

## Dependants' Protection Scheme - Health Declaration Form

**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.**

Dear Policyholder

It is necessary for you to declare the condition of your health for your Dependants' Protection Scheme (DPS) cover. If you are suffering from any undisclosed pre-existing serious illness, claims will not be admitted. Please refer to our website [www.greatasteallife.com](http://www.greatasteallife.com) for the list of serious illnesses.

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

Name: \_\_\_\_\_

Tel No: \_\_\_\_\_

NRIC No: \_\_\_\_\_

Mobile No: \_\_\_\_\_

Policy No: 

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Email Address: \_\_\_\_\_

### 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?

Yes  No

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/quadruplegia),
- 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?

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)
				<input type="checkbox"/> still on follow up <input type="checkbox"/> receiving treatment <input type="checkbox"/> fully recovered and discharged
				<input type="checkbox"/> still on follow up <input type="checkbox"/> receiving treatment <input type="checkbox"/> 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. Yes  No

Date	Type of test(s) / surgery done	Reason for test(s) / surgery done	Results	Name of clinic/hospital	Follow up/treatment required? (Please tick)
					<input type="checkbox"/> No follow up/treatment required <input type="checkbox"/> follow up/treatment required Type of treatment: _____ Name of Drug: _____
					<input type="checkbox"/> No follow up/treatment required <input type="checkbox"/> follow up/treatment required Type of treatment: _____ Name of Drug: _____

3. Have you ever used drugs or substances in an illegal way or drug addiction or had alcoholism? If 'Yes', please provide details below. Yes  No

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)
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> 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 details below. Yes  No

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. Yes  No

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 : Authorisation for Medical Information**

- 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.
- 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 "CPF Board") for:
  - 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
  - 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 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.
- 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