GROUP INSURANCE
PERSONAL HEALTH DECLARATION FORM

Great Eastern
A member of the OCBC Group

Policy No.	
Date Sent	

Important Note: **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, nothing may be payable under the policy.**

NOTE: 1. All questions must be answered in ink. Dashes, strokes, ditto and N.A. are not acceptable.
2. Any alteration to the answers must be signed in full.

The "Company" shall mean The Great Eastern Life Assurance Company Limited.

NAME OF POLICYHOLDER (EMPLOYER) _____

I) PARTICULARS of the EMPLOYEE / ELIGIBLE MEMBER

a. Name (According to NRIC / Passport)

b. NRIC / Passport* Number

c. Nationality

d. Occupation

e. Email Address (in current company)

f. Male Female Single Married

g. Date of Birth (Day / Month / Year)

h. Height ____ m Weight ____ kg

i. Date Employed (Day / Month / Year)

II) FAMILY HISTORY of the EMPLOYEE / ELIGIBLE MEMBER

Has any of your natural parents or sibling(s) died or suffered from cancer**, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, tuberculosis or any hereditary disease(s)?

Yes No **IF YES, PLEASE PROVIDE DETAILS BELOW (**for CANCER, please specify the type of cancer)**

If Alive			If Deceased	
Relationship (Father, mother, sister(s) or brother(s))	Please indicate type of Medical Condition and the exact Diagnosis	Age at time of Diagnosis	Age at Death	Cause of Death

III) DEPENDANT(S) PARTICULARS – Complete this section only if you are applying for Group Hospital and Surgical Insurance for your dependants. If you have more than 3 children, please furnish the information of all your children after the 3rd child on a separate sheet of paper.

Relationship	Name (as in NRIC / Passport)	NRIC / Passport No.	Gender	Date of Birth DD	Date of Birth MM	Date of Birth YYYY	Height (m)	Weight (kg)
Spouse								
1st Child								
2nd Child								
3rd Child								

*Please delete accordingly.

IV) HABITS of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE)

Please tick Yes or No. **If Yes, please provide details in the respective column(s).** Please note: Section IV under child(ren) column is not applicable for dependant aged 12 years & below.	Employee	Answer ONLY IF to be Insured: Spouse	Answer ONLY IF to be Insured: Child(ren)
	Yes or No	Yes or No	Yes or No
1 Have you ever smoked in the last 12 months? If Yes, please provide details of smoking: a. No. of sticks you smoke per day: b. No. of years since you have been smoking:			
2 Do you consume beer, wine or other alcoholic beverages? If Yes, please furnish details of alcohol consumption: a. Type of alcohol taken: b. Average weekly consumption with units of measurement:			
3 Do you engage in or intend to engage in any sport(s) or occupation of a dangerous / hazardous nature? E.g. scuba / skin diving, motor racing, military / private flying other than as a fare paying passenger, parachuting, etc? If Yes, please state details on the type of sports you participate in:			

V) PARTICULARS of HEALTH of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE)

Please tick Yes or No. **If Yes, please provide details under Section VI.**	Employee	Answer ONLY IF to be Insured: Spouse	Answer ONLY IF to be Insured: Child(ren)
	Yes or No	Yes or No	Yes or No
1a) Has any proposal for life or disability or health assurance on your life to this or any other insurance office ever been declined, postponed or accepted with special conditions (for example loading or exclusions)? b) Have you ever made a claim or intend to make a claim on the insurance policies (for example, for critical illness/disorder, disability, terminal illness, accident, hospitalisation)?			
2 Are you now receiving or considering to receive medical treatment from a doctor or intending to consult any doctor for any reason?			
3 Have you ever undergone any health screening or had any medical investigations carried out, whether on your own accord or on the recommendation of a doctor, such as X-ray, ultrasound, electrocardiogram (ECG), barium meal examination, CT scan, biopsy, blood or urine test, etc., in the past 5 years?			
4 Have you been advised to undergo any diagnostic test or surgical operation that has not yet been performed? Do you intend to have any tests or investigations in the coming year?			
5 Have you ever taken addictive drugs, narcotics, glue sniffing or been treated for drug addiction?			
6 Have you ever had or been treated for alcoholism?			
7 Have you ever had or been told to have or been treated for: a. Diabetes, thyroid disorders, or any other endocrine disorders? b. Asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, bronchitis, chest or breathing complaints or discomfort, and / or any other lung disorders? c. Raised cholesterol, high blood pressure, heart attack, rheumatic fever, Kawasaki disease, heart murmur, palpitation, coronary artery disease, mitral valve prolapse, or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or chest pain, and/or any disease or disorders of the heart or blood vessels? d. Epilepsy, fits, stroke, paralysis, dementia, Parkinson's disease, multiple sclerosis, motor neurone disease, weakness of limbs, polio, fainting spells, prolonged headache, unconsciousness, nervous breakdown, depression, or any other nervous or mental disorders, or disease of the brain? e. Gastritis, stomach or duodenal ulcer, blood in the stools, fistula, hernia, haemorrhoids or piles, irritable bowel syndrome, or any other stomach or bowel disorders? f. Jaundice, hepatitis B carrier or any form of hepatitis, liver disorder or gall bladder disorder? g. Albumin or protein in urine, blood or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, urinary or genital organs? h. Slipped disc, gout, any form of arthritis, joint pain or deformity, and/or disorders of the muscles, spine, limbs or joints or severe injury? 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? j. Ear discharge, nose bleeds, double vision, or visual impairment or impaired hearing or speech, or any other disorders of the ear, nose, or throat? k. Cancer, tumours, cysts or growths of any kind? l. Congenital anomalies, physical disability or any unusual skin lesions, or any other illness, disorder, operation, hospital admission, accident or injury not mentioned above?			

