	3.6400	3.7084	3.7776	3.8476	3.9184	3.9900
4	5.0665	5.1405	5.2154	5.2913	5.3680	5.5242	5.6842	5.8480	6.0156	6.1870
5	6.8771	7.0144	7.1542	7.2966	7.4416	7.7396	8.0484	8.3684	8.6999	9.0431
6	8.9775	9.2068	9.4420	9.6830	9.9299	10.4423	10.9801	11.5442	12.1359	12.7560
7	11.4139	11.7720	12.1415	12.5227	12.9159	13.7396	14.6153	15.5458	16.5339	17.5828
8	14.2401	14.7733	15.3270	15.9020	16.4991	17.7623	19.1229	20.5876	22.1634	23.8577
9	17.5185	18.2847	19.0859	19.9234	20.7989	22.6700	24.7125	26.9404	29.3692	32.0150
10	21.3215	22.3931	23.5213	24.7089	25.9587	28.6574	31.6434	34.9449	38.5926	42.6195
11	25.7329	27.1999	28.7551	30.4035	32.1504	35.9620	40.2379	45.0306	50.3985	56.4053
12	30.8502	32.8239	34.9311	37.1802	39.5805	44.8737	50.8950	57.7386	65.5100	74.3270
13	36.7862	39.4040	42.2187	45.2445	48.4966	55.7459	64.1097	73.7506	84.8529	97.6250
14	43.6720	47.1027	50.8180	54.8409	59.1959	69.0100	80.4961	93.9258	109.612	127.913
15	51.6595	56.1101	60.9653	66.2607	72.0351	85.1922	100.815	119.347	141.303	167.286
16	60.9250	66.6488	72.9390	79.8502	87.4421	104.935	126.011	151.377	181.868	218.472
17	71.6730	78.9792	87.0680	96.0218	105.931	129.020	157.253	191.735	233.791	285.014
18	84.1407	93.4056	103.740	115.266	128.117	158.405	195.994	242.585	300.252	371.518
19	98.6032	110.285	123.414	138.166	154.740	194.254	244.033	306.658	385.323	483.973
20	115.380	130.033	146.628	165.418	186.688	237.989	303.601	387.389	494.213	630.165
21	134.841	153.139	174.021	197.847	225.026	291.347	377.465	489.110	633.593	820.215
22	157.415	180.172	206.345	236.438	271.031	356.443	469.056	617.278	811.999	1067.28
23	183.601	211.801	244.487	282.362	326.237	435.861	582.630	778.771	1040.36	1388.46
24	213.978	248.808	289.494	337.010	392.484	532.750	723.461	982.251	1332.66	1806.00
25	249.214	292.105	342.603	402.042	471.981	650.955	898.092	1238.64	1706.80	2348.80
26	290.088	342.763	405.272	479.431	567.377	795.165	1114.63	1561.68	2185.71	3054.44
27	337.502	402.032	479.221	571.522	681.853	971.102	1383.15	1968.72	2798.71	3971.78
28	392.503	471.378	566.481	681.112	819.223	1185.74	1716.10	2481.59	3583.34	5164.31
29	456.303	552.512	669.447	811.523	984.068	1447.61	2128.96	3127.80	4587.68	6714.60
30	530.312	647.439	790.948	966.712	1181.88	1767.08	2640.92	3942.03	5873.23	8729.99
35	1120.71	1426.49	1816.65	2314.21	2948.34	4783.64	7750.23	12527.4	20189.0	32422.9
40	2360.76	3134.52	4163.21	5529.83	7343.86	12936.5	22728.8	39793.0	69377.5	120393
45	4965.27	6879.29	9531.58	13203.4	18281.3	34971.4	66640.4	126383	238388	447019
50	10435.6	15089.5	21813.1	31515.3	45497.2	94525.3	195373	401374	819103	1659761

