

**ADULT PROPOSAL FORM – Great Eastern Cares Term Plan**

Policy No.:

Company Direct No.:

Name of Representative: \_\_\_\_\_

**WARNING: PURSUANT TO SECTION 23(5) OF THE INSURANCE ACT 1966, 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 PARTICULARS OF LIFE TO BE ASSURED**

1a) Title MR/ MRS/ MADAM/ MS/ MISS/ DR  
Name (According to NRIC/ Passport)

b) Enter your **EMAIL** for our e-news updates.  
E-mail Address 1 \_\_\_\_\_ E-mail Address 2 \_\_\_\_\_

c) Residential Address\*  Postal Code

Country of Address \_\_\_\_\_

\*Address as indicated on NRIC.

d) Mailing Address  Postal Code

Country of Address \_\_\_\_\_

If the mailing address differs from residential address, please provide the reason(s):  
\_\_\_\_\_

Home Tel   Country Code

Office Tel   Ext  Country Code

Mobile Tel   Country Code

Fax No   Country Code

e) Date of Birth

f) Backdate to

g) NRIC / Passport No

h) Gender  Male  Female

i) Passport Expiry Date

j) Country of Birth \_\_\_\_\_

k) Nationality \_\_\_\_\_

l) Country of Residence \_\_\_\_\_

m) Singapore PR  Yes  No

n) City of Residence \_\_\_\_\_

o) Height  m

p) Weight  kg

q) Race  Chinese  Malay  Indian  Others

r) Marital Status  Single  Married  Widowed  Divorced

s) Name of Company/School: \_\_\_\_\_

t) Nature of Company Business: \_\_\_\_\_ u) Occupation/Position Held: \_\_\_\_\_

v) Exact Nature of duties involved: \_\_\_\_\_ w) Please state your annual income: \_\_\_\_\_

x) Source of Wealth: \_\_\_\_\_ y) Source of fund: \_\_\_\_\_

**B PARTICULARS OF THE PROPOSER (IF DIFFERENT FROM LIFE TO BE ASSURED)**

2a) Title MR/ MRS/ MADAM/ MS/ MISS/ DR  
Name (According to NRIC/ Passport)



b) Enter your **EMAIL** for our e-news updates.

E-mail Address 1 \_\_\_\_\_ E-mail Address 2 \_\_\_\_\_

c) Residential Address\* 

	Postal Code

Country of Address \_\_\_\_\_

\*Address as indicated on NRIC.

d) Mailing Address 

	Postal Code

Country of Address \_\_\_\_\_

If the mailing address differs from residential address, please provide the reason(s):  
\_\_\_\_\_

Home Tel 







  
Country Code

Office Tel 







 Ext 



  
Country Code

Mobile Tel 







  
Country Code

Fax No 







  
Country Code

e) Date of Birth 

D	D	M	M	Y	Y	Y	Y
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f) Gender  Male  Female

g) NRIC / Passport No

h) Passport Expiry Date 

D	D	M	M	Y	Y	Y	Y
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i) Nationality \_\_\_\_\_

j) Country of Birth \_\_\_\_\_

k) Singapore PR  Yes  No

l) Country of Residence \_\_\_\_\_

Country of Residence is defined as the country where the life assured has spent more than 183 days in the 12 months prior to the application.

m) City of Residence \_\_\_\_\_

City of Residence is defined as the city in the above country in which the life assured has spent more than 183 days in the 12 months prior to the application.

n) Relationship to the first Life to be Assured  Husband  Wife  Father  Mother  Guardian  Employer  Others. Please specify \_\_\_\_\_

o) Height 



 m

p) Weight 



 kg

q) Race  Chinese  Malay  Indian  Others r) Marital Status  Single  Married  Widowed  Divorced

s) Are you insured?  Yes  No If yes, please state the amount of insurance coverage \_\_\_\_\_

t) Name of Company/School: \_\_\_\_\_

u) Nature of Company Business: \_\_\_\_\_ v) Occupation/Position Held: \_\_\_\_\_

w) Exact Nature of duties involved: \_\_\_\_\_ x) Please state your annual income: \_\_\_\_\_

y) Source of Wealth: \_\_\_\_\_ z) Source of fund: \_\_\_\_\_

**C PARTICULARS OF THE POLICY APPLIED FOR**

Special Instruction:

