

**APPLICATION FOR CHANGE
FOR ACCIDENT & HEALTH POLICIES ONLY**

POLICY NUMBER (S): _____

NAME OF POLICYHOLDER: _____

NRIC NUMBER / PASSPORT NUMBER: _____

Please tick the check boxes

PAYMENT CHANGES

1. Change of Payment Frequency

Note: This is not applicable for Supreme Health Plan (SHP only allows for yearly mode)

Yearly

Monthly (Please submit GIRO Application Form - CS105 or Credit Card Authorisation Form - CS243)

2. Payment Method for Supreme Health Policy

I wish to change the Payment Method from CPF Medisave to Cash
(Note: Please select this option only if you wish to pay full premium via Cash/ Cheque, Recurrent Credit Card or Giro)

I wish to change the Payment Method from Cash to CPF Medisave
I confirm my CPF Medisave Account Number: _____ (Compulsory)
If you have obtained residency (Singapore Citizen/ Singapore Permanent Resident), please provide us a copy of your NRIC.

1. I understand that future premium(s) under the policy(ies) stated above will be deducted from my Medisave Account.
2. I authorise CPF Board to deduct the premium(s) due for the Live(s) to be covered as named under the policy(ies) stated above from my Medisave Account in accordance with the provision of the CPF Act (Chapter 36), and the regulations made thereafter as amended from time to time subject to all terms and conditions as may be imposed by CPF Board from time to time.
3. I authorise CPF Board to deduct the premium(s) due under the policy from my new Medisave Account should I be given a new Medisave Account upon obtaining Singapore Permanent Residence Status.
4. I authorise the CPF Board to disclose information/ seek information on a confidential basis to/ from any insurer(s) relating to:
 - (a) Payment of premium(s) due under this policy(ies) stated above, including the deduction of premiums from my Medisave Account/ new Medisave Account; and
 - (b) The making of refund(s) under this policy(ies) stated above, as CPF Board shall reasonable consider appropriate.
5. I/We, the Life/Lives Assured named under this application, hereby consent to the transfer and disclosure, at any time and without notice to me/ us, of any medical information on me/us, in the insurer's or the CPF Board's possession, between:
 - (a) The Insurer and the CPF Board; and
 - (b) The Insurer and other Insurers administering or operating an insurance scheme referred to in section 77(1)(k) of the Central Provident Fund Act (Chapter 36), for the purpose of assessing the insurability of me/us and/or the making of a claim under the Central Provident Fund (Medishield Scheme) Regulations (Rg.20) or under an insurance scheme referred to in section 77(1)(k) of the Central Provident Fund Act (Chapter 36).
6. I hereby consent to be bound by the terms and conditions under the policy stated above.

POLICY CHANGES

3. Change in Occupation/ Avocation/ Country of Residence

Change of Life Assured's occupation to _____. I understand that the new premium payable will be based on the new occupation.

Brief description of duties: _____

Date of Change: _____

The Life Assured has taken new avocation / hobby(ies). I understand that the new premium payable will be adjusted accordingly based on the newly acquired avocation / hobby(ies).

New Avocation / Hobby(ies): _____

Brief description: _____

Change of Country of Residence: _____ (other than Singapore)

Date of Departure: _____ Period of Stay: _____

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**4. Reduction of Benefits
(Applicable for Standalone Accident Plans Only)**

Reduction in sum assured
Benefit Type : _____ Sum Assured : From \$ _____ To \$ _____
Benefit Type : _____ Sum Assured : From \$ _____ To \$ _____

Downgrade of Plan
Plan Type : From _____ To _____

Note: Changes will take effective from next renewal

**5. Downgrade of Plan & Cancellation of Rider
(Applicable for HSP/ PHP/ Supreme Health/ Total Health/ Supreme MediCash)**

Downgrade of Plan (Supreme Health/ Total Health/ Supreme Medicash)

Supreme Health A Plus B Plus Standard Plan (To submit duly signed Policy Illustration & Product Summary. Please contact Distribution Representative for assistance.)
Total Health Platinum Select Gold Silver

Downgrade / Cancellation of Total Health Plus Rider

Total Health Plus Rider Downgrade to Essential
 Cancellation of Rider

Supreme MediCash A B

Downgrade of Plan (HSP / PHP)

Plan Type : From _____ To _____

Notes:

- i) Supreme Health Plan and Total Health Plan should be of matching plan types as per the Boxes.
- ii) Downgrade of plan and Cancellation of rider will take effect from next policy renewal date.
- iii) Foreigners have to maintain at P Plus and Platinum.
- iv) No matching of the plan types is required for Total Health Plus Rider and Supreme MediCash.

6. Delete Life Assured / Cancellation of Policy

To delete the following Life Assured:

Name of Life Assured	NRIC Number

Note: For deletion of Life Assured from the policy, please note that medical conditions that develop subsequently may not be covered if the life is to be added again.

Cancellation of Policy (Please indicate the policy number(s) on Page 1)

Supreme Health + Total Health* Others (PA standalone plans): _____
 Supreme Health only * Supreme MediCash
 Total Health only Global Advantage

Note:
*The Total Health for the same Life Assured will be terminated automatically upon the cancellation of this Supreme Health policy.

7. Other Requests

Others: _____

Current Signature of Policyholder / Assignee
(as per records)

Contact No. / E-mail Address

Date

Any photocopied/downloaded forms submitted must be an exact duplicate of the original. The Company will not be responsible for the validity of any photocopied / downloaded forms submitted which are not exact duplicates.