Time Value of Money Tables

TABLE A2
PRESENT VALUE OF AN ANNUITY DUE OF ONE DOLLAR
PVAD = ({1−[1/(1+i)^n]} / i)x(1+i) where i = rate and n = periods

i =	0.5%	1%	1.5%	2%	2.5%	3%	3.5%	4%	4.5%	5%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	1.9950	1.9901	1.9852	1.9804	1.9756	1.9709	1.9662	1.9615	1.9569	1.9524
3	2.9851	2.9704	2.9559	2.9416	2.9274	2.9135	2.8997	2.8861	2.8727	2.8594
4	3.9702	3.9410	3.9122	3.8839	3.8560	3.8286	3.8016	3.7751	3.7490	3.7232
5	4.9505	4.9020	4.8544	4.8077	4.7620	4.7171	4.6731	4.6299	4.5875	4.5460
6	5.9259	5.8534	5.7826	5.7135	5.6458	5.5797	5.5151	5.4518	5.3900	5.3295
7	6.8964	6.7955	6.6972	6.6014	6.5081	6.4172	6.3286	6.2421	6.1579	6.0757
8	7.8621	7.7282	7.5982	7.4720	7.3494	7.2303	7.1145	7.0021	6.8927	6.7864
9	8.8230	8.6517	8.4859	8.3255	8.1701	8.0197	7.8740	7.7327	7.5959	7.4632
10	9.7791	9.5660	9.3605	9.1622	8.9709	8.7861	8.6077	8.4353	8.2688	8.1078
11	10.7304	10.4713	10.2222	9.9826	9.7521	9.5302	9.3166	9.1109	8.9127	8.7217
12	11.6770	11.3676	11.0711	10.7868	10.5142	10.2526	10.0016	9.7605	9.5289	9.3064
13	12.6189	12.2551	11.9075	11.5753	11.2578	10.9540	10.6633	10.3851	10.1186	9.8633
14	13.5562	13.1337	12.7315	12.3484	11.9832	11.6350	11.3027	10.9856	10.6829	10.3936
15	14.4887	14.0037	13.5434	13.1062	12.6909	12.2961	11.9205	11.5631	11.2228	10.8986
16	15.4166	14.8651	14.3432	13.8493	13.3814	12.9379	12.5174	12.1184	11.7395	11.3797
17	16.3399	15.7179	15.1313	14.5777	14.0550	13.5611	13.0941	12.6523	12.2340	11.8378
18	17.2586	16.5623	15.9076	15.2919	14.7122	14.1661	13.6513	13.1657	12.7072	12.2741
19	18.1728	17.3983	16.6726	15.9920	15.3534	14.7535	14.1897	13.6593	13.1600	12.6896
20	19.0824	18.2260	17.4262	16.6785	15.9789	15.3238	14.7098	14.1339	13.5933	13.0853
21	19.9874	19.0456	18.1686	17.3514	16.5892	15.8775	15.2124	14.5903	14.0079	13.4622
22	20.8880	19.8570	18.9001	18.0112	17.1845	16.4150	15.6980	15.0292	14.4047	13.8212
23	21.7841	20.6604	19.6208	18.6580	17.7654	16.9369	16.1671	15.4511	14.7844	14.1630
24	22.6757	21.4558	20.3309	19.2922	18.3321	17.4436	16.6204	15.8568	15.1478	14.4886
25	23.5629	22.2434	21.0304	19.9139	18.8850	17.9355	17.0584	16.2470	15.4955	14.7986
26	24.4456	23.0232	21.7196	20.5235	19.4244	18.4131	17.4815	16.6221	15.8282	15.0939
27	25.3240	23.7952	22.3986	21.1210	19.9506	18.8768	17.8904	16.9828	16.1466	15.3752
28	26.1980	24.5596	23.0676	21.7069	20.4640	19.3270	18.2854	17.3296	16.4513	15.6430
29	27.0677	25.3164	23.7267	22.2813	20.9649	19.7641	18.6670	17.6631	16.7429	15.8981
30	27.9330	26.0658	24.3761	22.8444	21.4535	20.1885	19.0358	17.9837	17.0219	16.1411
35	32.1955	29.7027	27.4817	25.4986	23.7238	22.1318	20.7007	19.4112	18.2468	17.1929
40	36.3531	33.1630	30.3646	27.9026	25.7303	23.8082	22.1025	20.5845	19.2297	18.0170
45	40.4082	36.4555	33.0406	30.0800	27.5038	25.2543	23.2828	21.5488	20.0184	18.6628
50	44.3635	39.5881	35.5247	32.0521	29.0714	26.5017	24.2766	22.3415	20.6513	19.1687