If the premium is paid by CHEQUE, please write the name of the Proposer and the NRIC / Passport No. on the reverse side of the Cheque. The cheque should be crossed and made payable to "The Great Eastern Life Assurance Co Ltd" (where applicable).

3a) Premium Payable by:

Payment Mode  Annually  Half-yearly  Quarterly  Monthly by GIRO  
Payment Method  Cash  Cheque

Type of Policy/ Riders/ Supplementary Benefits	Sum Assured / Monthly or Daily Benefits (\$)	Term	Premium Term	Premium Payable (\$)
Basic Plan				
Other Riders				
Total				



Signature: \* \_\_\_\_\_  
 Name of Beneficial Owner: \* \_\_\_\_\_  
 Date: \* \_\_\_\_\_

**7) Beneficial Owner**

a) Title MR/ MRS/ MADAM/ MS/ MISS/ DR  
 Name (According to NRIC/ Passport) \_\_\_\_\_

b) Residential Address\* \_\_\_\_\_ Postal Code \_\_\_\_\_

Country of Address \_\_\_\_\_

\*Address as indicated on NRIC.

c) Mailing Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Country of Address \_\_\_\_\_

If the mailing address differs from residential address, please provide the reason(s):  
 \_\_\_\_\_

Home Tel \_\_\_\_\_  
 Country Code

Office Tel \_\_\_\_\_ Ext \_\_\_\_\_  
 Country Code

Mobile Tel \_\_\_\_\_  
 Country Code

Fax No \_\_\_\_\_  
 Country Code

d) NRIC Type: \_\_\_\_\_ e) NRIC/Passport No: \_\_\_\_\_

f) Gender:  Male  Female

g) Passport Expiry Date: \_\_\_\_\_

h) Nationality: \_\_\_\_\_ i) Date of Birth: \_\_\_\_\_

j) Relationship with policyholder: \_\_\_\_\_ k) Tax Residency:  I am NOT a U.S. Tax Resident  
 (Please Tick)  I am a U.S. Tax Resident

Signature: \* \_\_\_\_\_  
 Name of Beneficial Owner: \* \_\_\_\_\_  
 Date: \* \_\_\_\_\_

**F FAMILY HISTORY**

Relationship		Condition	Age at Onset	Age at Death
Have either of your natural parents or any siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease? If yes, please state condition, relationship, age at onset and age at death.				

Life to be Assured  
 Yes  No

**G MEDICAL AND UNDERWRITING QUESTIONS**

1a) Have any of your applications or reinstatements 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:

Insurer Name	Type of Policy	Reasons

Life to be Assured  
Yes No

b) Have you ever made any claims or are you intending to make any claims on your insurance policies (for example for critical illness / disorder, disability, terminal illness, accident, hospitalization)?  
If yes, please provide the details below:

Insurer Name	Nature of Claim	Year of Claim	Reason for Claim

2 Do you take part in or plan to take part in high risk sports or occupation (for example scuba or skin diving, motor racing, military flying, commercial flying (except international airline), private flying, mountaineering, sky diving, hang-gliding, parachuting)? If yes, please complete table or relevant questionnaire(s) accordingly.

Name of activity	How often do you take part in the activity each year?

