

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

Proposed Insured Details

1. Surname/Family Name

2. Given Name

3. Gender

☐ Male ☐ Female4. Date of Birth
Month Day Year5. Age Last
Birthday

6. NRIC/Passport No.

7. Country of Issuance

8. Country of Citizenship

9. If you are a Citizen of Singapore, have you resided in Singapore at any time during the past five years?

☐ Yes ☐ No

If you are currently residing in Singapore, but NOT a Citizen of Singapore, please complete questions 10 and 11.

10. Please select one of the following checkboxes:

- ☐ I am a Permanent Resident of Singapore
☐ I hold a work pass or permit required under the Singapore Employment of Foreign Manpower Act (Cap. 91A)
☐ I hold a pass or permit required under the Singapore Immigration Act (Cap. 133) that has a duration of longer than 90 days

11. How long have you been residing in Singapore in the immediate past 12 months?

- ☐ 1 – 90 days
☐ 91 – 182 days
☐ ≥183 days

12. Occupation

13. Employer

14. Annual Earned Income

US\$

15. Industry/Duties

16. Employer Address

17. Employer Telephone

18. Residential Address

Postal Code

18a. How long have you resided in the country listed in 18?

18b. If your response to 18a was less than 3 years, please list all of your countries of residence for the past 3 years.

19. Correspondence Address (if different from above)

Postal Code

20. Telephone (Home)

(Work)

(Mobile)

21. E-mail Address

Transamerica Life (Bermuda) Ltd.

Singapore Branch Office, 1 Finlayson Green #13-00, Singapore 049246

Co. Reg. No. T05FC6768E

APA 40SG-0611

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Proposed Owner Details (if other than Proposed Insured)

22. Owner Type

<input type="checkbox"/> Individual	<input type="checkbox"/> Corporation	<input type="checkbox"/> Trust, dated _____
<input type="checkbox"/> Partnership	<input type="checkbox"/> Other, describe _____	

GST Registered

<input type="checkbox"/> Yes	GST Registration No. _____	<input type="checkbox"/> No
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If Individual:

23. Surname/Family Name _____	24. Given Name _____	25. Relationship to Proposed Insured _____
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26. Gender

<input type="checkbox"/> Male	<input type="checkbox"/> Female
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27. Date of Birth

Month	Day	Year
____	____	____

28. NRIC/Passport No.

29. Country of Issuance

30. Country of Citizenship

31. If you are a Citizen of Singapore, have you resided in Singapore at any time during the past five years?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you are currently residing in Singapore, but NOT a Citizen of Singapore, please complete questions 32 and 33.

32. Please select one of the following checkboxes:

- ☐ I am a Permanent Resident of Singapore
- ☐ I hold a work pass or permit under the Singapore Employment of Foreign Manpower Act (Cap. 91A)
- ☐ I hold a pass or permit under the Singapore Immigration Act (Cap. 133) that has a duration of longer than 90 days

33. How long have you been residing in Singapore in the immediate past 12 months?

- ☐ 1 – 90 days
- ☐ 91 – 182 days
- ☐ ≥183 days

34. Residential Address

_____	Postal Code _____
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35. Correspondence Address (if different from above)

_____	Postal Code _____
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36. Telephone (Home)

(Work)

(Mobile)

37. E-mail Address

If Entity: (i.e. partnership, corporation, trust, other)

38. Full Name

39. Entity ID

40. Country of Domicile

41. Registered Address

_____	Postal Code _____
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42. Correspondence Address (if different from above)

_____	Postal Code _____
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43. Telephone



Beneficiary Information

44. If individual(s): (If other than immediate family member, provide insurable interest in Remarks.)

Full Name	Address	Share* (%)	Relationship to Proposed Insured

45. If Entity(ies) (i.e. partnership, corporation, trust, other)

Full Name	Address	Share* (%)	Relationship to Proposed Insured	Date of Trust (if applicable)

*If more than one Beneficiary is named, payment will be made in equal shares to the surviving beneficiaries, unless otherwise indicated. Any policy issued based upon this Application will be subject to Bermuda law. Your beneficiary may be changed at any time unless you specifically direct us otherwise. If you are interested in making a beneficiary designation that cannot be changed, you can designate an irrevocable beneficiary. Once an irrevocable beneficiary designation has been made, it cannot be changed without the irrevocable beneficiary's written consent.

