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DISTRICT JUDGE TEO GUAN KEE
3 SEPTEMBER 2026

IN THE STATE COURTS OF THE REPUBLIC OF SINGAPORE

[2026] SGDC 276

District Court Originating Claim No 1696 of 2024

Between

Cai Yanhong

… *Claimant*

And

Prudential Assurance Company Singapore (Pte) Limited

… *Defendant*

JUDGMENT

Contract – Contractual Terms – Rules of construction – Whether on a proper construction of the insurance policy coverage was engaged

Contract – Contractual Terms – Whether terms of the insurance policy were brought to the attention of the policyholder

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v
Prudential Assurance Company Singapore (Pte) Limited

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18 March, 28 April, 30 April, 25 June 2026

3 September 2026 Judgment reserved.

District Judge Teo Guan Kee:

Introduction

Parties

1 The Defendant is a company incorporated in Singapore. It is in the business of the sale of life insurance policies.

2 The Claimant is a natural person and, at all material times, the owner of a policy of insurance issued by the Defendant, about which more details will be provided below.

Background to the Dispute

3 In August 2016, the Claimant purchased a life insurance policy issued by the Defendant, being PruLife Multiplier Policy No. 57169659 (the "**Policy**"), through a bancassurance sales channel operated by Standard Chartered Bank (Singapore) Limited ("**SCB**").

4 The Policy provided a few different classes of coverage. Only one class is relevant to these proceedings, known as the Early Crisis Cover Multiplier (the "**ECCM**").

5 To give a flavour of the coverage provided under the ECCM, I set out below an extract of the Defendant's Product Summary for the ECCM, although it should be highlighted that the Product Summary expressly stated that it would not "constitute a contract":

> [The ECCM] is a supplementary benefit, which offers whole of life financial protection against medical conditions from its early stages to the intermediate stages. Any medical conditions benefit payout under [the ECCM] will reduce the sum assured of the PruLife Multiplier policy. It also provides a Special benefit and Premium Waiver benefit.

6 It is not disputed that the Claimant continued to maintain coverage under the Policy for all periods material to these proceedings.

7 The Claimant suffered a medical event on 8 April 2023 (the "**Medical Event**") whilst she was on a bus. She was then conveyed by ambulance and received treatment at the National University Hospital, Singapore.

8 The Claimant was diagnosed as having suffered a "subarachnoid haemorrhage from ruptured anterior communicating artery aneurysm".

Following this diagnosis, she underwent a procedure known as endovascular repair to treat the same.

9 The Claimant made a claim (the "**Policy Claim**") for a payout under the Policy (specifically, the ECCM) stemming from the Medical Event.

10 Following some correspondence between the parties, the Policy Claim was denied by the Defendant by way of a letter dated 8 September 2023.

11 On 9 October 2024, the Claimant commenced the proceedings herein against the Defendant, seeking sums and benefits which she claimed should have been made available to her under the Policy, pursuant to the Policy Claim.

Relevant procedural background

12 At the beginning of the trial, parties agreed that the trial of this matter would be conducted on an unbifurcated basis.

13 The following persons gave evidence as witnesses of fact at the trial before me:

(a) The Claimant;

(b) Tan Kah Tin ("**TKT**"), the Defendant's Head of Life Claims;

(c) Lim Yeong Tah ("**LYT**"), a former Head of Product Management for the Defendant and, based on his affidavit of evidence-in-chief ("**AEIC**"), presently a Senior Director, Production Development and Innovation at Prudential Services Singapore Pte Ltd;

(d) Tan Kwang Hui ("**TKH**"), an insurance specialist with Standard Chartered Bank.

14 Following the trial, the parties filed the following written submissions:

(a) Claimant's Closing Submissions filed on 11 June 2026 (the "**CCS**");

(b) Defendant's Closing Submissions filed on 11 June 2026 (the "**DCS**");

(c) Claimant's Reply Submissions filed on 25 June 2026 (the "**CRS**"); and

(d) Defendant's Reply Closing Submissions filed on 25 June 2026 (the "**DRS**").

Summary of the Claimant's case

15 Based on the Statement of Claim filed by the Claimant (the "**SOC**"), the Claimant's overarching position was that the Medical Event ought to have led to a payout under the Policy being made to her and that, therefore, the Defendant's denial of her claim under the Policy was a breach of contract in respect of which she is entitled to the remedies she has sought in these proceedings.

16 Based on the CCS, the Claimant appeared to rely on two arguments to establish her entitlement to a payout under the Policy.

17 First, as a matter of interpretation, the Claimant argued that coverage under the ECCM should have been triggered once she was "diagnosed" as having suffered from a stroke or brain aneurysm, without regard to the treatment prescribed for such condition.

18 Secondly, even if the Policy contained provisions providing that coverage under the ECCM would not be triggered unless the stroke or brain aneurysm led to the Claimant undergoing a certain type of treatment, the Defendant should not be able to rely on such provisions to deny her claim because these provisions had not been properly or adequately disclosed to her.

19 In this connection, the Claimant also referenced, in the SOC, a duty of utmost good faith (the "***uberrimae fidei* duty**") which she alleged the Defendant owed to her but which she averred the Defendant "had not met", although she did not plead any particulars as to how the Defendant breached this duty.

20 As regards the remedies sought by the Claimant, in the SOC, she prayed, without elaboration, for the following:

(a) "Early Crisis Cover Multiplier of $108,500";

(b) "Refund of 2 years premium (Paid on Aug 29th, 2023 and 2024 after the claim was rejected): $3109.62"; and

(c) "Waiver of remaining premiums under this policy: $1554.81 x 6 = 9328.8".

Summary of the Defendant's case

21 The Defendant denied that the Claimant was entitled to any payout under the terms of the Policy, properly construed.

22 In summary, the Defendant averred that the definition of "brain aneurysm surgery", for the purposes of the ECCM, was that set out in section 32 of the Policy Document, which provided as follows:

27 - Stroke	**Early Stage Medical Conditions: Brain aneurysm surgery; or**	The actual undergoing of surgical craniotomy to repair either an intracranial aneurysm or to remove an arterio-venous malformation. The surgical intervention must be certified to be absolutely necessary by a consultant neurologist. Endovascular repair or procedures are not covered.

23 Given that the above definition of "brain aneurysm surgery" specifically stated that "endovascular repair or procedures are not covered" and the procedure which the Claimant had undergone stemming from her Medical Event was an "endovascular repair or procedure" and not a craniotomy, the Defendant argued that the Claimant was not entitled to any payout under the ECCM.