3 In the past 12 months, have you travelled out of the country where you currently live for more than 14 days consecutively for non holiday purpose? Or do you expect to do this within the next 12 months?  
If yes, please provide the details below:

<b>Travel Period</b>	<input type="checkbox"/> Travelled in past 12 months <input type="checkbox"/> Travelling in next 12 months	<input type="checkbox"/> Travelled in past 12 months <input type="checkbox"/> Travelling in next 12 months
<b>Country</b>		
<b>City</b>		
<b>Purpose</b>		
<b>Frequency</b>		
<b>Duration per trip</b>		

4 Are you now receiving or considering to receive medical treatment from a doctor, or intending to consult any doctor for any reason?  
If yes, please state details:

Nature of treatment	Name of doctor	Name and address of clinic or hospital

5 Other than for the medical conditions or symptoms that you have already told us about, have you had or been advised to have any medical tests or investigations during the last 5 years? Or do you intend to have any tests or investigations in the coming year? (for example blood test, urine test, X-ray, ECG, Ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check)  
If yes, please provide the details below:

<b>Type of Test</b>		<b>Type of Test</b>	
<b>Date of Test</b>		<b>Date of Test</b>	
<b>Reason for Test</b>		<b>Reason for Test</b>	
<b>Test Results</b>		<b>Test Results</b>	
<b>Name of Doctors</b>		<b>Name of Doctors</b>	
<b>Name and address of Clinic</b>		<b>Name and address of Clinic</b>	

6 Have you smoked a cigarette or cigar in the last 12 months?  
If yes, how much do you smoke in a day? \_\_\_\_\_ cigarettes \_\_\_\_\_ cigars

7 Have you ever taken addictive drugs /narcotics or been treated for alcoholism or drug addiction?  
If yes for drug addiction, please complete the drug addiction questionnaire.

8 Do you consume beer, wine or other alcoholic beverages? If yes, please state the type of alcoholic beverages and average weekly consumption.  
\_\_\_\_\_

9 Have you ever had or been told that you have or been treated for any of the following medical condition or symptoms?

a) diabetes, thyroid disorders or any other endocrine disorders?

b) asthma, bronchitis, pneumonia, tuberculosis, breathlessness, coughing with blood, persistent cough (longer than 4 weeks) or any other lung diseases or disorders?

