DEPENDANTS' PROTECTION SCHEME HEALTH DECLARATION FORM

Great Eastern
A member of the OCBC Group

Dear Policyholder,

You are strongly encouraged to complete a health declaration for your Dependants' Protection Scheme (DPS) policy to be certain of your eligible coverage. If you are suffering from any undisclosed pre-existing serious illness, claims will not be admitted. If you are unsure about what constitutes as serious illness, please visit our website gogreat.sg/dps.

Steps to completing the Health Declaration Form:

1) Answer all the questions and provide supporting information if required
2) Email the completed form to dps-sg@greateasternlife.com with the subject line "DPS Health Declaration". Alternatively, you may choose to mail the form to us.

Please complete this form and return it to us within 21 days from the date of receiving your Welcome Letter.

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 THAT YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY.

A DETAILS OF POLICY AND POLICYHOLDER

Policy No.	
Full Name of Policyholder	
NRIC No.	
Email Address	
Contact No.	Mobile: Home:

B MEDICAL UNDERWRITING QUESTIONS

Please tick "Yes" or "No" to the questions below.

1. Please state: Height: _____ Weight: _____ Occupation: _____

	Yes	No
2. Have you ever had or been told to have or been treated for any of the following medical conditions? a) Ischaemic heart disease/coronary heart disease, heart valve disorders or arrhythmia (irregular heartbeats), b) stroke/ cerebrovascular disorders or arteriovenous malformation, c) renal failure or renal dialysis, d) diabetes with complications, e) chronic liver disorders, liver cirrhosis, hepatic encephalopathy, liver failure, f) dementia/Alzheimer's disease, g) severe psychiatric or mental illness, h) motor neuron disease, i) muscular dystrophy, j) paralysis (hemiplegia/paraplegia/quadriplegia), k) multiple sclerosis, l) rheumatoid arthritis with complications, m) systemic lupus erythematosus with complications, n) parkinson's disease with complications, o) pulmonary hypertension or chronic lung disease, p) aplastic anaemia, thalassaemia major or severe blood disorders, q) cancer, growth or tumour, r) drug addiction or alcoholism, s) AIDS/HIV infection or t) any other illness, disorder, injury, physical disability or abnormality not listed above? (If Yes, please provide further details below)	☐	☐

Medical Condition	Date/ Symptoms/ Signs	Date of investigation/ Type of tests done/ Results/ Name of clinic/ hospital	Treatment (name of drug)/ Surgery (period of hospital admission)	Present condition: (please tick)
				☐ Still on follow-up ☐ Receiving treatment or ☐ Fully recovered & discharged
				☐ Still on follow-up ☐ Receiving treatment or ☐ Fully recovered & discharged

3. Other than for the medical conditions or symptoms that you have already told us about, have you had or been advised by a doctor to have surgery or any medical tests / investigations (for example blood test, urine test, x-ray, ECG, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check) during the past 5 years? Or do you intend to have any surgery or tests or investigations in the coming year? (If Yes, please provide further details below)	☐	☐

Date	Type of test(s)/ surgery done	Reason for test(s)/ surgery done	Results	Name of clinic/ hospital	Follow up/ treatment required (please tick)
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____
					☐ No follow-up/ treatment required ☐ Follow-up/ treatment required ☐ Type of treatment: _____ ☐ Name of drug: _____

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

NBUHD/04-21

	Yes	No
4. Have any of your applications or reinstatement of a life insurance or health insurance policy ever been declined, postponed or accepted with special conditions (for example loading or exclusions)? (If Yes, please provide further details below)	☐	☐

Name of insurer	Type of Policy/ Loading/ Exclusion	Reasons

	Yes	No
5. Have you ever made any claims or are you intending to make any claims under any life, health or accident policies, whether individual or group plans, with us or any other insurer? (If Yes, please provide further details below)	☐	☐

Type of claim (e.g. critical illness, hospitalisation, disability, accident)	Details of claims	Date of claim	Name of insurer

C AUTHORISATION FOR MEDICAL INFORMATION

1. I agree and authorize any medical source, insurance office or organization 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 reinstatement or top-up is approved by the Company.
2. I hereby consent to the transfer and disclosure, at any time and without notice or liability to me of any medical information on me in the insurer's possession to the Central Provident Fund Board (the 'CPFB') for:
   a. The purpose of making of a claim under the DPS or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 35) which I may be insured under; or
   b. Any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act (Chapter 36).
3. I declare that the information provided by me in this form is true and correct and I have not withheld any material information, whether entered in by me or on my behalf.
4. I hereby agree that this consent shall not be affected by any subsequent physical or mental disorder, disability or incapacitation which I may suffer from. In addition, I hereby agree that this consent shall remain valid notwithstanding my death.

Signature of Policyholder	**Date**

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