24 Separately, the Defendant also denied an averment by the Claimant that she had purchased the Policy "from Prudential", noting instead that the Claimant had purchased the Policy through SCB, which had submitted the Claimant's completed proposal form to the Defendant on the Claimant's behalf.

25 The Defendant also denied that there had been any actionable failure on its part in disclosing relevant contractual clauses to the Claimant. Instead, it averred that the terms of the Policy had been explained to the Claimant.

Issues to be determined

26 It is necessary to highlight that neither the Claimant nor the Defendant took the position that there was no concluded contract of insurance between them. The Claimant has also not expressly pleaded mistake in the SOC.

27 With the foregoing in mind, I will consider the following issues:

(a) Issue 1: Was coverage under the ECCM engaged on a proper construction of the Policy?

(b) Issue 2: Did the Defendant fail to draw the Claimant's attention to relevant provisions?

Issue 1: Was coverage under the ECCM engaged on a proper construction of the Policy?

Applicable principles

28 It is axiomatic that, under Singapore law, the interpretation of contracts is based on the "objective principle".

29 In the seminal decision of the Court of Appeal (the "**CA**") in *Zurich Insurance (Singapore) Pte Ltd v B-Gold Interior Design & Construction Pte Ltd* [2008] 3 SLR(R) 1029 ("***Zurich Insurance***"), the CA established the importance of the objective principle by describing it as "the cornerstone of the theory of contract and permeates our entire approach to contractual interpretation."[1]

30 The CA then went on to cite, with apparent approval, the following description of the objective principle, taken from the English decision of *Deutsche Genossenschaftsbank v Burnhope* [1996] 1 Lloyd's Rep 113:

> It is true [that] the objective of the construction [of contracts] is to give effect to the intention of the parties. But our law of construction is based on an objective theory. The methodology is **not to probe the real intentions of the parties but to ascertain the contextual meaning** of the relevant contractual language. Intention is determined by reference to **expressed rather than actual intention**.
>
> (Emphasis added)

[1] *Zurich Insurance* at [125].

31 In ascertaining "expressed" intention, the standpoint to be adopted is that of a reasonable reader of the contract: *Zurich Insurance at* [131].

32 Separately, insofar as the different possible meanings of the term "context" were concerned, the CA stated in *Zurich Insurance* at [53] that

> …the word "context" has at least two possible meanings: **first, the document as a whole**, which includes the provisions other than those sought to be interpreted and the organisation of the document ("internal context"); and, second, the circumstances surrounding the formation of the contract, including the object or purpose for which it was entered into ("external context"). In this judgment, it is the *external* context of a contract (and not its internal context) that we refer to when we use the word "context".
>
> (Emphasis added)

33 In *Zurich Insurance*, the CA explicitly approved of a contextual approach to contractual interpretation (at [131]) and, in so doing, approved of a set of principles including one stating that the exercise of construction of a contract

> … is one based on the whole contract or an holistic approach. Courts are not excessively focused upon a particular word, phrase, sentence, or clause. Rather the **emphasis is on the document or utterance as a whole**.
>
> (Emphasis added)

34 Separately, the following remarks made by the CA in *Zurich Insurance* (at [132]) on the admissibility of extrinsic evidence to interpret written contracts are also apposite:

> (a) A court should take into account the essence and attributes of the document being examined.
>
> (b) Extrinsic evidence is admissible under proviso (f) to section 94 of the Evidence Act 1893 to aid in the interpretation of the written words

of a contract but it must be relevant, reasonably available to all the contracting parties and relate to a clear or obvious context.

(c) In some cases, the extrinsic evidence in question leads to possible alternative interpretations of the written words (ie, the court determines that *latent* ambiguity exists). A court may give effect to these alternative interpretations, always bearing in mind s 94 of the Evidence Act 1893. In arriving at the ultimate interpretation of the words to be construed, the court may take into account subjective declarations of intent.

The Policy Documents

35 As mentioned earlier, the Court in *Zurich Insurance* stated unambiguously that the entire contractual document forms part of the context to be considered in interpreting its provisions.

36 As such, in considering the Claimant's and the Defendant's competing interpretations of the ECCM, it is necessary to begin with an appreciation of how the Policy as a whole was structured.

37 The following documents contained the terms of the Policy which are applicable to this dispute:

(a) **Proposal Form** submitted by the Claimant dated 17 August 2016, pursuant to which she had applied to be issued with the Policy by the Defendant;

(b) Certificate of Life Assurance dated 29 August 2016 (the "**Insurance Certificate**"); and

(c) Policy booklet (entitled "**Policy Document**") setting out, *inter alia*, the terms and conditions of the Policy.

38 Beyond these three documents, the Defendant has also averred that a letter, dated 29 August 2016, sent by the Defendant to the Claimant informing her of the approval of her proposal to be issued with the Policy (the "**Approval Letter**") as well as "other documents listed in clause 1.1 of the Policy Document"[2] also contained terms of the contract between the parties.

39 However, neither party hereto has sought to rely on any specific terms within the Approval Letter or identified other documents as containing terms of the Policy which are relevant to this dispute.

40 Two other documents which featured prominently in both the AEICs of the Defendant's witnesses were the Benefit Illustration and Product Summary (collectively the "**BIPS**") for the ECCM.

41 In the DCS, the Defendant's counsel were at pains to point out that various versions of these had been provided to the Claimant on three separate occasions.[3]

42 It was also highlighted to the court that the Claimant had, as part of completing the Proposal Form, confirmed that she had been provided with the BIPS before she completed the Proposal Form.

[2] Defence at paragraph 14(e).

[3] DCS at paragraph 127.

43 Notwithstanding this, and whilst the significance of the BIPS to the parties' respective cases will be considered later in these grounds, the BIPS were not themselves contractual documents.

44 First and foremost, every version of the Product Summary provided to the Claimant began with the following statement:

> This Product Summary and Benefit Illustration are for illustrative purposes only and **shall not constitute a contract**. The following is a simplified description of the key product features. The **exact terms can be found in the policy document**.
>
> (Emphasis added)

45 Further, whilst section 1.1 of the Policy stated that "all written correspondence between [the parties] relating to [the Policy]" also constituted part of the contract between the parties, in my view, this could not have the effect of rendering the BIPS contractual documents.

