DECLARATION OF HEALTH

Great Eastern

Important Note:
1) **You are to disclose in this form fully and faithfully all the facts which you know or ought to know, notwithstanding that it has been previously declared in any policies, otherwise you may receive nothing from the Policy.**
2) **The Company may ask for any medical report as it sees fit. The Policyholder has to pay for the necessary medical examination.**

☐ Great Eastern Life Policy No.: ☐☐☐☐☐☐☐☐ ☐ Overseas Assurance Corporation Policy No.: ☐☐☐☐☐☐☐☐

Application for ☐ Increase sum assured ☐ Include riders / benefits ☐ Change Plan ☐ Others

Please provide details here eg. term and sum assured, etc _____

Particulars	(Parent / Proposer Assured) #		(Child / Spouse Assured)	
Name				
Date of Birth / Sex		Male / Female		Male / Female
Nationality				
Height / Weight	m	kg	m	kg
Occupation / Name of School				
State Exact Duties				

The Parent / Proposer Assured Column is applicable when
- applicant is buying insurance only on his / her own life. (Individual policy).
- applicant is attaching Payer Benefits Rider to the Basic Policy (Third Party policy).
- applicant is the key person assured for the company.

Please answer the following questions relating to the respective Life Assured: **(Delete wherever is not applicable.)**

		Proposer/Parent Assured	Child/Spouse Assured
1.	Has any proposal for life or health assurance on the life assured to this or any other office been declined, deferred or accepted at other than normal terms?	Yes/No	Yes/No
2.	Is the life assured now receiving or considering to receive medical treatment from a doctor or intending to consult any doctor for any reason? If 'Yes', please state type & reason for medication, _____	Yes/No	Yes/No
3*	Has the life assured ever had any medical investigation carried out whether on own accord or on the recommendation of a doctor such as X-ray, ultrasound, ECG, echocardiography, barium meal examination, CT scan, biopsy, blood or urine test, etc, in the past 3 years?	Yes/No	Yes/No
4.	Has the life assured smoked in the last 12 months?	Yes/No	Yes/No
	Does the life assured now smoke?	Yes/No	Yes/No
	If 'Yes', please state the number of sticks per day. No of sticks	_____	_____
	For how many years has the life assured been smoking? No of years	_____	_____
5*	Has the life assured ever taken addictive drugs / narcotics / glue sniffing or been treated for alcoholism or drug addiction?	Yes/No	Yes/No
6.	Does the life assured consume beer, wine or other alcoholic beverages?	Yes/No	Yes/No
	If 'Yes', please state the type of alcoholic beverages and average weekly consumption (AWC). Type	_____	_____
	AWC	_____	_____
7*	Has the life assured ever suffered from or received treatment for:		
	a. diabetes, thyroid disorders or any other endocrine disorders?	Yes/No	Yes/No
	b. asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/ discomfort, or any other lung disorders?	Yes/No	Yes/No
	c. raised cholesterol, high blood pressure, heart attack, rheumatic fever, Kawasaki disease, heart murmur, mitral valve prolapse or other heart valve disorder, breathlessness, irregular / fast heart rate, chest discomfort / pain, disease of or any other disorders of the heart or blood vessels?	Yes/No	Yes/No
	d. epilepsy, fits, stroke, paralysis, memory disturbance, confusion, dementia, falls, Parkinsons disease, multiple sclerosis, motor neurone disease, weakness of limbs, prolonged headache, unconsciousness, nervous breakdown, depression, any other nervous/mental disorders, or disease of the brain?	Yes/No	Yes/No
	e. gastritis, stomach / duodenal ulcer, blood in the stools, fistula, piles, or any other stomach / bowel disorders?	Yes/No	Yes/No
	f. jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder?	Yes/No	Yes/No
	g. blood, protein / sugar in the urine, kidney stones, infection or any other disorders of the kidney, bladder, or genital organs?	Yes/No	Yes/No
	h. slipped disc, gout, arthritis, pain / deformity / disorders of the muscles, spine, limbs or joints, or severe injury?	Yes/No	Yes/No
	i. anaemia, any other disorders of the blood, advised to abstain from donating blood, or received blood transfusion or blood products on account of haemophilia or any other reason?	Yes/No	Yes/No
	j. ear discharge, nose bleeds, double vision, impaired sight / hearing / speech, or any disorders of the eye, ear, nose or throat?	Yes/No	Yes/No
	k. cancer, tumours, cysts or growths of any kind?	Yes/No	Yes/No
	l. any other illness eg. (Hand, foot & mouth disease), disorder, operation, physical disability or accident not mentioned above?	Yes/No	Yes/No