		Life to be Assured																			
		Yes	No																		
c) cardiomyopathy, heart attack, heart murmur, heart valve disorder or disease, high blood pressure, high cholesterol, irregular or fast heart rate, chest discomfort or pain or any other disorders of the heart or blood vessels?		<input type="checkbox"/>	<input type="checkbox"/>																		
d) depression, epilepsy, fits, nervous breakdown, paralysis, stroke, numbness, prolonged headache (longer than 4 weeks), weakness of limbs, unconsciousness, or any other neurological, nervous, mental disorders?		<input type="checkbox"/>	<input type="checkbox"/>																		
e) duodenal ulcer, fatty liver, fistula, gallstone, gastritis, hepatitis, piles, stomach ulcer, blood in the stools, diarrhoea (longer than 1 week), jaundice or any other disorders of the digestive system including stomach, liver, gallbladder, pancreas, intestines, colon and rectum?		<input type="checkbox"/>	<input type="checkbox"/>																		
f) kidney infection, kidney stones, urinary tract infection, urinary incontinence, blood in urine, protein in urine or sugar in urine or any other disorders of the kidney, bladder, genital or urinary systems?		<input type="checkbox"/>	<input type="checkbox"/>																		
g) arthritis, gout, osteoporosis, slipped disc, any pain, deformity, physical disability or severe injury or any disease or disorder of the muscle, bones, spine, limbs or joints?		<input type="checkbox"/>	<input type="checkbox"/>																		
h) anaemia, haemophilia, systemic lupus erythematosus or any other disorders of the blood or autoimmune disease?		<input type="checkbox"/>	<input type="checkbox"/>																		
i) impaired hearing, impaired sight, impaired speech, ear discharge, double vision, nose bleeds (intermittent or continuous longer than 1 week) or any other disorders of eyes, ears, nose or throat?		<input type="checkbox"/>	<input type="checkbox"/>																		
j) cancer, enlarged nodes, unusual skin lesions, tumours, polyps, cysts or other growths?		<input type="checkbox"/>	<input type="checkbox"/>																		
k) excessive weight loss in the past 3 months, fatigue (for more than 1 week) in the past 3 months?		<input type="checkbox"/>	<input type="checkbox"/>																		
10 Do you have any other illness, disorder, symptoms, operation, physical disability, accident or injury not mentioned above?		<input type="checkbox"/>	<input type="checkbox"/>																		
11 Have you or has your husband or wife ever taken or been advised to take any tests for Sexually Transmitted Disease, including HIV and AIDS? If yes, please complete the table below:		<input type="checkbox"/>	<input type="checkbox"/>																		
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Type of Test</th> <th style="width:15%;">Date of Test</th> <th style="width:20%;">Reason for Test</th> <th style="width:15%;">Test Results</th> <th style="width:15%;">Name of Doctor</th> <th style="width:20%;">Name and address of Clinic</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Type of Test	Date of Test	Reason for Test	Test Results	Name of Doctor	Name and address of Clinic														
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12 <b>For Female applicants only:</b>																					
a) Are you currently pregnant? If yes, please state: Number of weeks pregnant: _____		<input type="checkbox"/>	<input type="checkbox"/>																		
b) Have you ever had or are you being monitored for any complications in your past or current pregnancies? (for example diabetes, hypertension, protein in urine, still birth, ectopic pregnancy, miscarriage, disseminated intravascular coagulation or hydatidiform mole)		<input type="checkbox"/>	<input type="checkbox"/>																		
