APPLICATION FOR REINSTATEMENT (FOR LIFE POLICIES ONLY)



WARNING: As required by Section 25(5) of the Insurance Act (Cap. 142), 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

POLICY NO.:

- 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) Only completed form with original signature will be accepted.
- 5) 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 submit:

- i) the Individual Self-Certification Form if the policyholder is an individual; or
- in the Entity Self-Certification Form if the policyholder is a company. 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, please also complete the Controlling Persons Self-Certification Form.

Note: If you have other in-force cash value policy(ies) and have previously provided a Self-Certification Form which is still valid, 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.

Section A: Particulars	: Particulars 1 st Assured (Policyholder / Assignee / Parent) 2 nd Assured (Child / Spous			se / Joint Policyholder)					
Name									
NRIC or Passport No.									
Height / Weight	nt / Weight m kg m				kg				
Annual Income (SGD)									
O attack B. Hadamadia									
Section B: Underwriting	Questions					1 st As	curod	2nd As	curod
Please answer the following questions relating to the respective Life Assured:						Yes	No No	Yes	No
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:						0	0	0	0
Smoking status:	status:sticks/day, Occupation & 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.						0	0	0	0
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?						0	0	0	0
b) asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort, or any other lung disease or disorder?						0	0	0	0
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 disorder?							0	0	0
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?						0	0	0	0
e) gastritis, stomach/duodenal ulcer, blood in stools, fistula, piles, or any other stomach/bowel disease or disorder?						0	0	0	0
f) jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disease or disorder?						0	0	0	0
g) blood, protein/sugar in urine, kidney stones, infection, or any other disease or disorder of kidney, bladder or genital organs?						0	0	0	0
h) slipped disc, gout, arthritis, pain/deformity/disease or disorder of the muscles, spine, limbs or joint, or severe injury?						0	0	0	0

POLI	CY NO.:								
i)	transfusion or blood produ	ase or disorder of the blood, advised to ab acts on account of haemophilia or any other		g blood, or r	eceived blood	0	0	0	0
j)	j) ear discharge, nose bleeds, double vision, impaired sight or hearing or speech, or any disease or any disorder of the eve. ear. nose or throat?					0	····	0	·····
) cancer, tumours, cysts or						·····	0	·····
l)	any other illness (e.g. Han above?	d, foot & mouth disease), disorder, operatio	n, physical disability	or accident	not mentioned	0	0	0	0
4) a	4) a) 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)						0	0	
b)		ouse ever taken or been advised to take a	any tests for Sexua	ally Transmit	tted Diseases,	0	0	0	0
	If yes to any of the above,	please attach your medical reports and co	mplete the table be	low:					
	Type & date of test	Reason for test	Reason for test Test results Name		Name & ac	Idress o	f docto	r or clini	<u>C</u>
								1 .	
							sured	2nd A	
5) LI	ave any of your natural na	rents or siblings died or suffered from cance	or hoart discass s	troko hiah h	lood proceuro	Yes	No	Yes	No
di	abetes, kidney disease, me yes, please complete the ta	ental disorder, tuberculosis or any hereditary	er, rieart disease, s / disease?	troke, riigir b	noou pressure,		0		0
	Relationship	Medical condition		Age a	ıt onset	Age at death (if applicat			able)
							•••••	••••••	•••••
		or reinstatement of a Life assurance or Hea ditions (i.e. loading/ exclusion). <i>If yes, pleas</i>			ed, postponed	0	0	0	0
	Insurer name	Type of Policy / Rider (Life, Critical Illness, Accident, Hospitalisation, Disability Income, etc.)			ason				
								•••••	*******
7) D in	o you have any existing polluding Great Eastern Life?	olicy(ies), or are you currently applying fo? If yes, please complete the table below:	r any policy(ies) w	ith any finan	icial institution	0	0	0	0
	Insurer name	Type of Policy / Rider (Life, Critical Illness, Accident, Hospitalisation, Disability Income, etc.) Sum Assured (\$)		Year of issue / Application			ation		
• • •							•••••		******
, a)		t? If yes, please state duration:				0	0	0	0
	Have you suffered from ar	ny breast lump or disease(s) of the breast, in ncy(ies) complication(s)? If yes, please com	rregular or painful m	nenstruation, ecial Health	abnormal pap <i>Questionnaire</i> .	0	0	0	0
For	reinstatement of LifeSec	ure policy or rider, please complete Que	stions 9 & 10:						
9) Do you need any assistance of another person or mechanical aids such as cane, crutches, wheelchair 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:					0	0	0	0	
0) A	re there any day to day ac	tivities such as housework, preparing for med doing in the last year due to your health	neals, shopping, usi	ing public tra	ansport, or any	0	0	0	
lf	yes, please provide details	:							

POLICY NO.:	
Section C: Declarations	
I/We agree to inform the Company if there is any change in the state reinstatement endorsement is issued by the Company. On receiving this	
data, and disclosing such personal data to the Companies' authorised ser	e Company, its related corporations (collectively, the "Companies"), as well cling, using, disclosing and sharing amongst themselves my/our personal rvice providers and relevant third parties for purposes reasonably required ts or services which I am/ we are applying for (including, without limitation,
These purposes are set out in Great Eastern's Privacy Statement, which i which I/we confirm I/we have read and understood.	s accessible at http://www.greateasternlife.com/sg/en/pncpolicies.htm and
	estionnaire(s)/forms and all subsequent written notices furnished to the and belief and that no material fact(s), that is, fact(s) likely to influence the urther agree that any information that I/we have provided to the Distribution
4. I/We agree that this application form and the policy, all subsequent wri statements given by me/us to the Company will make up the whole of the	
Signature of 1st Assured (Policyholder / Assignee / Parent) (and Company stamp, if applicable)	Signature of 2 nd Assured (Child* / Spouse / Joint Policyholder) * Only required if child is 16 years old & above
Date: _ D _ D / M _ M _ / _ Y _ Y _ Y _ Y	Date: _ D _ / _ M _ M _ / _ Y _ Y _ Y _ Y _
Contact No.:	Contact No.: