APPLICATION FOR BENEFIT AMENDMENT FOR ELDERSHIELD COMPREHENSIVE / GREAT CARESHIELD

Great Eastern
A member of the OCBC Group

WARNING: 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 YOU MAY RECEIVE NOTHING FROM THE POLICY.

A DETAILS OF POLICY AND POLICYHOLDER

Plan Type	ElderShield Comprehensive	GREAT CareShield
Policy No.		
Full Name of Policyholder		
NRIC No.		
Email Address		
Contact No.	Mobile: Home:	

B INCREASE IN BENEFITS

Notes
1. The maximum benefit amount is capped at $3,000 for ElderShield Comprehensive and $5,000 for GREAT CareShield.
2. Increase in benefits is only allowed for the first policy year.
3. Increase in benefits will take effect from the policy commencement.

I would like to increase my benefits for the policy indicated in Section A from $_____ to $_____ (in multiples of $100).

Please answer the following:

	Yes	No
1. Do you need assistance of another person or mechanical aids in the performance of your activities of daily living such as washing (bathing), dressing, feeding (eating), walking, transferring from bed to chair and maintaining continence; or in the past 12 months, have you stopped doing any of the following day to day activities due to your health condition(s): - housework, preparing meals, opening and sorting mails, using public transport, shopping for groceries or personal needs, participating in social activities?	☐	☐
2. Have you been diagnosed with the following condition(s): Cancer, Diabetes, Heart diseases, Stroke, Depression, Nervous breakdown, Kidney diseases, Liver diseases, Lung diseases, Dementia, Alzheimer's disease, Parkinson's disease, Motor neurone disease, Multiple Sclerosis, AIDs or HIV infection, Arthritis, Paralysis, Spinal conditions or any other serious condition(s)?	☐	☐

If the answer is "Yes" to any of the above questions, please give details below and complete the Special Health Questionnaire for each medical condition.

_____

_____

_____

C DECREASE IN BENEFITS

Notes
1. The minimum benefit amount to be maintained for the policy is $300.
2. Any subsequent increase in benefits will be subjected to satisfactory health underwriting once the decrease in benefits is effective.
3. Decrease in benefits will take effect from the next renewal date and there will be no refund of premium.

I would like to decrease my benefits for the policy indicated in Section A from $_____ to $_____ (in multiples of $100).

D DOWNGRADE OF PLAN TYPE (ONLY APPLICABLE TO GREAT CARESHIELD)

Note
Downgrade of plan will take effect from the next renewal date and there will be no refund of premium.

☐ I would like to downgrade my plan type for the policy indicated in Section A to "Enhanced".

- Please complete the next page -

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) Fax: (65) 6535 2836 / (65) 6534 5568
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

CS605 NOV 2020

Plan Type	ElderShield Comprehensive	GREAT CareShield
Policy No.		

E DECLARATION

1. If the benefits, terms or conditions of the basic ElderShield / CareShield Life are amended, The Great Eastern Life Assurance Company Limited (the "Company") may make corresponding amendments to the benefits, terms and conditions for those covered under the ElderShield Comprehensive / GREAT CareShield with effect from the next renewal date.
2. I agree and authorise any medical source, insurance office or organisation to release to the Company, and the Company to release to any medical source or insurance office any relevant information concerning me at any time, irrespective of whether the proposal is accepted by the Company.
3. I confirm that I am not an undischarged bankrupt and that no Statutory Demand has been served on me and no bankruptcy order has been made against me.
4. Any endorsement(s) or variation(s) on my policy which have been authorised by the Company shall apply to my policy upon the renewal of my policy on the effective date or upgrade, whichever is applicable.

5.1 ☐ I understand that the premiums will be increased to $_____ as advised by my Financial Representative. I would like to deduct the balance required premium as follows:

☐ **CPF MediSave**

To be deducted from the following CPF MediSave Account(s) for my current and future premium payments:

Name of CPF Account Holder	Date of Birth	NRIC No. / CPF Account No.	Relationship to Policyholder*	% of Premium**	Signature of CPF Account Holder
				%	
				%	

* The CPF Account Holder must be the Policyholder or the spouse / child / parent / grandchild / sibling of the Policyholder.

** Percentage in whole number. Total CPF contribution must add up to 100%. If there is no indication, total contribution will be taken as 100%. In the event when the deduction is unsuccessful or partial, balance premium will have to be paid by cash/cheque.

Authorisation by the CPF Account Holder(s)

(a) I/We authorise the CPF Board to deduct the premium(s) due for the Policyholder to be covered under the policy from my/our MediSave Account(s) in accordance with the provisions of the Central Provident Fund Act (Chapter 36), and the regulations made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the CPF Board from time to time.

(b) I/We authorise the CPF Board to deduct the available amount in my/our MediSave Account(s) in the event that the balance in my/our MediSave Account(s) is not sufficient to pay for the premium(s) due.

(c) I/We authorise the CPF Board to disclose/seek information on a confidential basis to/from any insurer(s) such information relating to the deduction from my/our MediSave Account(s) as CPF Board shall reasonably consider appropriate.

☐ **CHEQUE**

To pay full premium by cheque (I will send a crossed cheque made payable to "Great Eastern Life" with my policy no. and contact no. on the reverse side of the cheque)

☐ One-time request. Only for current premium. Future premiums shall be deducted from the MediSave Account(s) previously instructed or as indicated above.

☐ For current and future premium payments. I will send a crossed cheque yearly.

5.2 ☐ I do not know how much the premium is. Please send me a consent for deduction to advise on the premium change.

Signature of Policyholder	**Date**

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) Fax: (65) 6535 2836 / (65) 6534 5568
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

CS605 NOV 2020