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:20%;">Pregnancy</th> <th style="width:20%;">Date</th> <th style="width:60%;">Details of complications</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Past pregnancy</td> <td>_____ / _____</td> <td> </td> </tr> <tr> <td><input type="checkbox"/> Current pregnancy</td> <td>MM / YYYY</td> <td> </td> </tr> <tr> <td><input type="checkbox"/> Past pregnancy</td> <td>_____ / _____</td> <td> </td> </tr> <tr> <td><input type="checkbox"/> Current pregnancy</td> <td>MM / YYYY</td> <td> </td> </tr> </tbody> </table>		Pregnancy	Date	Details of complications	<input type="checkbox"/> Past pregnancy	_____ / _____		<input type="checkbox"/> Current pregnancy	MM / YYYY		<input type="checkbox"/> Past pregnancy	_____ / _____		<input type="checkbox"/> Current pregnancy	MM / YYYY						
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<input type="checkbox"/> Current pregnancy	MM / YYYY																				
c) breast lump(s), breast disease, irregular or painful menstruation, abnormal Pap Smear, growths or other gynaecological or breasts conditions?		<input type="checkbox"/>	<input type="checkbox"/>																		
13 Other than for the medical conditions or symptoms that you have already told us about, do you have a regular doctor whom you consult for medical reasons (excluding minor illnesses such as cold or flu)? If yes, please provide the details below: Life to be Assured		<input type="checkbox"/>	<input type="checkbox"/>																		
<table border="1" style="width:100%; border-collapse: collapse;"> <tbody> <tr> <td style="width:30%;">Date</td> <td> </td> </tr> <tr> <td>Reason for Visit</td> <td> </td> </tr> <tr> <td>Name of Doctor</td> <td> </td> </tr> <tr> <td>Name and address of clinic or hospital</td> <td> </td> </tr> </tbody> </table>		Date		Reason for Visit		Name of Doctor		Name and address of clinic or hospital													
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14 <b>You are not required to disclose the result of any Genetic Test done in the context of a Biomedical Research (Biomedical Research refers to any systematic investigation with the intention of developing or contributing to generalizable knowledge, regardless of where or when the research was conducted or the nature of the research) or a Direct-to-Consumer Genetic Test (Direct-to-Consumer Genetic Test means a genetic test that is provided directly to consumers by the manufacturer or supplier of the test). In the event of an accidental disclosure of such a Genetic Test result, we will not use the result for risk assessment unless the result is favourable to you.</b>																					
<p><b>For Singapore Citizens/ Permanent Residents/ Residents on Valid Passes*, please indicate accordingly if the total sum assured of your current application, any pending application(s) and existing policy(ies) on your life with GE and other insurance company(ies) exceeds the following amounts:</b></p>																					
a) \$2,000,000 for Life Protection or Total & Permanent Disability		<input type="checkbox"/>	<input type="checkbox"/>																		
b) \$3,000 per month for Long-Term Care (2 ADLs and above for 6 months)		<input type="checkbox"/>	<input type="checkbox"/>																		
c) \$3,000 per month for Long-Term Care (1 ADL)		<input type="checkbox"/>	<input type="checkbox"/>																		
d) \$500,000 for Critical Illness		<input type="checkbox"/>	<input type="checkbox"/>																		
e) \$10,000 for Disability Income		<input type="checkbox"/>	<input type="checkbox"/>																		
<b>For Non-Singapore Residents, please answer the following question:</b>																					
Have you ever undergone any genetic test?		<input type="checkbox"/>	<input type="checkbox"/>																		
If yes, please provide a copy of genetic test result.																					