46 During the entire sales process, the Claimant only had contact with representatives of SCB who, on the Defendant's case, were not representatives, employees or agents of the Defendant.[4]

47 LYT's evidence, in this regard, was that

> … for a sale of [the Defendant's] insurance policy carried out by SCB, during the sales process, [the Defendant] does not communicate with SCB's customers seeking to purchase the insurance policies until [the Defendant] decides to accept the proposal submitted by the customer of SCB. Only then will [the Defendant] correspond with the customer to confirm its acceptance of the proposal and send the customer of SCB the contractual documents, including the policy document in respect of the insurance policy they have purchased.[5]

[4] DCS at paragraph 64.

[5] LYT's AEIC at paragraph 16.

48 On each of the three occasions when the Claimant had been provided with the BIPS, any correspondence had been sent by TKH,[6] an employee of SCB and not the Defendant.

49 Accordingly, on the Defendant's own case, any correspondence sent by TKH could not have amounted to "written correspondence **between**" (emphasis added) the Claimant and the Defendant so as to have formed part of the Policy.

50 In the next part of these grounds, I consider the contents of the contractual documents which were pertinent to the question of whether endovascular repair was excluded from the ambit of the coverage provided under the ECCM.

Relevant features of the Policy documents

Proposal Form

51 In summary, the Proposal Form was a form in which the Claimant provided various material particulars to the Defendant, for the purpose of allowing the latter to assess the Claimant's request to be provided with coverage on the terms of the policy requested therein.

52 The Proposal Form did not itself set out the terms on which the ECCM coverage would be offered, beyond containing an annotation by the Claimant that she was seeking coverage thereunder for a sum assured of $108,500 and a term described as "whole life".[7]

[6] TKH's AEIC at paragraphs 16 and 30.

[7] TKT's AEIC at page 69.

53 The primary significance of the Proposal Form lay in the Defendant's reliance on two pieces of information contained therein:

(a) The Claimant had, in the Proposal Form, confirmed that the contents of the BIPS had been explained to her satisfaction.

(b) The Claimant had been made aware, in the Proposal Form, that she had a 14-day free-look period commencing from the date she received the Policy documents, during which she could review the said documents and ask for the Policy to be cancelled and for the premiums she had paid to essentially be refunded.

54 It is not in dispute that the Claimant did not exercise her right to cancel the Policy during the 14-day free-look period.

Insurance Certificate

55 The Insurance Certificate also did not contain provisions specifically describing the parties' respective obligations under the Policy.

56 That said, it did document the classes of coverage that the Claimant was entitled to receive under the Policy, and the sums assured.

57 In this regard, the Insurance Certificate provided as follows:

Benefits**	Sum Assured**	Multiplier Benefit**
Death	$180,000.00	$504,000.00
Accelerated Disability	$180,000.00	$504,000.00
Accelerated Terminal Illness	$180,000.00	$504,000.00
Crisis Cover 111	$180,000.00	$414,000.00
Early Crisis Cover Multiplier	$108,500.00	$249,550.00

Policy Document

58 The Policy Document was the focus of the parties' submissions and hence bears describing in some detail.

59 This document contained a total of 33 "sections", setting out the terms and conditions of the Policy.

60 Generally speaking, it appears that policyholders who took up a PruLife Multiplier policy could possibly be provided with different types of cover (also known as "benefits"). In this case, the Claimant was covered for the five classes set out in paragraph 57 above.

61 Some sections in the Policy Document contained provisions applicable to all types of cover. For example, section 8, entitled "Who do we pay?", set out a list of payees to whom possible benefits under the Policy might be paid (such as the policyowner or his nominated beneficiaries) and section 30, entitled "How to make a claim?", contained, *inter alia*, instructions on documents which had to be submitted in the event a claim could be made under the Policy.

62 All the sections between 8 and 30, however, essentially contained provisions pertaining to specific types of cover under the Policy, of which the ECCM was but one.

63 The provisions pertaining to the ECCM were contained in section 17 of the Policy Document.

64 Section 17.1 of the Policy Document provided that the following three specific benefits were offered under the ECCM:

> - **Medical Conditions benefit** – pays a percentage of the sum assured depending on the severity of the medical condition.
>
> - **Special benefit** – covers Diabetic Complications and Juvenile Medical Conditions.
>
> - **Premium Waiver benefit** – waives all future premiums for your **Early Crisis Cover Multiplier Benefit** from the first successful claim under the Early Stage Benefit, where 100% of the sum assured has not been paid out. This Premium Waiver benefit is not applicable to a successful claim for any of the Medical Conditions under the Special benefit.
>
> (Emphasis in original)

65 Based on the prayers for relief contained in the SOC, reproduced at paragraph 20 above, in these proceedings the Claimant has sought relief in the nature of the Medical Conditions benefit and Premium Waiver benefit referenced in section 17.1 of the Policy Document.

66 Before going on to describe the Medical Conditions benefit and the Premium Waiver benefit, I should add that in the CCS, the Claimant added, *inter alia*, a claim for the Special benefit mentioned in section 17.1.

67 With respect, this very belated claim was a non-starter and cannot be considered further.

68 First, a claim for the Special benefit was not part of the Claimant's pleaded case.

69 Secondly, section 17.3 of the Policy Document, which contained the provisions pertaining to the Special benefit, provided that the Special benefit would only be paid when the insured had been diagnosed with either "diabetic complications" or "Juvenile Medical Conditions" applicable to insureds below 18 years of age, and the Claimant has not asserted that she suffered from any condition falling within either of the foregoing categories.

(1) Medical Conditions benefit

70 Section 17.2 of the Policy provided the operative provisions for payment of the Medical Conditions benefit and stated as follows:

> If the life assured is shown on your Certificate of Life Assurance to be covered for this benefit and is diagnosed as having any one of the Medical Conditions listed, we pay the benefit according to the severity level of the Medical Condition.

71 The wording above was followed by various provisions (numbered sections 17.2.1 to 17.2.3 with additional sub-sections) setting out how the quantum of the Medical Conditions benefit which the Claimant was entitled to be paid would be ascertained once coverage under the ECCM was engaged.

72 The aforementioned provisions on the quantification of the Medical Conditions benefit were thereafter followed by section 17.2.4, entitled "What Medical Conditions are covered?".

73 This section began with the following words:

> We cover the following Medical Conditions and pay out the following benefits according to the respective severity levels shown below. The Medical Conditions must be diagnosed by a doctor registered with the Singapore Medical Council.