Details of Insurance Applied For

46. Plan Applied For

Plan Code

47. Face Amount Applied For

48. Risk Class Applied For (Standard Risk Class Unless Otherwise Indicated)

49. Additional Benefits

Amount Applied For

<input type="checkbox"/> Term Conversion Rider	
<input type="checkbox"/> Waiver of Premium/Waiver Provision Rider	
<input type="checkbox"/> Accident Indemnity Rider	<input type="text" value="US\$"/>
<input type="checkbox"/> Surrender Penalty Deferral Endorsement	
<input type="checkbox"/> Other	<input type="text" value="US\$"/>

50. Premium Payment Mode

<input type="checkbox"/> Annual	<input type="checkbox"/> Semi-Annual	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly
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Premium Payment Method

<input type="checkbox"/> Wire/TT	<input type="checkbox"/> Bank Draft	<input type="checkbox"/> Check
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51. For Flexible Premium Plans

Required Premium Per Year (RAP)	<input type="text" value="US\$"/>	
Planned Periodic Premium (PPP)	<input type="text" value="US\$"/>	<input type="text" value=""/> Years
+ Initial Lump Sum	<input type="text" value="US\$"/>	
= Total Initial Premium	<input type="text" value="US\$"/>	

DO NOT PAY ANY PREMIUM WITH THIS APPLICATION.

52. If the Automatic Premium Loan Provision is available, it is to be

<input type="checkbox"/> Effective	<input type="checkbox"/> Not Effective
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53. Mail Additional Premium Notices To (Address) (if applicable)

For the following questions, "you" means the person proposed to be insured.

54. Do you plan to travel to locations outside Singapore, Hong Kong, Taiwan, Japan, Australia, New Zealand, the U.S., Canada or Western Europe, for business or leisure, within the next 24 months? If "Yes", complete Foreign Nationals & Foreign Travel Questionnaire.

Yes ☐ No ☐

55. In the past two years, have you participated in aeronautics, power racing of competitive vehicles, skin or scuba diving, mountain climbing, rodeos or competitive skiing? If "Yes", complete Sports and Avocation Questionnaire.

Yes ☐ No ☐

56. Have you used nicotine at any time?

a. Cigarettes

Yes ☐ No ☐

b. Cigar/Pipe

Yes ☐ No ☐

Date Last Used/Quantity

57. Do you intend to fly other than as a passenger or have you flown other than as a passenger during past two years? If "Yes", complete Aviation Questionnaire.

Yes ☐ No ☐

58. Have you ever been convicted of a criminal act? If "Yes", give full details in Remarks.

Yes ☐ No ☐

59. Are you a member of the armed forces, including reserves? Do you intend to become a member? If "Yes", give full details in Remarks.

Yes ☐ No ☐

60. In the past five years, have you been convicted of or pleaded guilty to any driving violations. If "Yes", provide dates and type.

Yes ☐ No ☐

61. Total Life Insurance you have In Force with all Companies

Company

US\$

Issue Year

Business

Personal

Accidental Death Insurance

Waiver of Premium/Waiver Provision Coverage

62. Has any company declined to issue, reinstate or renew; rated, modified, postponed or cancelled, any life insurance on you? If "Yes", please provide details.

Yes ☐ No ☐

63. Do you have any applications for life insurance pending with any other companies? If "Yes", provide all details including company names, amounts applied for and total amounts to be placed.

Yes ☐ No ☐

64. Is this Application to replace or intended to replace any policy or policies with this or any other company? If "Yes", provide all details including names of companies, policy numbers and amounts to be replaced.

