CHANGE OF PAYER FOR SUPREME HEALTH PLAN

Great Eastern
A member of the OCBC Group

PLEASE READ THE FOLLOWING BEFORE COMPLETING THIS FORM

1. The Great Eastern Life Assurance Company Limited will be referred to as "the Company".
2. This form can only be used for change of payer in respect of one relevant policy.
3. Only completed form with original signature will be accepted.
4. Change of payer, once approved, will be effective from the next renewal date. Please submit your application at least 1 month before the next renewal date with
   (a) a copy of the New Payer's ID (front & back) if the New Payer is an individual; or
   (b) a copy of ACRA, and a copy of authorisation document listing the authorised person(s) appointed to conduct business on behalf including their specimen signatures if the New Payer is a company.
5. For premium payment using Medisave, the Life Assured must be the Policyholder or the spouse / child / parent / grandparent of the Policyholder, for whom the Policyholder is allowed to deduct premium from CPF Medisave account. For other relationships – uncle, aunt, brother, sister, you are required to seek approval from CPF Board.

A DETAILS OF POLICY & LIFE ASSURED

(1) Policy No.	
(2) Full Name of Life Assured	
(3) Identification No. of Life Assured	

B DETAILS OF NEW PAYER / POLICYHOLDER

(1) Full Name of New Payer		
(2) Date of Birth of New Payer (if an individual) or Date of Incorporation (if company)	(DD / MM / YYYY)	
(3) Identification No. of New Payer (if an individual) or Unique Entity No. or Registration No. (if company)		
(4) CPF Account No. of New Payer (Applicable if New Payer has CPF Account)		
(5) Residential Address of New Payer (if an individual) or Registered Address (if company)	Postal Code:	
(6) Other Mailing Address of New Payer (if Residential / Registered address is not to be used for mailing)	Postal Code:	
(7) Reason for using Other Mailing Address (applicable if New Payer is an individual)		
(8) Contact No. of New Payer	Mobile	+ (country code) - (area code for foreign numbers) - (contact number) + - -
	Home	+ - -
	Office	+ - -
(9) Relationship of New Payer to Life Assured	☐ Self ☐ Spouse ☐ Parent ☐ Child	
	☐ Grandparent ☐ Employer ☐ Others, pls specify:	

The Great Eastern Life Assurance Company Limited (Reg. No. 1908 00011G)
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

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Policy No.										

C DECLARATION BY NEW PAYER / POLICYHOLDER

Please tick accordingly.

☐ New Payer with CPF Account

1. I understand that future premium(s) under the policy stated above will be deducted from my Medisave Account.
2. I authorise CPF Board to deduct the premium(s) due for the Life/Lives to be covered as named under the policy stated above from my Medisave Account in accordance with the provision of the CPF 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 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 CPF Board to disclose/seek information on a confidential basis to/from any insurer(s) such information relating to:
   (a) payment of premium(s) due under the policy stated above, including deduction of premiums from my Medisave Account / new Medisave Account; and
   (b) the making of refund(s) under the policy stated above, as CPF Board shall reasonably consider appropriate.
5. I/We, the Life/Lives to be 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, 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 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.

☐ New Payer without CPF Account

Please note that the payment method will be defaulted to "Cash" if the New Payer does not have a CPF Account. Please inform the Company should you obtain a Medisave Account upon obtaining Singapore Permanent Residence status.

Date (DD / MM / YYYY)	**Signature of New Payer / Policyholder** If company, please place the company stamp & provide Name of authorised signatory: Identification No. of authorised signatory:	**Signature of Life Assured (16 years old & above), if Life Assured is not the New Payer / Policyholder**

Signature of Witness (at least 21 years old)

Name:

Identification No.:

Address:

Contact No.:

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