DEPENDANTS' PROTECTION SCHEME
APPLICATION FOR REINSTATEMENT / TOP-UP

Great Eastern
A member of the OCBC Group

This Form must be completed if you want to (a) reinstate your lapsed policy or (b) top-up your basic sum assured

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.

POLICY NO.: ☐☐☐☐☐☐☐☐☐☐ **NRIC NO. / CPF A/C NO.:** ☐☐☐☐☐☐☐☐☐

NAME OF POLICYHOLDER : _____

CONTACT: _____ **(HOME)** _____ **(HP)**

Instructions For Filling Up This Application Form

1. Please complete Section A only if a) you want to reinstate your lapsed policy or b) your top-up is done more than 60 days after your renewal date. If your top-up is done within 60 days from your renewal date, you need not complete Section A.
2. Section B is compulsory for payment instructions.

Section A : Medical Underwriting Questions

1. Have you ever had or been told to have or been treated for any of the following medical conditions? If Yes, please provide details below. (a) ischaemic heart disease/coronary heart disease, heart valves disorders or arrhythmia (irregular heartbeats), (b) cancer, (c) stroke/cerebrovascular disorders, tumour of the brain or arteriovenous malformation, (d) renal failure or renal dialysis, (e) diabetes with complications, (f) chronic liver disorders, liver cirrhosis, hepatic encephalopathy, liver failure, (g) AIDS/HIV infection, (h) dementia/Alzheimer's disease, (i) severe psychiatric or mental illness, (j) motor neuron disease, (k) muscular dystrophy, (l) paralysis (hemiplegia/paraplegia/quadriplegia), (m) chronic lung disease, (n) rheumatoid arthritis with complications, (o) multiple sclerosis, (p) systemic lupus erythematosus with complications, (q) parkinson disease with complications, (r) pulmonary hypertension, (s) aplastic anaemia, thalassaemia major or severe blood disorders, or (t) any other illness, disorder, injury, physical disability or abnormality not listed above?

Yes ☐ No ☐

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 ☐ fully recovered and discharged
				☐ still on follow up ☐ receiving treatment ☐ fully recovered and discharged

2. 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 last 5 years? Or do you intend to have any surgery or tests or investigations in the coming year? If Yes, please provide 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) If Yes, please provide details including type of treatment & name of drug
					☐ Yes ☐ No If Yes, _____

3. Have you ever used drugs or substances in an illegal way or drug addiction or had alcoholism? If yes, please provide details below. ☐ ☐

Type of substance/ alcohol used	Period of usage	Date of completion of treatment	Name of clinic/hospital	Date of complete abstinence	Fully discharged? (Please tick)
					☐ Yes ☐ No

Please complete the next page.

Reinstatement / Top-Up after 60 days from renewal date is subject to underwriting by the Company.

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

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CS902 MAY 2016

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 the details below.

Name of Insurer	Type of Policy / Loading / Exclusion	Reasons

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 details below.

Type of claim (eg. critical illness, hospitalization, disability, accident)	Details of claims	Date of claim	Name of insurer

6. Please state: Height: ☐ • ☐☐ m 7. Weight: ☐☐☐ • ☐ kg 8. Occupation: _____

Section B : Premium Payment Method, Declaration and Authorisation

1. I wish to arrange for my premium payment method as follows:
Please tick the appropriate box.

1.1 ☐ **Cash / Cheque made payable to "Great Eastern Life".**

1.2 ☐ **Deduction from my CPF Ordinary Account and/or Special Account Only. I have ensured there is sufficient fund in my CPF OA and/or SA.**

a. I authorise the Central Provident Fund Board (the "CPFB") to deduct premium(s) from my **Ordinary and/or Special account** 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 CPFB from time to time.

b. I authorise the CPFB to disclose information/seek information on a confidential basis to/from my insurer(s) such information relating to:
i) payment of premiums due under this proposal, including the deduction of premiums from my Ordinary and/or Special Account; and
ii) the making of refunds under this proposal, as CPFB shall reasonably consider appropriate.

2. 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.

3. 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 reinstatement or top-up is approved by the Company.

4. 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 36) 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).

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 or Thumb Print of Policyholder: _____ Date: _____

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