74 The text above was followed by a table with 29 rows, with the pertinent portions, for the purpose of the dispute before me, stating as follows:

	Category	**Early Stage Medical Conditions (Early Stage Benefit)**	**Intermediate Stage Medical Conditions (Intermediate Stage Benefit)**
…			
27	Stroke	Brain aneurysm surgery or Cerebral shunt insertion	Carotid artery surgery

…

> You can find the definitions of the Early Stage and Intermediate Stage Medical Conditions in **Section 32.**

75 Section 32 of the Policy Document, referred to in section 17.2.4 reproduced above, was entitled "Definitions of the Early Stage and Intermediate Stage Medical Conditions". It contained 29 rows, matching those in section 17.2.4.

76 Row 27 of section 32 provided as follows:

Category	Types of Medical Conditions (according to Severity Levels)	Definition
…		
27 - Stroke	**Early Stage Medical Conditions: Brain aneurysm surgery; or**	The actual undergoing of surgical craniotomy to repair either an intracranial aneurysm or to remove an arterio-venous malformation. The surgical intervention must be certified to be absolutely necessary by a consultant neurologist. Endovascular repair or procedures are not covered.
	Cerebral shunt insertion	The actual undergoing of surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid. The need of a shunt must be certified to be absolutely necessary by a consultant neurologist.
	Intermediate Stage Medical Conditions: Carotid artery surgery	The actual undergoing of Endarterectomy of the carotid artery which has been necessitated as a result of at least 80% narrowing of the carotid artery as diagnosed by an arteriography or any other appropriate diagnostic test that is available. Endarterectomy of blood vessels other than the carotid artery are specifically excluded.

77 At this point, it bears highlighting that the Defendant has not seriously challenged the Claimant's assertion that she had suffered a stroke or a ruptured brain aneurysm during the Medical Event, and had been diagnosed as having suffered from the same.

78 In any event, there is evidence supporting this in the form of a Medical Specialist Report endorsed by one Associate Professor Yeo Tseng Tsai ("**Dr Yeo**") of the Neurosurgery Division of the National University Hospital, dated 24 July 2023,[8] which was exhibited in TKT's AEIC.

79 TKT did not take issue with the contents of Dr Yeo's report.

80 Further, at trial, the Claimant also asked TKT, in cross-examination, whether, based on a statement in Dr Yeo's report confirming that the Claimant had undergone "brain aneurysm surgery", TKT would agree that the Claimant had suffered a "stroke due to brain bleeding". TKT, who gave evidence in her capacity as the Defendant's Head of Claims, stated that she agreed.[9]

(2) Premium Waiver benefit

81 The operative provisions for the Premium Waiver benefit were set out in sections 17.4 and 17.5.2 of the Policy Document, which provided as follows:

> **17.4 Premium Waiver benefit**
>
> Once the first claim under the Early Stage Benefit (refer to Section 17.2.1) is approved, all future premium payments for your Early Crisis Cover Multiplier Benefit will be waived from the next premium due date following the date of diagnosis of the Medical Condition. Coverage will continue until your Early Crisis Cover Multiplier Benefit terminates (refer to Section 17.10)
>
> …
>
> **17.5.2 Premium Waiver benefit claim**
>
> Subject to **Section 17.4** above, once your Premium Waiver benefit claim is approved, all future premium payments for your **Early Crisis Cover Multiplier Benefit** will be waived from the

[8] TKT's AEIC at pages 234 to 249.

[9] NE 28 April 2026 46/16-47/10.

> next premium due date following the date of diagnosis of the Medical Condition.
>
> Coverage will continue until your **Early Crisis Cover Multiplier Benefit** terminates (refer to **Section 17.10**).
>
> (Emphasis in original)

82 It will be apparent from section 17.4 above that the availability of the Premium Waiver benefit was contingent upon the availability of a payout of the Medical Conditions benefit. The success of the Claimant's claim for the Medical Conditions benefit would thus also be determinative of her claim for remedies stemming from the Premium Waiver benefit provisions.

Interpreting the Policy

83 The starting point for contractual interpretation is to examine the text of the contract itself: see, for instance, *Kuvera Resources Pte Ltd v JPMorgan Chase Bank, NA* [2023] 2 SLR 389 at [38].

84 In this case, it is not disputed that the documents making up the Policy embodied the entire agreement between the parties hereto.

85 Indeed, section 1.1 of the Policy Document provided precisely for this to be the case by identifying the Policy Document and other specific documents (the relevant ones of which I have identified in paragraph 37 above) as constituting

> … the entire agreement between you and us relating to your policy with us and supersedes all previous representations, warranties and agreements whether written or oral.

86 Under section 17.2 of the Policy Document, the Defendant undertook to pay the same if:

(a) the life assured [i.e. the Claimant in this case] was shown on the [Insurance Certificate] to be covered for [the Medical Conditions benefit]; and

(b) was "diagnosed" as having any one of the "Medical Conditions listed".

87 It is not disputed that the requirement in sub-paragraph (a) above was satisfied, for the Insurance Certificate stated unambiguously that one of the classes of coverage afforded to the Claimant under the Policy was the ECCM.[10]

88 As for the requirement in paragraph 86(b) above, this would be satisfied if the Claimant were "diagnosed" with "any one of the Medical Conditions listed".

89 I appreciate that the word "diagnosed" is not defined in any of the documents comprising the Policy.

90 The word "diagnosed" featured heavily in the Claimant's CCS and CRS. Her argument was essentially that her entitlement to the benefits under the ECCM was triggered once she was "diagnosed" as having suffered from a ruptured brain aneurysm.

91 Under section 59(1)(i) of the Evidence Act 1893, I am required to take judicial notice of, *inter alia*, "the meaning of English words".

92 As a matter of *language*, in my view it is not typical to conflate diagnosis with *treatment*.

[10] See paragraph 57 above.

93 For instance, the online Merriam-Webster Dictionary lists the meanings of the verb "diagnose" as:

> (a) to recognize (something, such as a disease) by signs and symptoms;
>
> (b) to recognize a disease or **condition** in; and
>
> (c) to analyse the cause or nature of.[11]

94 That being said, it is equally clear from section 17.2 of the Policy Document that not every diagnosis will engage coverage under the ECCM. Instead, such coverage will only be engaged if the insured is diagnosed with "one of the Medical Conditions listed".

95 The nearest "list" of medical conditions following the text in section 17.2 was set out in section 17.2.4, the relevant portion of which I have reproduced at paragraph 74.