The Great Eastern Life Assurance Company Limited
The Overseas Assurance Corporation Limited
Customer Service Department
1 Pickering Street #01-01 Great Eastern Centre Singapore 048659 INFOLink: 1800-248 2888 Facsimile 6535 2836 / 6534 5568
E-mail: wecare@Lifeisgreat.com.sg Website: http://www.Lifeisgreat.com.sg

RAPP

Please answer the following questions relating to the respective Life Assured

		Proposer/Parent Assured	Child/Spouse Assured
8*	Has the life assured or the spouse (if applicable) ever been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related conditions?	Yes/No	Yes/No
9*	Has the life assured ever had HIV testing done (please state reason and results); or in the last three months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin leisons?	Yes/No	Yes/No
10.	Has the life assured's natural parents or any sibling 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.	Yes/No	Yes/No
11.	Does the life assured engage or have intention of engaging in any sport, or occupation of a dangerous nature e.g. scuba/skin diving, motor-racing, military/ private flying other than as a fare-paying passenger, etc?	Yes/No	Yes/No
12.	Has the life assured, during the past 5 years, ever stayed in or travelled to a country(ies) different from where he / she live at present? If 'Yes', please state the countries and number of times per year.	Yes/No	Yes/No
13*	**For Female Applicant only**		
	a. Is the life assured now pregnant? If 'Yes', please state number of months.	Yes/No	Yes/No
	b. Has the life assured ever had any complication in previous pregnancies?	Yes/No	Yes/No
	c. Has the life assured ever been found to have or are you aware of any breast lump or disease of the breast?	Yes/No	Yes/No
	d. Has the life assured ever had any abnormal Pap Smear test or been told by any doctors to have a repeat test within the next 6 months?	Yes/No	Yes/No
	e. Has the life assured ever had recurrent / persistent irregular / painful / unusually heavy menstruation?	Yes/No	Yes/No
	f. Has the life assured ever been advised to have mammogram, biopsy, operation of the breast, ultrasound of the pelvis or any other gynaecological investigations?	Yes/No	Yes/No

Additional Questions For Alteration / Addition / New Application of PAYCARE RIDER

14 a. Monthly benefit :$_____ b. Term of cover (10, 15, 18, 20, 21, 25, @55, @60) : _____ years

c. Benefit expiry (55/60 years) : _____ years d. Pre-benefit period (45/90/180 days) : _____days

15. For how long would the life assured continue to be paid from his/her employment in the event of a disability? State period: _____

16* Has any illness, disorder, operation, disability, accident or medical condition caused the life assured's absence from work or education for any period(s) or 2 weeks or more during the last 5 years or has caused his/her referral to a hospital or a consultant? If yes, please give details.

_____

_____

IMPORTANT NOTE: **In case of a disability claim, if the combined benefit exceeds 75% of your income prior to the claim, the benefit paid may be lower than the benefit insured.**

*** If the answer is YES to questions 3*, 5*, 7*, 8*, 9*, 13* & 16*, please complete a separate Special Health Questionnaire (N101V3).**
For Long Term Care Products, please complete a separate supplementary questionnaire.

Declaration

I / We declare that to the best of my / our knowledge and belief, the information given is true and complete, that I / We have not withheld any material facts which are likely to influence the assessment and acceptance of this application. I / We understand and agree that payment received (if any) before acceptance of this proposal by the Company does not bind the Company to any additional assurance I / We have applied for and that the said additional assurance will not take effect until this proposal has been fully accepted and the full premium paid.

Dated at _____ (Country) on _____ of _____ 20 _____

Signature & NRIC of Parent / Proposer Assured	Signature & NRIC of Spouse (Child need not sign if this is a Child Policy)	Signature & NRIC of Assignee (To affix Company Stamp if applicable)

Email address

For Official Use

RAPP