

# GROUP INSURANCE PERSONAL HEALTH DECLARATION FORM



|            |                      |
|------------|----------------------|
| Policy No. | <input type="text"/> |
| Date Sent  | <input type="text"/> |

**Important Note:** Pursuant to Section 25(5) of the Insurance Act (Cap.142), you are to disclose in this form, fully and faithfully, all the facts which you know or ought to know, otherwise, nothing may be payable under the policy.

- NOTE:** 1. All questions must be answered electronically or in ink. Dashes, strokes, ditto and N.A. are not acceptable.  
2. Any alteration to the answers in ink must be signed in full  
3. For electronic submission, please send to groupunderwriting@greatasteasternlife.com. Do note that we can only accept submission via your corporate email address.

The "Company" shall mean The Great Eastern Life Assurance Company Limited.

**NAME OF POLICYHOLDER (EMPLOYER)** \_\_\_\_\_

## I) PARTICULARS of the EMPLOYEE / ELIGIBLE MEMBER

|                                                                  |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
|------------------------------------------------------------------|--|-------------------------------------------------------------------------------|--|--|----------------------------------|--|-------------------------------------------------------------------------------|--|--|
| a. Name (According to NRIC / Passport)                           |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| <input type="text"/>                                             |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| b. NRIC / Passport* Number                                       |  |                                                                               |  |  | c. Nationality                   |  |                                                                               |  |  |
| <input type="text"/>                                             |  |                                                                               |  |  | <input type="text"/>             |  |                                                                               |  |  |
| d. Occupation                                                    |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| <input type="text"/>                                             |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| e. Email Address (in current company)                            |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| <input type="text"/>                                             |  |                                                                               |  |  |                                  |  |                                                                               |  |  |
| f. Male <input type="checkbox"/> Female <input type="checkbox"/> |  | g. Date of Birth                                                              |  |  | h. Height <input type="text"/> m |  | i. Date Employed                                                              |  |  |
| Single <input type="checkbox"/> Married <input type="checkbox"/> |  | Day <input type="text"/> Month <input type="text"/> Year <input type="text"/> |  |  | Weight <input type="text"/> kg   |  | Day <input type="text"/> Month <input type="text"/> Year <input type="text"/> |  |  |

## II) FAMILY HISTORY of the EMPLOYEE / ELIGIBLE MEMBER

Has any of your natural parents or sibling(s) died or suffered from cancer\*\*, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)?

Yes ☐ No ☐

**IF YES, PLEASE PROVIDE DETAILS BELOW (\*\*for CANCER, please specify the type of cancer)**

| If Alive                                                  |                                                                      |                             | If Deceased     |                |
|-----------------------------------------------------------|----------------------------------------------------------------------|-----------------------------|-----------------|----------------|
| Relationship<br>(Father, mother, sister(s) or brother(s)) | Please indicate type of Medical Condition<br>and the exact Diagnosis | Age at time<br>of Diagnosis | Age at<br>Death | Cause of Death |
|                                                           |                                                                      |                             |                 |                |
|                                                           |                                                                      |                             |                 |                |
|                                                           |                                                                      |                             |                 |                |

## III) DEPENDANT(S) PARTICULARS – Complete this section only if you are applying for Group Hospital and Surgical Insurance for your dependants. If you have more than 3 children, please furnish the information of all your children after the 3<sup>rd</sup> child on a separate sheet of paper.

| Relationship          | Name (as in NRIC / Passport) | NRIC /<br>Passport No. | Gender | Date of Birth |    |      | Height<br>(m) | Weight<br>(kg) |
|-----------------------|------------------------------|------------------------|--------|---------------|----|------|---------------|----------------|
|                       |                              |                        |        | DD            | MM | YYYY |               |                |
| Spouse                |                              |                        |        |               |    |      |               |                |
| 1 <sup>st</sup> Child |                              |                        |        |               |    |      |               |                |
| 2 <sup>nd</sup> Child |                              |                        |        |               |    |      |               |                |
| 3 <sup>rd</sup> Child |                              |                        |        |               |    |      |               |                |

\*Please delete accordingly.