96 In my view, there were a number of *contextual* features in section 17.2.4 which bear on the Claimant's argument that the term "diagnosed", in the phrase "diagnosed as having any one of the Medical Conditions listed" in section 17.2, should bear its ordinary English meaning.

97 Row 27 of section 17.2.4 did refer to "brain aneurysm", but only as part of a reference to "brain aneurysm surgery", alongside references to "cerebral shunt insertion" and "carotid artery" surgery, under columns entitled either

[11] https://www.merriam-webster.com/dictionary/diagnose

"Early Stage Medical Conditions" or "Intermediate Stage Medical Conditions", as can be seen from the reproduced provisions.

98 In my view, this collocation of treatments in columns entitled "medical conditions" was relevant context that had to be taken into account in considering when coverage under the ECCM was engaged.

99 If "diagnosed" was construed as being mutually exclusive with "treatment", the reference to treatment methods in all but the first column in row 27 of section 17.2.4 would render terms appearing under the columns entitled "Early Stage Medical Conditions" and "Intermediate Stage Medical Conditions" redundant. Specifically, both instances of the term "surgery" and "cerebral shunt insertion" would be robbed of any application.

100 Such an interpretation would run counter to the "interpretive presumption against redundant words": *Zurich Insurance* at [65].

101 Further, section 17.2.4 ends with an instruction that the policyholder could "find the definitions of the Early Stage and Intermediate Stage Medical Conditions in **Section 32**." (emphasis in original)

102 This was a clear signpost to another part of the Policy Document setting out, *inter alia*, the definition of "brain aneurysm surgery", which appeared under the column entitled "Early Stage Medical Conditions".

103 Turning to section 32, as mentioned earlier, the rows in this section matched those in section 17.2.4. Row 27 of section 32 clearly stated, as part of the definition of "brain aneurysm surgery", that "endovascular repair or procedures are not covered".

104 Having regard to the foregoing, in my view, on a proper contextual appreciation of the terms of the Policy, it is fairly clear that the meaning of the term "diagnosed" in section 17.2 must be informed by the phrase "as having any one of the Medical Conditions listed", as the latter phrase circumscribes the former term.

Contra proferentem

105 The Claimant has asserted that the rule of *contra proferentem* favours her interpretation of the Policy, because where an insurance contract is ambiguous, it must be construed against the insurer who drafted it.[12]

106 In *Tay Eng Chuan v Ace Insurance Ltd* [2008] 4 SLR(R) 95 ("***Tay Eng Chuan***"), the CA cited with apparent approval the following description of the *content* of the *contra proferentem* rule:

> [A] person who puts forward the wording of a proposed agreement may be assumed to have looked after his own interests, so that **if the words leave room for doubt about whether he is intended to have a particular benefit there is a reason to suppose that he is not**.
>
> (Emphasis added)

107 In my view, there is no room for the application of the principle of *contra proferentem* in this case.

108 Whilst it might superficially appear that the use of the term "diagnosed" in section 17.2 introduces an ambiguity when considered alongside terms like "brain aneurysm surgery" in section 17.2.4, in my view the Policy Document as a whole is reasonably consistent in establishing that the term "diagnosed" could

[12] CCS at paragraph 83.

not be narrowly confined to exclude all forms of treatment, for otherwise substantial tracts of section 17.2.4 and section 32 would be rendered redundant.

Secret definition of "brain aneurysm surgery"

109 In the CCS, the Claimant claimed that the term "brain aneurysm" had been "secretly redefined" because section 17.2.4 simply listed "brain aneurysm surgery" as a covered medical condition "without any asterisk, without any footnote, without any warning".[13]

110 It was also highlighted by the Claimant that section 17.7 of the Policy Document, which was entitled "What is not covered?", did not mention the absence of coverage for endovascular repair at all.

111 Throughout the CCS, there were also repeated allegations made by the Claimant that the Defendant had failed to "disclose" that "brain aneurysm" had been defined as not including endovascular repair and that the definition had been "buried".

112 With respect, the characterisation of the definition of "brain aneurysm surgery" as having been "hidden" or "buried" in the Policy Document was not a fair one.

113 As highlighted earlier, the term "stroke" in section 17.2.4 of the Policy Document was followed immediately by terms that were clearly in the nature of treatments (such as "brain aneurysm surgery" and "cerebral shunt insertion").

[13] CCS at paragraph 14.

114 The table in section 17.2.4 was immediately followed by a statement that the definitions of the "Early Stage … Medical Conditions", corresponding to the column in the table in which the "medical condition" described as "brain aneurysm surgery" was located, were to be found in section 32 of the Policy Document. There was therefore an *express* direction of the reader's attention to section 32 of the Policy Document.

115 Section 17.2.4 of the Policy Document and its reference to section 32 also came before section 17.7. In these circumstances, even if section 17.7 did not directly refer to section 32, a reasonable reader would already be aware, after reading section 17.2.4, that "diagnosed" and "diagnosis" in this context might not merely refer to the identification of a medical condition but also engage issues of the treatment to be undertaken in response to the same.

116 The effect of the Claimant's argument is that policyholders should not be bound by a term of their insurance policy if they independently form a belief that it is not necessary for them to read all the provisions of their policy. I am not aware of any authority which supports such a principle.

117 Accordingly, and whilst I will separately consider the Claimant's contention that she should not be bound by the terms of section 32 because it had not been properly disclosed to her, as a matter of *interpretation of the contractual language*, there was no secret or hidden redefining of the term "brain aneurysm surgery".

Relevance of other insurers' policies

118 In LYT's AEIC, he exhibited documents pertaining to two insurance policies issued by insurers other than the Defendant to support his assertion that "it is not unusual in the industry for medical conditions entitling a life assured

to payment under an Early Critical Illness policy to be defined with reference to the treatment prescribed for such medical conditions".[14]

119 Specifically, the documents exhibited in LYT's AEIC pertaining to policies issued by other insurers were (based on LYT's description of the same):

(a) Product Summary for a December 2016 version of a "My WholeLifePlan" life insurance policy issued by Aviva Ltd ("**Aviva**"); and

(b) October 2025 sample policy document of a "Limited Early Critical Secure" policy issued by Income Insurance ("**Income**").

120 For completeness, in my view, adducing these documents in LYT's AEIC did not assist the court in deciding the key issue in dispute in these proceedings.

121 The key dispute in question, which has been considered earlier, was over the *meaning* of words used in the Policy.

122 It does not follow that, simply because other insurers use similar wording, those insurers must necessarily be taken to have placed the same *meanings* on their policy wording as the Defendant did in relation to the wording of its own Policy.