15 Any medical / health screening report to be submitted with this application?

Life to be Assured	
Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

If the answer is "Yes" to any of the questions 4, 9-12 (except 12a), please complete the Special Health Questionnaire.

#### Footnote

\* Resident on valid pass means any individual who is:

- a) a Singapore resident who holds a work pass/permit and has resided in Singapore for not less than a total of 183 days in last 12 months
- b) a Singapore resident who holds a pass/permit with a duration longer than 90 days and has resided in Singapore for at least 90 consecutive days in last 12 months

## H DECLARATION

- 1 I/ We declare that the information I/ we have given to The Great Eastern Life Assurance Company Limited ("GE") and any of its medical examiner in this proposal form and any documents are true and complete and I/ we am/ are fully responsible for the truth of the information given in these documents. If I/ we have withheld any information or given false information in this proposal, and GE issues the policy, I/ we agree GE reserves the right to re-underwrite, terminate or void the policy. I/ We agree that all information given in this proposal together with any documents I/ we provide in relation to myself/ ourselves under this policy will form the basis of the contract of insurance and any temporary insurance (if any), and I/ we agree that I/ we will be legally bound by the information given once this proposal form is signed.
- 2 I/ We agree to inform GE about any change in my/ our health and/or the Life Assured's health and/or any facts which are likely to influence the assessment and acceptance of this proposal arising between the date of this proposal and the date GE issues the policy. Once GE receives this information, GE is entitled to decide whether to accept or reject this proposal.
- 3 I/ We agree that (i) acceptance of this proposal shall be at GE's sole discretion at all times; and (ii) GE will have no liability until GE has accepted this proposal through its issuance of a letter of acceptance to me/ us and I/ we have paid the first premium or the single premium (as the case may be) in full.
- 4 I/ We agree that should I/ we decide not to take up the proposal under the standard or revised terms offered by GE, then the amount refundable to me/ us shall be the premium(s) paid less any adjustment to reflect the change in market value of the underlying assets (if applicable), less any cost(s) incurred by GE in assessing the risk under the proposal.
- 5 I/ We authorise and agree to the following:
  - (a) Any medical source, insurance office, reinsurer or organisation can release my/ our relevant information to GE and vice versa, regardless of whether GE accepts this proposal;
  - (b) GE or any of its approved medical examiners or laboratories can carry out the necessary medical assessments and tests to underwrite and assess my/ our health in relation to this proposal and any claims I/ we make under it; and
  - (c) GE can use or reveal as GE reasonably considers appropriate, any information GE has collected or hold (whether provided in this proposal or otherwise) to allow GE, its related companies or independent third parties, within or outside Singapore, to deal with any matters relating to this proposal or policy or any other policies that I/ we currently have with GE.A copy of this authorisation shall have the same effect as the original.
- 6 I/ We confirm that I am/ we are not an undischarged bankrupt and that no bankruptcy application (including any statutory demands) or order has been made against me/ us within the last 12 months.
- 7 For hardcopy policy document- I/ We agree that my/ our policy will be mailed directly to me/ us according to the mailing address as provided in the proposal form.
- 8 For electronic policy document- I/ We agree that when my/ our policy document is available on eConnect at [econnect.greataeasternlife.com](http://econnect.greataeasternlife.com), GE will notify me/ us of the same by sending a SMS to my/ our mobile number as provided in the proposal form or where applicable, any mobile number which I/ we provide to GE in writing, whichever is latest according to GE's records.  
I/ We further agree that my/ our policy document will be deemed to have been received by me/ us via eConnect on the day GE has successfully delivered the aforesaid SMS ("Relevant Day"). I/ We understand and acknowledge that I/ we may terminate the policy within the free-look period (as set out in my/ our policy contract), in accordance with the terms of the policy. For the avoidance of doubt, the free-look period commences the day after the Relevant Day.
- 9 I/ We agree that GE will contact me/ us and send all policy communications for this policy and my/ our existing policy(ies) to my/ our mailing address, mobile number and email address ("Contact Details") as provided in the proposal form or where applicable, to the Contact Details which I/ we provide GE in writing, whichever is the latest according to GE's records. I/ We further agree that GE may send me/ us hardcopy policy communications, where electronic copies are unavailable.  
For the avoidance of doubt, any updates to my/ our Contact Details will not affect the email address and mobile number I/ we used to register for my/ our GREAT ID account(s).
- 10 I/ We, the Proposer, have been given the following documents, and I/ We have read and understood them:
  - (a) Your Guide To Life Insurance (I/ We have received a hard copy or been told where to find it on [www.greataeasternlife.com](http://www.greataeasternlife.com) or [www.lia.org.sg](http://www.lia.org.sg)) (if applicable);
  - (b) Product Summary;
  - (c) Policy Illustration;
  - (d) Cover Page.With reference to the specific documents in (b) Product Summary and (c) Policy Illustration, I/ we, have specifically taken note of the following information:
  - (a) Benefits, limitations and risks of the policy;
  - (b) Conditions under which benefits will be payable;
  - (c) Conditions under which the policy will terminate;
  - (d) Exclusions where benefits will not be payable;
  - (e) Free-look provision; and
  - (f) Fees and charges to be borne by me/ us, including but not limited to cash payments in the form of commission, costs of benefits and services paid to the distribution channel (where applicable).

11 I have decided to buy this product without seeking any advice from any financial advisory representative and I take sole responsibility to ensure that this product is appropriate to meet my financial needs and insurance objectives.

12 No insurer shall be deemed to provide cover and no insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit may, in the insurer's opinion, expose that insurer to the risk of or result in any breach or violation of, or non-compliance with, any sanction, prohibition, restriction or regulations imposed by any state or transnational organisation including but not limited to the United States of America, the United Nations, the European Union, the United Kingdom, the Republic of Singapore and any state or country where the insurer or its related entity carries on business ("Sanctions").

If the insured, policy holder, beneficial owner of the policy, life assured(s) (if applicable), beneficiary, payee or any affiliate, successor or assign of any of the foregoing (collectively the "Insured") is designated or listed as a person subject to Sanctions ("Restricted Party") or has any involvement whatsoever with any Restricted Party, whether directly or indirectly, or has been charged, or convicted or has had judgment taken against them under any local or foreign law or regulations implementing any Sanctions, the insurer shall be entitled, in its sole discretion and without incurring any liability whatsoever, to exercise any one or more of the following rights and/or remedies against the Insured, namely (i) cancel, terminate, void and/or nullify any policy, contract, transaction or business; (ii) liquidate and/or close-out any financial product or investment; (iii) withhold and/or suspend any payment, transfer and/or receipt of any money, refund or benefit; (iv) decline and/or refuse any transaction or request; and/or (v) take or refrain from taking any step or action necessary to eliminate, reduce or minimise the risk of any breach or violation of any Sanctions or exposure to any Sanctions.

