APPLICATION FOR REINSTATEMENT FOR ELDERSHIELD / GREAT CARESHIELD

Great Eastern
A member of the OCBC Group

Reinstatement is subject to approval of underwriting by the Company and payment of outstanding premiums.

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	GREAT CareShield
Policy No.		
Full Name of Policyholder		
NRIC No.		
Email Address		
Contact No.	Mobile:	Home:
Current Height and Weight	Height: ☐ • ☐☐ M	Weight: ☐☐☐ • ☐ KG

B DECLARATION OF HEALTH

I request to reinstate the expired policy indicated in Section A on the terms and conditions of the latest version of the Policy issued by the Great Eastern Life Assurance Company (the "Company") subject to the terms of this Reinstatement.

Please answer the questions below accordingly.

Since the termination date:

	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 questions above, please give details below and complete the Special Health Questionnaire for each medical condition.

_____

_____

_____

C DECLARATION

I declare that the to the best of my knowledge and belief, the information given is true, correct and complete, that I have not withheld any material facts which are likely to influence the assessment or acceptance of this application.

By providing the information set out above, I/we agree and consent to Great Eastern, its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my/our personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties 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, without limitation, any policy renewals and policy upgrade, substitutions or replacements).

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.

There is <u>no change</u> to my existing premium payment arrangement, unless otherwise instructed in Section D.
(Note: For existing payment method on CPF MediSave / GIRO / Credit Card, a deduction will be made automatically upon approval of underwriting)

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

CS604 NOV 2020

Plan Type	ElderShield	GREAT CareShield
Policy No.		

D CHANGE IN PAYMENT METHOD (TO BE FILLED OUT AND SIGNED ONLY WHEN YOU WISH TO CHANGE YOUR PAYMENT METHOD)

Please tick the relevant box(es) below:

I would like to **change the payment method** for the policy indicated in Section A as follows:

☐ **CPF MEDISAVE**

To deduct 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.

☐ **GIRO / CREDIT CARD**

Please attach the GIRO / Credit Card form and indicate if it is meant for full premium or only the balance after MediSave deduction.

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

CS604 NOV 2020