APPLICATION FOR REINSTATEMENT (FOR LIFE POLICIES ONLY)

Great Eastern
An OCBC Company

WARNING: As required by Section 23(5) of the Insurance Act 1966, you must complete this form fully and faithfully, disclosing all facts which you know or ought to know, otherwise the insurance policy may not be valid.

Important Notes

1) The Great Eastern Life Assurance Company Limited will be referred to as "the Company".
2) Reinstatement is subject to underwriting and payment of premiums and Interest outstanding from date of lapse to reinstatement.
3) Upon underwriting, we may require medical information, the costs of which will be payable by the policyholder.
4) If there are any changes in your personal particulars, please submit the Update of Personal Particulars Form.

Additional Forms to be submitted

1) Pursuant to the Singapore Income Tax Act and regulations thereunder, which implement the standard for automatic exchange of financial account information in tax matters (commonly known as the "Common Reporting Standard" or "CRS"), the Company is legally obliged to obtain a self-certification form from the holder of a policy to which CRS applies, in order to determine the tax residence(s) of such policyholder. CRS does not apply to A&H policies and non-cash value policies. Therefore, please complete the following (if applicable):
   i) If Policyholder is an **Individual,** please complete the **Individual Self-Certification Form**.
   ii) If Policyholder is a **Company,** please complete a separate **Entity Self-Certification Form and Controlling Person Self-Certification Form (if applicable).**
   **For Controlling Persons of a policyholder who is a passive Non-Financial Entity ("NFE"), or an Investment Entity located in a Non-Participating Jurisdiction and managed by another Financial Institution.

   Note: If you have other in-force cash value policy(ies) and have previously provided a Self-Certification Form within the last 90 days, you do not have to submit a new Self-Certification Form.
2) For Reinstatement of PaySecure / PayAssure policy or rider, please attach additional Supplementary Form for PaySecure/ PayAssure

POLICY NO.: _____

Section A: Particulars	**1st Assured (Policyholder / Assignee / Parent)**		**2nd Assured (Child / Spouse / Joint Policyholder)**	
Name				
NRIC or Passport No.				
Height / Weight	m	kg	m	kg
Annual Income				
Source of Wealth & Source of Fund	**Source of Wealth:**	**Source of Fund:**	**Source of Wealth:**	**Source of Fund:**
Occupation & Name of Company				

Section B: Underwriting Questions

Please answer the following questions relating to the respective Life Assured: (Please √ wherever applicable)	**1st Assured**		**2nd Assured**	
	Yes	**No**	**Yes**	**No**
1) Since the commencement of insurance, is there any change in your smoking status, occupation and/or sporting activity(ies)? ***If 'Yes', please provide details below:***	☐	☐	☐	☐
Smoking Status: _____ sticks/day, _____ years / Occupations & duties: / Sporting Activity(ies):				
2) Have you taken any addictive drugs (e.g. narcotics) or been treated for alcoholism or drug addiction? ***If yes, please attach copy of test results and complete a separate Special Health Questionnaire.***	☐	☐	☐	☐
3) Have you ever had or been told to have or been treated for any medical condition or symptoms listed below? ***If yes, please complete a separate Special Health Questionnaire***.				
a) diabetes, thyroid disorders or any other endocrine disorders?	☐	☐	☐	☐
b) asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints / discomfort, or any other lung disease or disorders?	☐	☐	☐	☐
c) raised cholesterol, high blood pressure, heart attack, rheumatic fever, Kawasaki disease, heart murmur, mitral valve prolapse, breathlessness, irregular / fast heart beat, chest discomfort / pain, any other heart or blood vessels disease or disorders?	☐	☐	☐	☐
d) epilepsy, fits, stroke, paralysis, memory disturbance, confusion, dementia, falls, Parkinsons disease, multiple sclerosis, motor neurone disease, weakness of limbs, prolonged headache, unconsciousness, nervous breakdown, depression, any other nervous / mental disorders, or disease of the brain?	☐	☐	☐	☐
e) gastritis, stomach / duodenal ulcer, blood in stools, fistula, piles, or any other stomach / bowel disease or disorders?	☐	☐	☐	☐
f) jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disease or disorder?	☐	☐	☐	☐
g) blood, protein / sugar in the urine, kidney stones, infection or any other disease or disorders of the kidney, bladder or genital organs?	☐	☐	☐	☐
h) slipped disc, gout, arthritis, pain / deformity / disease or disorders of the muscles, spine, limbs or joints, or severe injury?	☐	☐	☐	☐
i) anaemia, any other disease or disorders of the blood, advised to abstain from donating blood, or received blood transfusion or blood products on account of haemophilia or any other reasons?	☐	☐	☐	☐
j) ear discharge, nose bleeds, double vision, impaired sight or hearing or speech, or any disease or any disorders of the eye, ear, nose or throat?	☐	☐	☐	☐
k) cancer, tumours, cysts or growths of any kind?	☐	☐	☐	☐
l) any other illness (e.g. Hand, foot & mouth disease), disorder, operation, physical disability or accident not mentioned above?	☐	☐	☐	☐

POLICY NO.: _____

(Please √ wherever applicable)	1st Assured Yes	1st Assured No	2nd Assured Yes	2nd Assured No
4a) Have you had or been advised to have any medical tests or investigations during the last 5 years or do you intend to have any tests or investigations in the coming year? (e.g. urine test, blood test, X-ray, ECG, Ultrasound, CT scan, biopsy, mammogram, pap smear)	☐	☐	☐	☐
4b) Have you or has your spouse ever taken or been advised to take any tests for Sexually Transmitted Diseases, including HIV & AIDS? ***If yes to any of the above, please attach your medical reports and complete the table below:***	☐	☐	☐	☐