| IV) HABITS of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE)                                                                                                                                                                                                                             |                                                                     |                                                                     |                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------|
| Please tick Yes or No. If Yes, please provide details in the respective column(s).<br>Please note: Section IV under child(ren) column is not applicable for dependant aged 12 years & below.                                                                                                              | Employee                                                            | Answer ONLY IF to be Insured                                        |                                                                     |
|                                                                                                                                                                                                                                                                                                           | Yes or No                                                           | Spouse<br>Yes or No                                                 | Child(ren)<br>Yes or No                                             |
| 1 Have you ever smoked in the last 12 months?<br>If Yes, please provide details of smoking:<br>a. No. of sticks you smoke per day:<br>b. No. of years since you have been smoking:                                                                                                                        | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ |
| 2 Do you consume beer, wine or other alcoholic beverages?<br>If Yes, please furnish details of alcohol consumption:<br>a. Type of alcohol taken:<br>b. Average weekly consumption with units of measurement:                                                                                              | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ |
| 3 Do you engage in or intend to engage in any sport(s) or occupation of a dangerous / hazardous nature? E.g. scuba / skin diving, motor racing, military / private flying other than as a fare paying passenger, parachuting, etc? If Yes, please state details on the type of sports you participate in: | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ | <input type="checkbox"/> <input type="checkbox"/><br>_____<br>_____ |

| V) PARTICULARS of HEALTH of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE)                                                                                                                                                                                                                                                          |                                                   |                                                   |                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|---------------------------------------------------|---------------------------------------------------|
| Please tick Yes or No. If Yes, please provide details under Section VI.                                                                                                                                                                                                                                                                              | Employee                                          | Answer ONLY IF to be Insured                      |                                                   |
|                                                                                                                                                                                                                                                                                                                                                      | Yes or No                                         | Spouse<br>Yes or No                               | Child(ren)<br>Yes or No                           |
| 1a) Has any proposal for life or disability or health assurance on your life to this or any other insurance office ever been declined, postponed or accepted with special conditions (for example loading or exclusions)?                                                                                                                            | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| b) Have you ever made a claim or intend to make a claim on the insurance policies (for example, for critical illness/disorder, disability, terminal illness, accident, hospitalisation)?                                                                                                                                                             | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 2 Are you now receiving or considering to receive medical treatment from a doctor or intending to consult any doctor for any reason?                                                                                                                                                                                                                 | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 3 Have you ever undergone any health screening or had any medical investigations carried out, whether on your own accord or on the recommendation of a doctor, such as X-ray, ultrasound, electrocardiogram (ECG), barium meal examination, CT scan, biopsy, blood or urine test, etc., in the past 5 years?                                         | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 4 Have you been advised to undergo any diagnostic test or surgical operation that has not yet been performed? Do you intend to have any tests or investigations in the coming year?                                                                                                                                                                  | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 5 Have you ever taken addictive drugs, narcotics, glue sniffing or been treated for drug addiction?                                                                                                                                                                                                                                                  | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 6 Have you ever had or been treated for alcoholism?                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 7 Have you ever had or been told to have or been treated for:                                                                                                                                                                                                                                                                                        |                                                   |                                                   |                                                   |
| a. Diabetes, thyroid disorders, or any other endocrine disorders?                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| b. Asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, bronchitis, chest or breathing complaints or discomfort, and / or any other lung disorders?                                                                                                                                                                               | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| c. Raised cholesterol, high blood pressure, heart attack, rheumatic fever, Kawasaki disease, heart murmur, palpitation, coronary artery disease, mitral valve prolapse, or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or chest pain, and/or any disease or disorders of the heart or blood vessels? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| d. Epilepsy, fits, stroke, paralysis, dementia, Parkinson's disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, unconsciousness, nervous breakdown, depression, or any other nervous or mental disorders, or disease of the brain?                                                    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| e. Gastritis, stomach or duodenal ulcer, blood in the stools, fistula, hernia, haemorrhoids or piles, irritable bowel syndrome, or any other stomach or bowel disorders?                                                                                                                                                                             | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| f. Jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?                                                                                                                                                                                                                                                  | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| g. Albumin or protein in urine, blood or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, urinary or genital organs?                                                                                                                                                                                          | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| h. Slipped disc, gout, any form of arthritis, joint pain or deformity, and/or disorders of the muscles, spine, limbs or joints or severe injury?                                                                                                                                                                                                     | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| i. Anaemia, any other disorders of the blood, advised to abstain from donating blood, or received blood transfusion or blood products on account of haemophilia or any other reason?                                                                                                                                                                 | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| j. Ear discharge, nose bleeds, double vision, or visual impairment or impaired hearing or speech, or any other disorders of the ear, nose, or throat?                                                                                                                                                                                                | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| k. Cancer, tumours, cysts or growths of any kind?                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| l. Congenital anomalies, physical disability or any unusual skin lesions, or any other illness, disorder, operation, hospital admission, accident or injury not mentioned above?                                                                                                                                                                     | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