Time Value of Money Tables

TABLE A2 (CONTINUED)
PRESENT VALUE OF AN ANNUITY DUE OF ONE DOLLAR
PVAD = ({1−[1/(1+i)^n]}/ i)x(1+i) where i = rate and n = periods

i =	5.5%	6%	6.5%	7%	7.5%	8%	8.5%	9%	9.5%	10%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	1.9479	1.9434	1.9390	1.9346	1.9302	1.9259	1.9217	1.9174	1.9132	1.9091
3	2.8463	2.8334	2.8206	2.8080	2.7956	2.7833	2.7711	2.7591	2.7473	2.7355
4	3.6979	3.6730	3.6485	3.6243	3.6005	3.5771	3.5540	3.5313	3.5089	3.4869
5	4.5052	4.4651	4.4258	4.3872	4.3493	4.3121	4.2756	4.2397	4.2045	4.1699
6	5.2703	5.2124	5.1557	5.1002	5.0459	4.9927	4.9406	4.8897	4.8397	4.7908
7	5.9955	5.9173	5.8410	5.7665	5.6938	5.6229	5.5536	5.4859	5.4198	5.3553
8	6.6830	6.5824	6.4845	6.3893	6.2966	6.2064	6.1185	6.0330	5.9496	5.8684
9	7.3346	7.2098	7.0888	6.9713	6.8573	6.7466	6.6392	6.5348	6.4334	6.3349
10	7.9522	7.8017	7.6561	7.5152	7.3789	7.2469	7.1191	6.9952	6.8753	6.7590
11	8.5376	8.3601	8.1888	8.0236	7.8641	7.7101	7.5613	7.4177	7.2788	7.1446
12	9.0925	8.8869	8.6890	8.4987	8.3154	8.1390	7.9690	7.8052	7.6473	7.4951
13	9.6185	9.3838	9.1587	8.9427	8.7353	8.5361	8.3447	8.1607	7.9838	7.8137
14	10.1171	9.8527	9.5997	9.3577	9.1258	8.9038	8.6910	8.4869	8.2912	8.1034
15	10.5896	10.2950	10.0138	9.7455	9.4892	9.2442	9.0101	8.7862	8.5719	8.3667
16	11.0376	10.7122	10.4027	10.1079	9.8271	9.5595	9.3042	9.0607	8.8282	8.6061
17	11.4622	11.1059	10.7678	10.4466	10.1415	9.8514	9.5753	9.3126	9.0623	8.8237
18	11.8646	11.4773	11.1106	10.7632	10.4340	10.1216	9.8252	9.5436	9.2760	9.0216
19	12.2461	11.8276	11.4325	11.0591	10.7060	10.3719	10.0555	9.7556	9.4713	9.2014
20	12.6077	12.1581	11.7347	11.3356	10.9591	10.6036	10.2677	9.9501	9.6496	9.3649
21	12.9504	12.4699	12.0185	11.5940	11.1945	10.8181	10.4633	10.1285	9.8124	9.5136
22	13.2752	12.7641	12.2850	11.8355	11.4135	11.0168	10.6436	10.2922	9.9611	9.6487
23	13.5832	13.0416	12.5352	12.0612	11.6172	11.2007	10.8098	10.4424	10.0969	9.7715
24	13.8750	13.3034	12.7701	12.2722	11.8067	11.3711	10.9629	10.5802	10.2209	9.8832
25	14.1517	13.5504	12.9907	12.4693	11.9830	11.5288	11.1041	10.7066	10.3341	9.9847
26	14.4139	13.7834	13.1979	12.6536	12.1469	11.6748	11.2342	10.8226	10.4376	10.0770
27	14.6625	14.0032	13.3924	12.8258	12.2995	11.8100	11.3541	10.9290	10.5320	10.1609
28	14.8981	14.2105	13.5750	12.9867	12.4414	11.9352	11.4646	11.0266	10.6183	10.2372
29	15.1214	14.4062	13.7465	13.1371	12.5734	12.0511	11.5665	11.1161	10.6971	10.3066
30	15.3331	14.5907	13.9075	13.2777	12.6962	12.1584	11.6603	11.1983	10.7690	10.3696
35	16.2370	15.3681	14.5766	13.8540	13.1929	12.5869	12.0302	11.5178	11.0453	10.6086
40	16.9287	15.9491	15.0650	14.2649	13.5390	12.8786	12.2763	11.7255	11.2207	10.7570
45	17.4579	16.3832	15.4214	14.5579	13.7800	13.0771	12.4399	11.8605	11.3322	10.8491
50	17.8628	16.7076	15.6816	14.7668	13.9479	13.2122	12.5487	11.9482	11.4030	10.9063