123 Further, LYT did not suggest, in his AEIC, that he had any first-hand knowledge as to how Aviva or Income construed the wording of their respective policies. He also did not suggest that he had been authorised by either Aviva or

[14] LYT's AEIC at paragraph 39.

Income to give evidence on the *meaning* of the policy wordings of the Aviva and Income policies which he exhibited in his AEIC.

124 As such, to the extent that he was purporting to speak to the meanings of the Aviva and Income policy wordings exhibited in his AEIC, I consider that there is really no basis for me to give any weight to LYT's evidence on the Aviva or Income policies.

Conclusion: Issue 1

125 By virtue of the foregoing, on an objective view of the Policy, shorn of the Claimant's subjective expectations about the coverage she was to be afforded thereunder, there was no "room for doubt" about the coverage accorded under the ECCM, namely, that ECCM coverage would not be engaged where an insured underwent "endovascular repair or procedures".

Issue 2: Did the Defendant fail to draw the Claimant's attention to relevant provisions?

126 This brings us to the next argument raised by the Claimant, which was that she should not be bound by the definition of "brain aneurysm surgery" in section 32 of the Policy because the Defendant had failed to properly disclose this to her.

127 The sole authority relied on by the Claimant, in this regard, was the English decision of *Interfoto Picture Library Ltd v Stiletto Visual Programmes Ltd* [1989] 1 QB 433 ("**Interfoto**").

128 In *Interfoto*, the English Court of Appeal upheld a general principle (hereafter referred to as the "***Interfoto* Principle**") that

> …if one condition in a set of printed conditions is particularly onerous or unusual, the party seeking to enforce it must show that that particular condition was fairly brought to the attention of the other party.[15]

129 In reliance upon this principle, the Claimant argued that the definition of "brain aneurysm surgery", in particular, its exclusion of endovascular repair, had not been fairly brought to her attention and that, accordingly, the Defendant was not entitled to rely on the same to deny her claim under the Policy.

130 With respect, I am unable to accept this submission.

131 As a preliminary point, as a matter of law, it is at best unclear whether the *Interfoto* Principle would apply to the Policy.

132 In *R Manokaran v Chuah Ah Leng* [2022] SGHC 39 ("***Manokaran***"), Dedar Singh Gill expressly rejected an argument that the *Interfoto* Principle should apply to a "signed contract" and instead limited the application of the *Interfoto* Principle to cases in which there was no signed contract. His Honour further held that this position held true "even for contracts between businesses and consumers".[16]

133 Even assuming, for present purposes, that the *Interfoto* Principle applied with full force to the Policy, I am of the view that the Defendant did not fail to adequately bring the provisions relevant to the ECCM coverage at issue in these proceedings to the notice of the Claimant.

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[15] *Interfoto* at 439A.

[16] *Manokaran* at [114] to [117].

134 In the Proposal Form, the Claimant confirmed that a copy of the BIPS had been provided to her and that the contents thereof had been explained to her and to her satisfaction.[17]

135 Further, whilst the Claimant did not initial the page of the BIPS containing a definition of "brain aneurysm surgery" expressly stating that "endovascular repair or procedures are not covered", she did initial a page of the BIPS acknowledging receipt of all pages of the Product Summary forming part of the BIPS and confirming that the contents thereof had been explained to her satisfaction.

136 This is in my view significant because, whilst the BIPS was not itself a contractual document, it contained provisions that were effectively *identical* to provisions in sections 17.2, 17.2.4 and 32 considered earlier in these grounds as being relevant to the Claimant's claim herein.[18]

137 It was particularly striking to note, with reference to the Claimant's assertion that there had been no "asterisk"[19] indicating that the definition of "brain aneurysm surgery" had been secretly redefined, that the term "medical conditions" in the Product Summary *was* marked with an asterisk,[20] and part of the annotation accompanying that asterisk indicated that where medical conditions were not defined by the Life Insurance Association of Singapore, "the definitions are determined by the insurance company".[21]

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[17] TKT's AEIC at page 74.

[18] TKT's AEIC at pages 51 to 53 and 66.

[19] See paragraph 109 above.

[20] TKT's AEIC at page 52.

[21] TKT's AEIC at page 53.

138 I reiterate that the BIPS was not one of the documents making up the Policy. However, the question under consideration is not one of construction but whether the Claimant's attention had been drawn to a provision of the Policy which she was about to sign up to (in the case of the BIPS) or had signed up to (in the case of the Policy Document).

139 It is also worth highlighting that whilst the Claimant's position was that TKH had omitted to direct her attention to the definition of "brain aneurysm surgery" in the BIPS altogether, this was not consistent with contemporaneous evidence.

140 As mentioned earlier, the Claimant had confirmed in the Proposal Form that the contents of the BIPS had been explained to her satisfaction. She had also initialled a page of the Product Summary confirming receipt of all the pages of the Product Summary (see paragraph 135 above).

141 Further, before the Claimant had initialled the final version of the BIPS shown to her, she had been sent copies of the BIPS twice by TKH by email. In one of his emails attaching an earlier copy of the BIPS, TKH had specifically informed the Claimant that the definition of "Critical illnesses covered" could be found on "page 21" of the attached Product Summary.

142 For present purposes, it suffices to note that the "page 21" referred to by TKH in the aforementioned email marked the beginning of materially the same list set out in section 17.2.4 of the Policy Document, an indication that the definition of "Early Stage … Medical Conditions" could be found in the "last section" of that document as well as the asterisked notation I have described in paragraph 137 above. The final section of the BIPS also set out the same

definition of brain aneurysm surgery that was found in section 32 of the Policy Document.

143 In the premises, assuming that the *Interfoto* Principle applied to the Policy and that the section 32 definition of "brain aneurysm surgery" was a provision that ought to have been drawn to the attention of the Claimant, the evidence supports the Defendant's assertion that this had been done and there is no objective evidence, beyond the inconclusive absence of the Claimant's initials on the page of the Product Summary actually setting out the definition of brain aneurysm surgery, which the Claimant has highlighted in support of her position.

144 Separately, the Claimant's complaint of a failure of disclosure by the Defendant also seemed to conflate the concept of drawing her attention to the Policy provisions, which was what the *Interfoto* Principle required, with that of advising her on the *medical significance* of those provisions.

