DEPENDANTS' PROTECTION SCHEME
APPLICATION FOR REINSTATEMENT / TOP UP

Great Eastern
A member of the OCBC Group

Reinstating / Topping up Your Coverage

1. DPS is a term-life insurance plan that provides coverage of $70,000 up to the end of the policy year during which you turn 60 years old. From the policy anniversary in which you are 60 age last birthday up to the end of the policy year during which you turn 65 years old, the sum assured is $55,000.
2. The coverage offered is determined by the amount of premiums paid. If you noticed your coverage being lower than expected, you may have paid lesser premiums for the policy. We encourage you to top-up the shortfall to ensure that you receive the maximum cover for your policy.
3. We offer different payment methods such as internet banking, AXS, fund deduction from your CPF savings or cheque. You can choose the payment method that best suits you.

Pay via Internet Banking	**Pay via AXS**	**Pay via fund deduction from CPF savings**	**Pay via Cheque**
1. Select "Great Eastern Life (10 digits)" as the Bill Payee Organisation for OCBC, DBS/POSB, UOB or Standard Chartered Bank account holders. 2. Enter your policy number in the bill reference. 3. Click on *Pay Bills* to complete the payment.	1. Choose "Great Eastern Life". 2. Select DPS. 3. Enter your policy number, name, contact no. and payment amount. AXS payment is available at the physical machines, on the AXS m-Station app and on the AXS e-Station on their website.	1. Check your CPF savings to ensure that there are sufficient funds to pay the premiums. 2. Complete this form and email it to dps-sg@greateasternlife.com. Alternatively, you may choose to mail the form to us.	1. Send a crossed cheque payable to "The Great Eastern Life Assurance Co. Ltd". 2. Write your policy number on the back of the cheque.

4. This form is required if
   (i) you are topping up after 60 days from the date of your renewal date; or
   (ii) if you wish to reinstate your policy. Please note that a lapsed policy can only be reinstated within 120 days from the renewal date, after which you will be required to complete the proposal form.
   You may email the completed form to dps-sg@greateasternlife.com. Alternatively, you may choose to mail the form to us.

For more information regarding DPS, please visit www.greateasternlife.com/dps.

A DETAILS OF POLICY AND POLICYHOLDER

Policy No.		
Full Name of Policyholder		
NRIC No.		
Email Address		
Contact No.	Mobile:	Home:

B MEDICAL UNDERWRITING QUESTIONS

Please tick "Yes" or "No" to the questions below. If your answer is "Yes", please provide details accordingly. **Yes** **No**

1. Please ensure you provide your height and weight: Height: ☐ • ☐☐ m Weight: ☐☐☐ • ☐ kg

2. Has any insurer ever declined or postponed your application or reinstatement for life or health insurance? ☐ ☐
   (If Yes, please provide further details below)

Name of insurer	Type of Policy	Reasons

3. Has any insurer accepted your application or reinstatement for life or health insurance with special terms (e.g. loading or exclusions)? ☐ ☐
   (If Yes, please provide further details below)

Name of insurer	Type of Policy / Loading / Exclusion	Reasons

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
Customer Service Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659
Tel: 1800-248 2888 (Local), (65) 6248 2888 (Overseas)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

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B MEDICAL UNDERWRITING QUESTIONS (CONTINUED)

Please tick "Yes" or "No" to the questions below. If your answer is "Yes", please provide details accordingly. **Yes** **No**

4. Have you ever made or planned to make any life, health or accident claims, including corporate insurance, from us or any other insurer? ☐ ☐
(If Yes, please provide further details below)

Type of claim (e.g. critical illness, hospitalisation, disability, accident)	Details of claims	Date of claim	Name of insurer

5. Have you ever had, been told to have or been treated with any of the following medical conditions? ☐ ☐
a) Ischaemic heart disease/coronary heart disease, heart valve disorders or arrhythmia (irregular heartbeats), b) stroke/cerebrovascular disorders or arteriovenous malformation, c) renal failure or renal dialysis, d) diabetes with complications, e) chronic liver disorders, liver cirrhosis, hepatic encephalopathy, liver failure, f) dementia/Alzheimer's disease, g) severe psychiatric or mental illness, h) motor neuron disease, i) muscular dystrophy, j) paralysis (hemiplegia/paraplegia/quadriplegia), k) multiple sclerosis, l) rheumatoid arthritis with complications, m) systemic lupus erythematosus with complications, n) parkinson's disease with complications, o) pulmonary hypertension or chronic lung disease, p) aplastic anaemia, thalassaemia major or severe blood disorders, q) cancer, growth or tumour, r) drug addiction or alcoholism, s) AIDS/HIV infection or t) any other illness, disorder, injury, physical disability or abnormality not listed above?
(If Yes, please provide further details below)

Medical Condition	Date / Symptoms / Signs	Date of investigation / Type of tests done/ Results / Name of clinic / hospital	Treatment (name of drug) / Surgery (period of hospital admission)	Present condition: (Please tick)
				☐ Still on follow-up ☐ Receiving treatment or ☐ Fully recovered & discharged
				☐ Still on follow-up ☐ Receiving treatment or ☐ Fully recovered & discharged

6. Excluding the medical conditions or symptoms that you have already told us about, have you had or been advised by a doctor to have surgery, medical tests or investigations such as blood test, urine test, x-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check etc during the past 5 years? ☐ ☐
(If Yes, please provide further details below)

Date	Type of test(s) / surgery done	Reason for test(s) / surgery done	Results	Name of clinic / hospital	Follow up / treatment required (please tick)
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____

7. Do you intend to have any surgery, tests or investigations in the coming year? ☐ ☐
(If Yes, please provide further details below)

Date	Type of test(s) / surgery done	Reason for test(s) / surgery done	Results	Name of clinic / hospital	Follow up / treatment required (please tick)
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____

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C DECLARATION

- I declare that the information provided by me in this form is true and correct and I have not withheld any material information, whether entered in by me or on my behalf.
- I agree and authorise any medical source, insurance office or organisation to release to The Great Eastern Life Assurance Company Limited ("GE"), and GE to release to any medical source or insurance office any relevant information concerning me at any time, irrespective of whether the reinstatement or top-up is approved by GE.
- I hereby consent to the transfer and disclosure, at any time and without notice or liability to me of any medical information on me in the insurer's possession to the Central Provident Fund Board
  (a) for the purpose of making a claim under the DPS or any other insurance scheme referred to in the Central Provident Fund Act 1953 which I may be insured under; or
  (b) any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act 1953. I hereby agree that this consent shall not be affected by any subsequent physical or mental disorder, disability or incapacitation which I may suffer from. In addition, I hereby agree that this consent shall remain valid notwithstanding my death.
- There is no change to my existing premium payment arrangement, unless otherwise instructed by me.
  (Note: For existing payment method on CPF savings, a deduction will be made automatically upon approval of underwriting.)

WARNING: PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY.

Signature of Policyholder	**Date**

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