Time Value of Money Tables

TABLE A2 (CONTINUED)
PRESENT VALUE OF AN ANNUITY DUE OF ONE DOLLAR
PVAD = ({1−[1/(1+i)^n]} / i)x(1+i) where i = rate and n = periods

i =	10.5%	11%	11.5%	12%	12.5%	13%	13.5%	14%	14.5%	15%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	1.9050	1.9009	1.8969	1.8929	1.8889	1.8850	1.8811	1.8772	1.8734	1.8696
3	2.7240	2.7125	2.7012	2.6901	2.6790	2.6681	2.6573	2.6467	2.6361	2.6257
4	3.4651	3.4437	3.4226	3.4018	3.3813	3.3612	3.3413	3.3216	3.3023	3.2832
5	4.1359	4.1024	4.0696	4.0373	4.0056	3.9745	3.9438	3.9137	3.8841	3.8550
6	4.7429	4.6959	4.6499	4.6048	4.5606	4.5172	4.4747	4.4331	4.3922	4.3522
7	5.2922	5.2305	5.1703	5.1114	5.0538	4.9975	4.9425	4.8887	4.8360	4.7845
8	5.7893	5.7122	5.6370	5.5638	5.4923	5.4226	5.3546	5.2883	5.2236	5.1604
9	6.2392	6.1461	6.0556	5.9676	5.8820	5.7988	5.7177	5.6389	5.5621	5.4873
10	6.6463	6.5370	6.4311	6.3282	6.2285	6.1317	6.0377	5.9464	5.8577	5.7716
11	7.0148	6.8892	6.7678	6.6502	6.5364	6.4262	6.3195	6.2161	6.1159	6.0188
12	7.3482	7.2065	7.0697	6.9377	6.8102	6.6869	6.5679	6.4527	6.3414	6.2337
13	7.6500	7.4924	7.3406	7.1944	7.0535	6.9176	6.7867	6.6603	6.5383	6.4206
14	7.9230	7.7499	7.5835	7.4235	7.2698	7.1218	6.9794	6.8424	6.7103	6.5831
15	8.1702	7.9819	7.8013	7.6282	7.4620	7.3025	7.1493	7.0021	6.8606	6.7245
16	8.3938	8.1909	7.9967	7.8109	7.6329	7.4624	7.2989	7.1422	6.9918	6.8474
17	8.5962	8.3792	8.1719	7.9740	7.7848	7.6039	7.4308	7.2651	7.1063	6.9542
18	8.7794	8.5488	8.3291	8.1196	7.9198	7.7291	7.5469	7.3729	7.2064	7.0472
19	8.9451	8.7016	8.4700	8.2497	8.0398	7.8399	7.6493	7.4674	7.2938	7.1280
20	9.0952	8.8393	8.5964	8.3658	8.1465	7.9380	7.7395	7.5504	7.3701	7.1982
21	9.2309	8.9633	8.7098	8.4694	8.2414	8.0248	7.8189	7.6231	7.4368	7.2593
22	9.3538	9.0751	8.8115	8.5620	8.3256	8.1016	7.8889	7.6870	7.4950	7.3125
23	9.4649	9.1757	8.9027	8.6446	8.4006	8.1695	7.9506	7.7429	7.5459	7.3587
24	9.5656	9.2664	8.9845	8.7184	8.4672	8.2297	8.0049	7.7921	7.5903	7.3988
25	9.6566	9.3481	9.0578	8.7843	8.5264	8.2829	8.0528	7.8351	7.6291	7.4338
26	9.7390	9.4217	9.1236	8.8431	8.5790	8.3300	8.0950	7.8729	7.6629	7.4641
27	9.8136	9.4881	9.1826	8.8957	8.6258	8.3717	8.1321	7.9061	7.6925	7.4906
28	9.8811	9.5478	9.2355	8.9426	8.6674	8.4086	8.1649	7.9352	7.7184	7.5135
29	9.9422	9.6016	9.2830	8.9844	8.7043	8.4412	8.1937	7.9607	7.7409	7.5335
30	9.9974	9.6501	9.3255	9.0218	8.7372	8.4701	8.2191	7.9830	7.7606	7.5509
35	10.2043	9.8293	9.4809	9.1566	8.8542	8.5717	8.3075	8.0599	7.8275	7.6091
40	10.3299	9.9357	9.5710	9.2330	8.9191	8.6268	8.3543	8.0997	7.8615	7.6380
45	10.4061	9.9988	9.6233	9.2764	8.9551	8.6568	8.3792	8.1205	7.8787	7.6524
50	10.4524	10.0362	9.6537	9.3010	8.9751	8.6730	8.3924	8.1312	7.8875	7.6596