145 This is most apparent in submissions in the CCS in which the Claimant asserted that the exclusion of "endovascular repair and procedures" from the definition of "brain aneurysm surgery" in section 32 of the Policy Document deprived her of the "core purpose" for obtaining brain aneurysm coverage.[22] This was part of a submission that a "clause that defeats the core purpose of the contract may be unenforceable if it was not adequately disclosed".

146 The Claimant submitted that "endovascular coiling is the first treatment of choice for a ruptured brain aneurysm, and it is only in the event that an aneurysm is deemed unsuitable for endovascular coiling that craniotomy

[22] CCS at paragraph 92.

(clipping) is considered"[23], that craniotomy was a procedure that had a "30.6% morbidity and mortality rate for patients with ruptured aneurysms"[24] and that no "reasonable person" purchasing "Early Crisis Cover" would have expected the "safer, standard-of-care treatment" to be excluded from coverage.

147 As mentioned earlier, the interpretation of a contract turns, not on the parties' subjective (or even "real") intentions, but on the expressed intention as reflected in the contract. The Claimant's subjective expectations of what the ECCM would or would not cover therefore could not drive the court's interpretation of the Policy.

148 Insofar as the *Interfoto Principle* is concerned, with respect, I am unable to discern anything in *Interfoto* which required the Defendant to draw the Claimant's attention, not merely to the existence of the definition of "brain aneurysm surgery" in section 32 of the Policy Document, but to the comparative advantages and disadvantages of undergoing endovascular repair as opposed to craniotomy.

149 As such, to the extent the failures by which the Claimant felt aggrieved were failures to explain the medical significance of the definitions to the Claimant, I am of the view that such failures could not possibly engage the *Interfoto* Principle.

150 For completeness, beyond the BIPS, after the Claimant's proposal had been accepted by the Defendant and the Policy Document had been sent to the

[23] CCS at paragraph 91.

[24] CCS at paragraph 93.

Claimant, the Claimant was still, in a practical sense, not immediately bound by the terms of the Policy.

151 This is because, as stated in section 1.2 of the Policy Document, the Claimant had a period of 14 days after the date of receipt of the Policy to review its terms and conditions and to make a written request for the Policy to essentially be cancelled, with the refund of any premium paid, less expenses and any amount owed to the Defendant.

152 I have highlighted the foregoing to only make the point that, even if the *Interfoto* Principle required the Claimant's attention to be expressly drawn to the actual terms contained in the documents actually forming part of the Policy, given that the relevant final Policy wording was materially identical to that contained in the BIPS, which had been brought to the Claimant's attention, it could not in my view be said that the terms of sections 17 and 32 of the Policy were imposed on the Claimant in a manner that bound her without an opportunity to fully consider whether she wished to accept the terms thereof.

Conclusion: Issue 2

153 By reason of the foregoing, I am of the view that the Claimant would not be able to rely on the *Interfoto* Principle to assert that she was not bound by the definition of "brain aneurysm surgery" in the Policy.

154 For the avoidance of doubt, in stating the foregoing, I am not to be taken as having made any finding as to any duty or liability which may be owed to the Claimant by any person which is not a party to these proceedings, including but not limited to SCB and/or its employees.

155 The above suffices to dispose of the Claimant's claim. For completeness, however, I will deal with some arguments raised by the parties herein which have fallen by the wayside in light of my reasoning thus far.

Other arguments raised by the Claimant

Argument that the Defendant breached its duty of uberrimae fidei.

156 The sole averment in the SOC expressly referencing the duty of *uberrimae fidei* was the following single sentence:

> There is a duty of uberrima fides (utmost good faith) between insurer and insured which actually exists before inception of the policy, for instance the duty of disclosure.

157 With respect, it is impossible to glean from the sentence above any material facts forming the basis for an allegation of a breach of the duty of *uberrimae fidei* by the Defendant, assuming that was the intent of that averment.

158 This difficulty is compounded by the reference, in that averment, to a duty which "exists **before inception** of the policy" (emphasis added).

159 LYT gave clear evidence to the effect that, where the sale of one of the Defendant's policies is carried out by SCB (as the Defendant's bancassurance partner), the Defendant does not communicate with prospective policyholders during the sales process conducted through SCB until the Defendant decides to accept the prospective policyholder's proposal for insurance.[25]

[25] LYT's AEIC at paragraph 16.

160 It was impossible to tell, from the SOC, which aspect of the operations surrounding this relationship the Claimant took issue with, for the purpose of her claim that the Defendant had breached its duty of *uberrimae fidei*.

161 The Claimant's failure to properly plead this cause of action (such as it was) thus unfairly deprived the Defendant of the opportunity to meet the Claimant's case.

162 The impression that the Claimant did not actually have a consistent case premised on *uberrimae fidei* is only reinforced by a comparison of the Claimant's Opening Statement filed for the trial (the "**COS**") and the CCS. In these two documents, the Claimant attempted to give examples of the ways in which the Defendant had supposedly breached its duty of *uberrimae fidei*, but the examples given materially differed between the two documents.

163 There is hence no scope for me to consider the Claimant's allegations based on a breach of the duty of *uberrimae fidei*.

164 Separately, given the manner in which the averment reproduced at paragraph 156 above was framed, it would appear that the duty in question is one imposed by operation of law by reason of the Policy being in the nature of an insurance contract, as opposed to a term expressly or impliedly forming part of the Policy: see *The Stansfield Group Pte Ltd (trading as Stansfield College) and another v Consumers' Association of Singapore and another* [2011] SGHC 122 ("***Stansfield***") at [190].

165 In these circumstances, even if there had been a breach of the duty of *uberrimae fidei*, it would appear that the remedy available to the Claimant would be avoidance of the contract of insurance (i.e. rescission of the Policy),

and not the award of damages that the Claimant has prayed for: see *Stansfield* at [190] and [198].

Argument that the Defendant breached MAS 120

166 The Claimant pleaded in the SOC that the Defendant did not comply with the requirements of a document she identified as "MAS 120".

167 In relation to this allegation, I begin by noting that the SOC did not properly identify the document referred to as "MAS 120".

168 This was construed by the Defendant, in its Defence filed on 30 October 2024 (the "**Defence**"), to be a reference to Notice No. 120 issued by the Monetary Authority of Singapore ("**MAS**"), entitled "Disclosure and Advisory Process Requirements for Accident and Health Insurance Products".