| V) PARTICULARS of HEALTH of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE)<br>(Continued)                                                                                                                                                                                                               |                                                                    |                                                                    |                                                                    |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--------------------------------------------------------------------|--|
| Please tick Yes or No. If Yes, please provide details under Section VI.                                                                                                                                                                                                                                                  | Employee                                                           | Answer ONLY IF to be Insured                                       |                                                                    |  |
|                                                                                                                                                                                                                                                                                                                          | Yes or No                                                          | Spouse<br>Yes or No                                                | Child(ren)<br>Yes or No                                            |  |
| 8 Have you or your spouse been told to have, or received any medical advice or counselling or treatment in connection with sexually transmitted disease, AIDS, or AIDS Related Complex or any other AIDS related condition?                                                                                              | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 9. a. Have you ever had HIV testing done? (If Yes, please state reason and result under Section VI.)                                                                                                                                                                                                                     | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| b. Have you ever in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?                                                                                                                                    | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 10 Do you have a regular attending doctor?<br>If Yes, please state the name of doctor _____ and the address of clinic _____.                                                                                                                                                                                             | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 11 <b>FOR FEMALE ONLY (Also to be completed for child(ren) aged 12 years &amp; above)</b>                                                                                                                                                                                                                                |                                                                    |                                                                    |                                                                    |  |
| a. Have you ever been found to have or are you aware of any breast lumps or any other disease or disorders of the breast?                                                                                                                                                                                                | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| b. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?                                                                                                                                                                        | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?                                                                                                                                                                                       | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations?                                                                                                                                                                     | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| e. Are you pregnant now?<br>If Yes, please state the weeks / months of pregnancy. (*Delete as appropriate)                                                                                                                                                                                                               | <input type="checkbox"/> <input type="checkbox"/><br>____wks/mths* | <input type="checkbox"/> <input type="checkbox"/><br>____wks/mths* | <input type="checkbox"/> <input type="checkbox"/><br>____wks/mths* |  |
| f. Were there any complications during any of your pregnancy(ies) such as gestational diabetes, hypertension, etc?                                                                                                                                                                                                       | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 12 <b>To answer this question if the Life to be Insured's age is 1 and below.</b>                                                                                                                                                                                                                                        |                                                                    |                                                                    |                                                                    |  |
| 12.1 Name of Life to be Insured: _____                                                                                                                                                                                                                                                                                   |                                                                    |                                                                    |                                                                    |  |
| 12.2 Is the Life to be Insured a premature baby (i.e. less than 37 weeks of gestation)?<br>If yes, please state the following information obtainable from the Child Health Booklet.                                                                                                                                      |                                                                    |                                                                    | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| a) Gestation Period: _____ weeks                                                                                                                                                                                                                                                                                         |                                                                    |                                                                    |                                                                    |  |
| b) Weight and Length at Birth: _____ weight _____ length                                                                                                                                                                                                                                                                 |                                                                    |                                                                    |                                                                    |  |
| c) APGAR score at _____ 1 minute _____ 5 minute                                                                                                                                                                                                                                                                          |                                                                    |                                                                    |                                                                    |  |
| 12.3 Were there significant events during pregnancy/delivery such as but not limited to birth difficulty, congenital deformities, lack of mental development, respiratory distress syndrome, prolonged neonatal jaundice, G6PD deficiency, respiratory disorder? If yes, please provide details below.<br>_____<br>_____ |                                                                    |                                                                    | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 12.4 Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment check?<br>If yes, please provide details below.<br>_____<br>_____                                                                                                                           |                                                                    |                                                                    | <input type="checkbox"/> <input type="checkbox"/>                  |  |
| 12.5 Date and result of last routine check.<br><br>Date: _____ Result: _____                                                                                                                                                                                                                                             |                                                                    |                                                                    |                                                                    |  |