Time Value of Money Tables

TABLE A2 (CONTINUED)
PRESENT VALUE OF AN ANNUITY DUE OF ONE DOLLAR
PVAD = ({1−[1/(1+i)^n]}/ i)x(1+i) where i = rate and n = periods

i =	16%	17%	18%	19%	20%	22%	24%	26%	28%	30%
n=1	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000	1.0000
2	1.8621	1.8547	1.8475	1.8403	1.8333	1.8197	1.8065	1.7937	1.7813	1.7692
3	2.6052	2.5852	2.5656	2.5465	2.5278	2.4915	2.4568	2.4235	2.3916	2.3609
4	3.2459	3.2096	3.1743	3.1399	3.1065	3.0422	2.9813	2.9234	2.8684	2.8161
5	3.7982	3.7432	3.6901	3.6386	3.5887	3.4936	3.4043	3.3202	3.2410	3.1662
6	4.2743	4.1993	4.1272	4.0576	3.9906	3.8636	3.7454	3.6351	3.5320	3.4356
7	4.6847	4.5892	4.4976	4.4098	4.3255	4.1669	4.0205	3.8850	3.7594	3.6427
8	5.0386	4.9224	4.8115	4.7057	4.6046	4.4155	4.2423	4.0833	3.9370	3.8021
9	5.3436	5.2072	5.0776	4.9544	4.8372	4.6193	4.4212	4.2407	4.0758	3.9247
10	5.6065	5.4506	5.3030	5.1633	5.0310	4.7863	4.5655	4.3657	4.1842	4.0190
11	5.8332	5.6586	5.4941	5.3389	5.1925	4.9232	4.6819	4.4648	4.2689	4.0915
12	6.0286	5.8364	5.6560	5.4865	5.3271	5.0354	4.7757	4.5435	4.3351	4.1473
13	6.1971	5.9884	5.7932	5.6105	5.4392	5.1274	4.8514	4.6059	4.3868	4.1903
14	6.3423	6.1183	5.9095	5.7147	5.5327	5.2028	4.9124	4.6555	4.4272	4.2233
15	6.4675	6.2293	6.0081	5.8023	5.6106	5.2646	4.9616	4.6949	4.4587	4.2487
16	6.5755	6.3242	6.0916	5.8759	5.6755	5.3152	5.0013	4.7261	4.4834	4.2682
17	6.6685	6.4053	6.1624	5.9377	5.7296	5.3567	5.0333	4.7509	4.5026	4.2832
18	6.7487	6.4746	6.2223	5.9897	5.7746	5.3908	5.0591	4.7705	4.5177	4.2948
19	6.8178	6.5339	6.2732	6.0333	5.8122	5.4187	5.0799	4.7861	4.5294	4.3037
20	6.8775	6.5845	6.3162	6.0700	5.8435	5.4415	5.0967	4.7985	4.5386	4.3105
21	6.9288	6.6278	6.3527	6.1009	5.8696	5.4603	5.1103	4.8083	4.5458	4.3158
22	6.9731	6.6648	6.3837	6.1268	5.8913	5.4756	5.1212	4.8161	4.5514	4.3198
23	7.0113	6.6964	6.4099	6.1486	5.9094	5.4882	5.1300	4.8223	4.5558	4.3230
24	7.0442	6.7234	6.4321	6.1668	5.9245	5.4985	5.1371	4.8273	4.5592	4.3254
25	7.0726	6.7465	6.4509	6.1822	5.9371	5.5070	5.1428	4.8312	4.5619	4.3272
26	7.0971	6.7662	6.4669	6.1951	5.9476	5.5139	5.1474	4.8342	4.5640	4.3286
27	7.1182	6.7831	6.4804	6.2060	5.9563	5.5196	5.1511	4.8367	4.5656	4.3297
28	7.1364	6.7975	6.4919	6.2151	5.9636	5.5243	5.1542	4.8387	4.5669	4.3305
29	7.1520	6.8099	6.5016	6.2228	5.9697	5.5281	5.1566	4.8402	4.5679	4.3312
30	7.1656	6.8204	6.5098	6.2292	5.9747	5.5312	5.1585	4.8414	4.5687	4.3317
35	7.2098	6.8541	6.5356	6.2489	5.9898	5.5402	5.1639	4.8447	4.5706	4.3329
40	7.2309	6.8695	6.5468	6.2572	5.9959	5.5435	5.1657	4.8457	4.5712	4.3332
45	7.2409	6.8765	6.5517	6.2607	5.9984	5.5447	5.1663	4.8460	4.5714	4.3333
50	7.2457	6.8797	6.5539	6.2621	5.9993	5.5452	5.1666	4.8461	4.5714	4.3333