Type & date of test	Reason for test	Test results	Name & address of doctors or clinic

5) Have any of your natural parents or siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease? ***If yes, please complete the table below:***	☐	☐	☐	☐

Relationship	Medical Condition	Age at onset	Age at death (if applicable)

6) Has any of your application or reinstatement of a Life assurance or Health assurance ever been declined, postponed or accepted with special conditions (i.e. loading / exclusion). ***If yes, please complete the table below:***	☐	☐	☐	☐

Insurer name	Type of Policy / Rider (Life, Critical Illness, Accident, Hospitalisation, Disability Income, etc.	Sum Assured ($)	Year of issue / Application

7) Do you have any existing policy(ies), or are you currently applying for any policy(ies) with any financial institution including Great Eastern Life? ***If yes, please complete table below:***	☐	☐	☐	☐

Insurer name	Type of Policy / Rider (Life, Critical Illness, Accident, Hospitalisation, Disability Income, etc.	Sum Assured ($)	Year of issue / Application

8) **You are not required to disclose the result of any Genetic Test done in the context of a Biomedical Research (Biomedical Research refers to any systematic investigation with the intention of developing or contributing to generalizable knowledge, regardless of where or when the research was conducted or the nature of the research) or a Direct-to-Consumer Genetic Test (Direct-to-Consumer Genetic Test means a genetic test that is provided directly to consumers by the manufacturer or supplier of the test). In the event of an accidental disclosure of such a Genetic Test result, we will not use the result for risk assessment unless the result is favourable to you.**				
For Singapore Citizens/ Permanent Residents/ Residents on Valid Passes*, please indicate accordingly if the total sum assured of your current application, any pending application(s) and existing policy(ies) on your life with GE and other insurance company(ies) exceeds the following amounts:				
a) $2,000,000 for Life Protection or Total & Permanent Disability	☐	☐	☐	☐
b) $500,000 for Critical Illness	☐	☐	☐	☐
c) $10,000 for Disability Income	☐	☐	☐	☐
For Non-Singapore Residents, please answer the following question:				
Have you ever undergone any genetic test? If yes, please provide a copy of genetic test result.	☐	☐	☐	☐
9) **For females only:**				
a) Are your currently pregnant? ***If yes, please state duration:*** _____ months	☐	☐	☐	☐
b) Have you suffered from any breast lump or disease(s) of the breast, irregular or painful menstruation, abnormal pap smear, growths or pregnancy(ies) complication(s)? ***If yes, please complete a separate Special Health Questionnaire.***	☐	☐	☐	☐

Footnote:
**Resident on valid pass means any individual who is:*
a) a Singapore resident who holds a work pass/permit and has resided in Singapore for not less than a total of 183 days in last 12 months
b) a Singapore resident who holds a pass/permit with a duration longer than 90 days and has resided in Singapore for at least 90 consecutive days in last 12 months

POLICY NO.: _____

(Please √ wherever applicable)	1st Assured		2nd Assured	
	Yes	No	Yes	No
For reinstatement of LifeSecure policy / rider, please complete Questions 10 & 11:				
10) Do you need any assistance of another person or mechanical aids such as cane, crutches, wheelchar or walker in the performance of the activities of daily living such as washing (bathing), dressing, feeding (eating), walking, transferring from bed to chair, and maintaining continence? ***If yes, please provide details:*** _____	☐	☐	☐	☐
11) Are there any day to day activities such as housework, preparing for meals, shopping, using public transport, or any hobby which you have stopped doing in the last year due to your health condition(s)? ***If yes, please provide details:*** _____	☐	☐	☐	☐

Section C: Declarations

1. I/We agree to inform the Company if there is any change in the state of health between the date of this application and before the date the reinstatement endorsement is issued by the Company. On receiving this information, the Company is entitled to accept or reject the application.
2. By providing the information set out above, I/we agree and consent to Great Eastern and its related corporations (collectively, the "Companies"), as well as their respective representatives, agents, the Companies' authorised service providers and relevant third parties (the Companies and all the other foregoing parties, collectively, "Great Eastern Persons") collecting, using, disclosing, and sharing amongst themselves my/our personal data, for purposes reasonably required by the Companies to evaluate my/our proposal and to provide the products or services which I am/we are applying for (including any policy renewals and policy upgrades, substitutions or replacements) and such other purposes as described in Great Eastern's Privacy Statement (collectively, the "Purposes").
   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/we confirm I/we have read and understood.
3. I/We declare that the information given in this application and any questionnaire(s)/forms and all subsequent written notices furnished to the Company are true, correct and complete to the best of my/our knowledge and belief and that no material fact(s), that is, fact(s) likely to influence the assessment and acceptance of this application have been withheld. I/We further agree that any information that I/we have provided to the Financial Representative are disclosed in this application.
4. I/We agree that this application form and the policy, all subsequent written notices given by the Company to me/us and all subsequent written statements given by me/us to the Company will make up the whole of the Contract of insurance between the Company and me/us.

_____
Signature of 1st Assured (Policyholder / Assignee / Parent)
(and Company Stamp, if applicable)

Date: ___ ___ / ___ ___ / ___ ___ ___ __

Contact No. : _____

_____
Signature of 2nd Assured (Child* / Spouse / Joint Policyholder)
* Only required if childe is 16 years old & above

Date: ___ ___ / ___ ___ / ___ ___ ___ __

Contact No. : _____