169 The Defendant's assumption about the identity of the document in question eventually proved to be correct, because the Claimant, in her bundle of authorities prepared for the trial, exhibited a copy of the 1 June 2022 version of the MAS Notice (to be referred to as "**MAS 120**" hereafter) described in the preceding paragraph.

170 Whilst the SOC pleaded generally that the Defendant had not complied with MAS 120, it did not contain any description or particulars as to the alleged non-compliance. These alleged failures appeared, for the first time, in the COS.

171 That said, the Claimant still has not taken any steps to make these part of her pleaded case. The Defendant therefore has not had occasion to plead to nor adduce evidence to address the alleged instances of non-compliance raised in the COS.

172 In any event, I accept the Defendant's submission that the Claimant's reliance on MAS 120 as a document entitling her to any remedy in this suit is misconceived.

173 As the Defendant's counsel have pointed out, the Claimant has not explained how, even assuming the Defendant had breached some provision of MAS 120, such a breach would, *per se*, entitle the Claimant to claim damages from the Defendant or generally give rise to any private right of action exercisable by the Claimant in her personal capacity. No such right of private action is expressly provided for in sections 67, 72 and 154(4) of the Insurance Act, pursuant to which MAS 120 states it was issued.

174 For the avoidance of doubt, in stating the foregoing I am not to be taken as having expressed any view as to whether the Defendant did or did not breach MAS 120, as it was not necessary for me to consider this question.

175 For completeness, I note that, in the CCS[26] and the CRS[27], the Claimant sought to cast her reliance on MAS 120 as "evidence of industry standards and regulatory expectations" relevant to my consideration of whether the Defendant breached its duty of *uberrimae fidei*. In this regard, I would refer parties to the preceding segment in these grounds explaining why there is no basis for me to consider a case premised on a breach of the duty of *uberrimae fidei*.

[26] CCS at paragraph 95.

[27] CRS at paragraph 50.

Argument that SCB and/or its employees were agents of the Defendant

176 One argument raised by the Claimant was that TKH had been acting as the Defendant's "authorised sales agent" in dealing with the Claimant in connection with the Policy.[28]

177 As such, the Claimant argued, TKH's "knowledge and his failures are attributable to [the Defendant] as principal".

178 Specifically, the Claimant highlighted that TKH admitted at trial that he did not know that craniotomy and endovascular repair had different morbidity rates. This meant, the Claimant argued, that TKH could not have fulfilled a "disclosure obligation" as an agent of the Defendant because he himself did not understand what needed to be disclosed.[29]

179 With respect, I am unable to agree with this line of reasoning.

180 It is not clear why TKH should be regarded, in law, as the *Defendant's* agent for the purpose of the sale of the Policy to the Claimant.

181 On this issue, in which the Claimant bears the burden of demonstrating that SCB or its employees should be regarded as the Defendant's agent for the sale of the Policy, the Claimant has not referred this court to any authority to demonstrate why TKH should be regarded, in law, as the Defendant's agent.

182 To the contrary, the Defendant's counsel have highlighted that, in *Zurich Insurance*, the CA referred to a "…rule that a person who agrees to procure

[28] CCS at paragraph 78.

[29] CCS at paragraph 79.

insurance for another should be regarded as the *latter's agent* for the purpose of obtaining that insurance…"[30] which, if applied to the facts of this case, would make TKH an agent of the *Claimant*.

183 With respect, the Claimant's failure to identify the legal basis of her assertion of an agency relationship between the Defendant and SCB or its representatives would suffice for the court to reject the same.

184 For completeness, I note that in the CRS, the Claimant did highlight some features of documents relating to the Policy which she argued would lead a "reasonable customer" to believe that TKH was "authorised to act for [the Defendant]".[31] Specifically, she highlighted that:

(a) The Proposal Form bore the Defendant's logo and a field entitled "agency number" allegedly "next to [TKH's name]".

(b) TKH signed his name in a box which was entitled "Signature of Financial Consultant (Witness)".

185 Preliminarily, the assertion in sub-paragraph (a) of the preceding paragraph is factually incorrect. Looking at the document referred to in the CRS[32], TKH's name did not appear next to the "agency number" stated in the Proposal Form.

186 To some degree, this court has had to speculate as to the legal basis which the Claimant intended to invoke in highlighting the matters set out in

[30] *Zurich Insurance* at [157].

[31] CRS at page 5, B.7.

[32] CRS at page 5, B.7

paragraph 184 above, as this was not fleshed out in any meaningful way in the CCS or the CRS.

187 However, to the extent that the Claimant intended to make an argument that the facts I have just rehearsed gave TKH *apparent* authority to act on behalf of the Defendant, such an argument would be fatally undermined by the principle that in insurance law, the purported agent (here, TKH) is held out as having authority to act for the insurer (here, the Defendant) only if there is a representation by the insurer that the agent has such authority: *Tan Yi Lin Cheryl v AIA Singapore Pte Ltd* [2021] SGHC(A) 23 at [16].

188 With respect, the facts highlighted by the Claimant, as reproduced in paragraph 184 above, are simply incapable of bearing the weight of the significance which the Claimant sought to have this court ascribe to them. In my view, neither the "agency number" nor TKH's signature as a "financial consultant (witness)" could reasonably amount to a representation of the type required.

189 In *Zurich Insurance*, the CA did go on to opine that in such circumstances, the person who has "agreed to procure insurance" for another person, and was hence the "latter's agent" for the purpose of obtaining insurance, would owe the latter a duty of care.

190 However, in this case, neither SCB nor TKH has been made a party to these proceedings and the Claimant has not pleaded any cause of action against SCB or its employees premised on them having acted as *her* agent. The question of whether SCB or its employees may be liable as the Claimant's agent therefore does not arise and, for the avoidance of doubt, I should not be taken to have expressed any view on this question.

Judgment

191 By virtue of the foregoing, the Claimant's claim is dismissed.

192 For the avoidance of doubt, nothing herein shall be construed as a finding or direction that the contract of insurance embodied in the Policy has been brought to an end by these proceedings. I reiterate that neither party has suggested that this should be the case.

193 The costs and disbursements of this suit are to be fixed by this court if the parties are unable to agree on the same. Any party wishing to claim disbursements from the other shall forward its list of disbursements to the other party in these proceedings within 7 days hereof. Thereafter, the parties are to file and exchange their respective written submissions on costs and disbursements within 14 days hereof, limited to six pages, if required.

Teo Guan Kee
District Judge

Ms Cai Yanhong, claimant in person;
Mr Joavan Christopher Pereira [Virtus Law LLP] for defendant