ACCESS TO ONLINE LEARNING RESOURCES

(1) Login using your SCI profile credentials using this link: https://www.scicollege.org.sg/Account/Login.

(2) Click the "eBook/eMock Examination/Supplementary Notes" icon from the Student dashboard.

(3) The examination module which you had registered for would be displayed on your screen.

(4) Learning Resources include: eBOOK, eMOCK and video tutorials.

HI V1.4 – List of Changes

There will not be any changes to the testable contents for Version 1.4.

Chapter 1 – Overview of Healthcare Environment in Singapore			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
3C	3.13	6	Included footnote.
4B	4.9	8	Amended.
4B	4.12	8	The phrase "from middle of 2022" has been amended to "from 1 November 2022".
Chapter 2 – Medical Expense Insurance			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
Appendix 2C	-	40	Amended.
Chapter 3 – Group Medical Expense Insurance			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
4B4	4.22	60	Amended.
Chapter 5 – Long-Term Care Insurance			
Section/ Paragraph	**Paragraph**	**Page**	**Amendments**
7A4	7.5	96	Amended.
7B2	7.10	96	Amended.
Chapter 9 Part I – Healthcare Financing			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
2A1	2.4	170	The phrase "from the middle of 2022" has been amended to "from 1 November 2022".
2A2	2.7	170	The phrase "in the middle of 2022" has been amended to "from 1 January 2023". The sentence "Permanent Residents will continue to receive 25% subsidy." has been added.
2A3	2.10	171	Amended.
3B1	3.12 (a)	174	Amended.
5	5.2	185	"NTUC Income IncomeShield" has been amended to "Income Insurance Limited's IncomeShield".
Chapter 9 Part II – Healthcare Financing			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
6	6.4	205	"NTUC Income Insurance Co-operative Limited" has been amended to "Income Insurance Limited".
6H	6.23	209	"NTUC Income Insurance Co-operative Limited" has been amended to "Income Insurance Limited".
7	7.8	211	"NTUC Income" has been amended to "Income Insurance Limited".

8F	8.29 to 8.37	219 to 220	Amended.
Chapter 13 – Notice No: MAS 120 – Disclosure and Advisory Process Requirements for Accident and Health Insurance Products			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
1	1.1	282	Amended.
Appendix 13A	-	285 to 312	Amended.
Chapter 15 – Case Studies			
Section/Paragraph	**Paragraph**	**Page**	**Amendments**
2B	Table 15.1	344	Amended the Enhance IncomeShield Advantage Plan premium amount.
Appendix 15B	-	351 to 355	Amended.

Singapore College of Insurance
9 Temasek Boulevard #14-01/02/03,
Suntec Tower Two, Singapore 038989

General Enquiry: (65) 6221 2336
Fax: (+65) 6220 6684

Email: talk2us@scidomain.org.sg
Website: www.scicollege.org.sg

CPE Registration No.:199408491M
Period Of CPE Registration:
From 26 September 2019 to 25 September 2023

HI.7.2020.4