The Insured shall indemnify the insurer and hold the insurer harmless from and against any and all losses, damages, costs and/or expenses suffered and/or incurred by the insurer, including but not limited to legal costs and attorney's fees.

13 I/ We agree that the policy will be issued as a Singapore policy and that the policy will be entered in the register of Singapore policies.

I/ We acknowledge that I am/ we are responsible for making sure that I am/ we are allowed to buy this policy under the laws and regulations that apply to my/ our nationality and the country where I/ we live. I/ We understand that GE and/or its related companies cannot accept liability for any legal consequences under the laws of any other country or any tax effects that may arise in connection with buying this policy.

I/ We declare that any funds and assets I/ we place with GE, and any profits/returns that are generated from these funds and assets, will comply with the tax laws of the countries where I am/ we are resident(s) and of which I am/ we are citizen(s).



#### 14 Policy Application, Service and Administration

By providing the information set out above, I/ we agree and consent to GE and its related corporations (collectively, the "Companies"), as well as their respective representatives, agents, the Companies' authorised service providers and relevant third parties (the Companies and all the other foregoing parties, collectively, "Great Eastern Persons"), collecting, using, disclosing, and/or sharing amongst themselves my/ our personal data, 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 any policy renewals and policy upgrades, substitutions or replacements) and such other purposes as described in Great Eastern's Privacy Statement (collectively, the "Purposes") which is accessible from Great Eastern Singapore's website, which I/ we confirm I/ we have read and understood.

My/ our consents herein supplement but do not supersede nor replace any other consents I/ we may have previously provided to Great Eastern Persons, and my/ our consents herein are cumulative and additional to any rights which any of the Great Eastern Persons may have to collect, use, and/or disclose of my/ our Personal Data, with or without my/ our consent, to the extent permitted under applicable law.

In addition, where personal data of any person is disclosed by me/ us, I/ we further confirm and represent that I/ we have obtained the consent of the individual concerned for the Purposes, unless such consent is not required under applicable laws: (i) to collect such personal data; (ii) for the disclosure of such personal data to the Great Eastern Persons; and (iii) for the Great Eastern Persons' collection, use and/or disclosure of such personal data.

#### Declaration by Representative

I hereby declare and confirm that I have personally seen the Proposer. I have also sighted the proof of identity and certify that the particulars are the same as stated on the proposal.

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date

#### I MARKETING CONSENT

Keep up to date on the latest happenings in Great Eastern. Be the first to be informed of our products, promotions and more! With your consent, we\* will send only related content to you.

Let us\* know the best ways to keep in touch.

I would like to receive notifications on the above content via:

- Post  
 Email,  
 WhatsApp, SMS, and other phone-based messages  
 Voice calls  
 All the above

Your privacy is of utmost importance to us and you can withdraw your consent via Great Eastern's website at any time.

\*We/us refers to Great Eastern, our related corporations, respective representatives and agents. For more details, please refer to the [Privacy and Security Policy](#) on Great Eastern website.

#### WARNING:

**If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. Please check to ensure you are fully satisfied with the information declared in this proposal.**

#### J POLICY DOCUMENT

I/ We would like to receive (please tick one):

- electronic policy document (not applicable for company proposal)  
 policy document mailed directly to me/ us

Signature of Proposer \_\_\_\_\_

Signature of Life to be Assured \_\_\_\_\_

Signature of Witness  
(Representative) \_\_\_\_\_

Dated on:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Day) (Month) (Year)

#### K CORRESPONDENCE

Do you wish to receive updates and notifications about your policy via email?  Yes  No