Yes ☐ No ☐

65. Do you have any undischarged bankruptcy at this time? If "Yes", please state type & details.

Yes ☐ No ☐



66. Financial Statement (Personal Insurance Only)

Complete the following if the face amount applied for is between US\$1,000,001 and US\$5,000,000.

(Complete the Personal Financial Supplement if the face amount exceeds US\$5,000,000.)

Purpose of Insurance

- ☐ Income Replacement
- ☐ Estate Planning
- ☐ Protection for Dependents

Proposed Insured Employment Information

Commencement Date of Employment: _____ (mm/dd/yyyy)

Percentage of employer shares owned: _____

Proposed Insured Financial InformationAnnual Income

US\$	Current Year	Last Year
Annual Earned Income		
Bonuses		
Total Income		

Assets

US\$	Current Year	Last Year
Cash		
Other Assets		
Total Assets		

Liabilities

US\$	Current Year	Last Year
Types of liabilities e.g. Mortgage		
Total Liabilities		

Estimated net worth US\$: _____

- (i) you may not be insurable on standard terms;
- (ii) you may have to pay a higher premium in view of higher age;
- (iii) this may result in losing the financial benefits accumulated over the years.

In your own interest, we would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison. You should be sure that you are making a decision that is in your best interest.

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

Declaration & Authorization to Obtain Information

I, the Proposed Insured, and I, the Proposed Owner (if different), hereby represent that the statements and answers given in this Application are true, complete and correctly recorded.

I, the Proposed Insured, and I, the Proposed Owner (if different), agree:

- (1) This Application shall consist of Part 1, Part 2, and any required Application Supplement(s), and shall be the basis for any policy issued on this Application;
(2) Life insurance coverage on this Application shall not take effect until after all of the following conditions have been met:

- (a) Part 1 and Part 2 of the Application, and all medical examinations, tests, screenings and questionnaires required by Transamerica Life (Bermuda) Ltd. ("the Company") are completed and received at our Branch Office in satisfactory condition;
(b) The Company has communicated to the Proposed Owner that the policy has been approved for issue, and if approved other than as applied for, the Company has received the Proposed Owner's written acceptance at its Branch Office;
(c) The Company has received the full initial premium at its Branch Office during the lifetime of and while the Proposed Insured is in good health; and
(d) All the statements and answers given in this Application are true, complete and have not changed as of the date of the Company's receipt of the full initial premium at its Branch Office.

- (3) No premium shall be paid or accepted before the Company requests it in writing;

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental and/or treatment of me and any non-medical information of me to give the Company or its legal representative, any and all such information.

I, the Proposed Insured, and I, the Proposed Owner (if different), understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection to my Application, claim or may be otherwise lawfully required or as I may authorize.

(4) No waiver or modification shall be binding upon the Company unless in writing and signed by its Chief Executive or a Vice President and Secretary or an Assistant Secretary:

- (5) A copy of the Benefits Illustration, Product Summary, and Fact Find (if applicable) has been provided. The contents of these documents have been explained to my satisfaction, and I have read and understood them;
(6) I have been informed and directed to view or download a copy of Your Guide to Life Insurance from www.transamerica.com.sg or www.lia.org.sg; and
(7) I have read the Section 25 (5) Insurance Act (Cap. 142) warning stated on the front of this Application form.

I, the Proposed Insured, and I, the Proposed Owner (if different), understand that omissions or misstatements in this Application could cause an otherwise valid claim to be denied under any policy issued from this Application.

If a material fact is not disclosed in this Application, 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 which you may have provided to the insurance representative but was not included in this Application. Please check to ensure you are fully satisfied with the information declared in this Application.

I, the Proposed Insured, and I, the Proposed Owner (if different), know that I may request to receive a copy of this Authorization. **I, the Proposed Insured, and I, the Proposed Owner (if different), agree** that a photocopy of this Authorization shall be valid as the original. **I, the Proposed Insured, and I, the Proposed Owner (if different), agree** this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether living or deceased.