\*Please delete accordingly.

| VI) If the answer to any of the questions in Section V is Yes, please provide with FULL DETAILS here. |                                                       |                                                                                           |                     |    |                                              |
|-------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------|----|----------------------------------------------|
| Question Number                                                                                       | Name of Person Concerned (Employee/Spouse/Child(ren)) | Details of Diagnostic Test with reason & result / Doctor's Diagnosis / Injury / Treatment | Duration of Illness |    | Name of Doctor Consulted & Address of Clinic |
|                                                                                                       |                                                       |                                                                                           | From                | To |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |
|                                                                                                       |                                                       |                                                                                           |                     |    |                                              |

**DECLARATION:** I hereby declare that, to the best of my knowledge and belief the statements and answers given in this health declaration are true, complete and that I have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this application. I understand that any misstatement of fact, whether by commission or omission may be grounds for the Company in its absolute and sole discretion to decline to pay any benefit which may otherwise have been payable. I agree that this application, together with any additional statements signed by me which shall be deemed to be part of this declaration, shall be the basis of the contract of the insurance.

I understand that my application will be subject to acceptance by the Company, and that I and/or my Dependant(s) will not be insured under any of the insurance plan(s) for which my or my Dependant(s)'s application is subject to acceptance until the Company advises the Policyholder the terms and conditions on accepting insurance on myself and/or my Dependant(s), and that the Company reserves the right to decline insurance or impose special terms and conditions.

I understand that:

- (a) if my application for my and/or my Dependant(s)' insurance under any of the above plan(s) is accepted, my and/or Dependant(s)' insurance under the plan shall terminate if the Policyholder does not renew the plan before the expiry of any period of insurance, or cancel the plan, or if I and/or my Dependant(s) attain the age at which I and/or my Dependant(s)' insurance terminates as specified in the terms and conditions of the insurance plan, and
- (b) these plan(s) are yearly renewable and that the terms and conditions of the insurance plan(s) I and/or my Dependant(s) are insured under, including the premiums payable, at any renewal of the plan(s), may change upon agreement between the Policyholder and the Company.

I confirmed to have read and understood the contents of the following documents:

- (a) Your Guide to Health Insurance (you can download from [www.lia.org.sg/consumers/library/consumers\\_guides](http://www.lia.org.sg/consumers/library/consumers_guides))
- (b) Product Summary for voluntary plan

I further agree that this form may be submitted to the Company by facsimile, electronic mail or other electronic means, including via a website or electronic portal designated by the Company. A copy of this form received via any of the above means may be stored electronically or using other means by or as authorized by the Company and the Company shall be entitled to rely on such copy, which shall have the same legal effect and validity as if were the original.

**AUTHORISATION:** I, the undersigned, authorise any medical source, insurance office/ organisation or the Life Insurance Association's medical registry to release any medical record or knowledge about me and/or my Dependant(s) to the Company for risk assessment of my Group Insurance Application. I further consent to, and agree to procure my Dependant(s) to agree and consent, the Company in releasing any information declared in my and/or my dependant(s)' Personal Health Declaration Form / Personal Statement and/or information revealed in my and/or my Dependant(s)' questionnaires, medical reports and laboratory reports to my employer or the administrator and/or the appointed insurance intermediary servicing this Group Insurance Policy. A photocopy of this authorisation shall be as effective and valid as the original.

**PERSONAL DATA:** By providing the information set out above, I agree and consent, and agree to procure my dependant(s) to agree and consent, to the "Company", its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my or my Dependant(s)'s personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate my proposal and to provide the relevant products or services which I am applying or have applied for (including, without limitation, any policy renewals and policy upgrades, substitutions or replacements).

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at <http://www.greateasternlife.com/sg/en/privacy-and-security-policy.html> and which I confirm I have read and understood.

Date: \_\_\_\_\_  
Day/Month/Year  
(Current Date of Completion of this form)

\_\_\_\_\_  
**Signature of Employee/ Eligible Member**  
(If this is an application for Dependant(s), the Employee will sign on behalf of the Dependant(s))

\_\_\_\_\_  
**Name of the Employee/ Eligible Member**