DEPENDANTS' PROTECTION SCHEME HEALTH DECLARATION FORM

Great Eastern
A member of the OCBC Group

Dear Policyholder,

You are strongly encouraged to complete a health declaration for your Dependants' Protection Scheme (DPS) policy to be certain of your eligible coverage. If you are suffering from any undisclosed pre-existing serious illness, claims will not be admitted. If you are unsure about what constitutes as serious illness, please visit our website www.greateasternlife.com/dps.

Steps to completing the Health Declaration Form:

1) Answer all the questions and provide supporting information if required
2) Email the completed form to dps-sg@greateasternlife.com with the subject line "DPS Health Declaration". Alternatively, you may choose to mail the form to us.

Please complete this form and return it to us within 21 days from the date of receiving your Welcome Letter.

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.

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 state: Height: _____ Weight: _____ Occupation: _____

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

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

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

NBUHD/10-23

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**

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: _____

C AUTHORISATION FOR MEDICAL INFORMATION

1. 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.
2. 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.
3. 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.

Signature of Policyholder	**Date**