Note: If information is to be released by a person or facility located in the U.S., the Authorization for Release and Disclosure of Health Related Information form must be completed and attached.

Consent To Being Insured

I, the Proposed Insured, hereby irrevocably give my written consent to the purchase by the Proposed Owner, of a life insurance policy on my life from Transamerica Life (Bermuda) Ltd.

Governing Law

The governing law of the policy applied for will be the laws of Bermuda and all parties agree to comply with all laws and regulations applicable under it.

U.S. Tax Information

The Proposed Insured and the Proposed Owner each represents and warrants that he/she/it is not a U.S. person for U.S. federal income tax purposes, and the Proposed Owner is not acting on behalf of a U.S. person. A U.S. person is either a resident or a citizen of the U.S. or an entity organized in the U.S. A false statement or misrepresentation by a U.S. person could lead to penalties under U.S. law. If your tax status changes and you become a U.S. citizen or resident, you will notify us within 30 days.



Declaration of Beneficial Ownership

I, the Proposed Owner, hereby declare and confirm that, unless otherwise indicated below*, I am the Beneficial Owner and ultimately own or have effective control over this insurance policy. I acknowledge and agree that the Company shall be entitled to rely on my declaration above on the beneficial ownership and purpose of this insurance policy.

(To be completed only if you are not the Beneficial Owner)

*The following individual(s) is/are the Beneficial Owner(s) and ultimately own(s) or has/have effective control of this insurance policy. Please enclose a copy of the identity card or passport of the Beneficial Owner(s).

Name(s)	NRIC Type	NRIC/Passport Number	Nationality	Date of Birth	Relationship to the policyholder
1)					
2)					
3)					

‘Beneficial Owner’ as defined in MAS Notice 314 on Prevention of Money Laundering and Countering the Financing of Terrorism means the natural person who ultimately owns or controls a customer or the person on whose behalf a transaction is being conducted and includes the person who exercises ultimate effective control over a body corporate or unincorporate.

For the avoidance of doubt, ‘Beneficial Owner’ does not mean the nominated beneficiary(ies) under the policy.

Authorized Signatures

Signed at _____ on _____
City, Country Date (mm/dd/yyyy)

X

Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor)

X

Witness to Signature of Proposed Insured

Signed at _____ on _____
City, Country Date (mm/dd/yyyy)

X

Signature of Proposed Owner (if other than Proposed Insured)

X

Witness to Signature of Proposed Owner

If Proposed Owner is a corporation, an authorized officer, other than the Proposed Insured must sign as a Proposed Owner, give full corporate title and name of corporation with the company stamp below. If Proposed Owner is a Trust, authorized Trustee(s) must sign as Proposed Owner, give full name and date of Trust below.

X

Signature of Insurance Advisor



Report by Distributor

Distributor's Name

Office ID

Producer ID (Distributor)

Solicitor's Name

Producer ID (Solicitor)

Producer MAS Representative Notification Framework ID

Administrative Staff Name

Solicitor's Statement

1. What is the purpose for insurance?

2. How long have you known the Proposed Insured?

3. Proposed Insured is

☐ Single

☐ Married

☐ Divorced

☐ Widowed

4. To the best of your knowledge, does the Proposed Insured have any existing life insurance or annuity policies?

Yes ☐ No ☐

5. To the best of your knowledge, could replacement be involved?

Yes ☐ No ☐

6. Name of referring bank.

7. Is this Application submitted in respect of an Accredited Investor as defined in the Financial Advisers Act (Chapter 110)? Yes ☐ No ☐
If 'No', please attach a copy of the option page of the Fact Find Form with this Statement.

Solicitor's Declaration

I have personally seen the Proposed Insured/Owner and explained the terms of the insurance to him/her and have verified the NRIC/Passport No. of the Proposed Insured/Owner.

I declare that all the answers provided to me by the Proposed Insured/Owner are accurately declared in the Application. I have not withheld any other information which may influence the acceptance of this Application by the Company.

X

Date (mm/dd/yyyy)

Signature of Solicitor