V) PARTICULARS of HEALTH of the EMPLOYEE / ELIGIBLE MEMBER (and DEPENDANT(S) IF APPLICABLE) (Continued)

Please tick Yes or No. **If Yes, please provide details under Section VI.**	Employee	Answer ONLY IF to be Insured Spouse	Child(ren)
	Yes or No	Yes or No	Yes or No
8 Have you or your spouse been told to have, or received any medical advice or counselling or treatment in connection with sexually transmitted disease, AIDS, or AIDS Related Complex or any other AIDS related condition?			
9. a. Have you ever had HIV testing done? (If Yes, please state reason and result under Section VI.) b. Have you ever in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?			
10 Do you have a regular attending doctor? If Yes, please state the name of doctor _____ and the address of clinic _____ .			
11 **FOR FEMALE ONLY (Also to be completed for child(ren) aged 12 years & above)** a. Have you ever been found to have or are you aware of any breast lumps or any other disease or disorders of the breast? b. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs? c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months? d. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? e. Are you pregnant now? If Yes, please state the weeks / months of pregnancy. (*Delete as appropriate) f. Were there any complications during any of your pregnancy(ies) such as gestational diabetes, hypertension, etc?	____wks/mths*	____wks/mths*	____wks/mths*
12 **To answer this question if the Life to be Insured's age is 1 and below.** 12.1 Name of Life to be Insured: _____ 12.2 Is the Life to be Insured a premature baby (i.e. less than 37 weeks of gestation)? If yes, please state the following information obtainable from the Child Health Booklet. a) Gestation Period: _____ weeks b) Weight and Length at Birth: _____ weight _____ length c) APGAR score at _____ 1 minute _____ 5 minute 12.3 Were there significant events during pregnancy/delivery such as but not limited to birth difficulty, congenital deformities, lack of mental development, respiratory distress syndrome, prolonged neonatal jaundice, G6PD deficiency, respiratory disorder? If yes, please provide details below. _____ _____ 12.4 Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment check? If yes, please provide details below. _____ _____ 12.5 Date and result of last routine check. Date: _____ Result: _____			

*Please delete accordingly.

VI) If the answer to any of the questions in Section V is Yes, please provide with FULL DETAILS here.					
Question Number	Name of Person Concerned (Employee/Spouse/Child(ren))	Details of Diagnostic Test with reason & result / Doctor's Diagnosis / Injury / Treatment	Duration of Illness From	Duration of Illness To	Name of Doctor Consulted & Address of Clinic

DECLARATION: I hereby declare that, to the best of my knowledge and belief the statements and answers given in this health declaration are true, complete and that I have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this application. I understand that any misstatement of fact, whether by commission or omission may be grounds for the Company in its absolute and sole discretion to decline to pay any benefit which may otherwise have been payable. I agree that this application, together with any additional statements signed by me which shall be deemed to be part of this declaration, shall be the basis of the contract of the insurance.

I understand that my application will be subject to acceptance by the Company, and that I and/or my Dependant(s) will not be insured under any of the insurance plan(s) for which my or my Dependant(s)'s application is subject to acceptance until the Company advises the Policyholder the terms and conditions on accepting insurance on myself and/or my Dependant(s), and that the Company reserves the right to decline insurance or impose special terms and conditions.

I understand that:

(a) if my application for my and/or my Dependant(s)' insurance under any of the above plan(s) is accepted, my and/or Dependant(s)' insurance under the plan shall terminate if the Policyholder does not renew the plan before the expiry of any period of insurance, or cancel the plan, or if I and/or my Dependant(s) attain the age at which I and/or my Dependant(s)' insurance terminates as specified in the terms and conditions of the insurance plan, and

(b) these plan(s) are yearly renewable and that the terms and conditions of the insurance plan(s) I and/or my Dependant(s) are insured under, including the premiums payable, at any renewal of the plan(s), may change upon agreement between the Policyholder and the Company.

I confirmed to have read and understood the contents of the following documents:

(a) Your Guide to Health Insurance (you can download from www.lia.org.sg/consumers/library/consumers_guides)

(b) Product Summary for voluntary plan

I further agree that this form may be submitted to the Company by facsimile, electronic mail or other electronic means, including via a website or electronic portal designated by the Company. A copy of this form received via any of the above means may be stored electronically or using other means by or as authorized by the Company and the Company shall be entitled to rely on such copy, which shall have the same legal effect and validity as if were the original.

AUTHORISATION: I, the undersigned, authorise any medical source, insurance office/ organisation or the Life Insurance Association's medical registry to release any medical record or knowledge about me and/or my Dependant(s) to the Company for risk assessment of my Group Insurance Application. I further consent to, and agree to procure my Dependant(s) to agree and consent, the Company in releasing any information declared in my and/or my dependant(s)' Personal Health Declaration Form / Personal Statement and/or information revealed in my and/or my Dependant(s)' questionnaires, medical reports and laboratory reports to my employer or the administrator and/or the appointed insurance intermediary servicing this Group Insurance Policy. A photocopy of this authorisation shall be as effective and valid as the original.

PERSONAL DATA: By providing the information set out above, I agree and consent, and agree to procure my dependant(s) to agree and consent, to the "Company", its related corporations (collectively, the "Companies"), as well as their respective representatives and agents ("Representatives") collecting, using, disclosing and sharing amongst themselves my or my Dependant(s)'s personal data, and disclosing such personal data to the Companies' authorised service providers and relevant third parties for purposes reasonably required by the Companies to evaluate my proposal and to provide the relevant products or services which I am applying or have applied for (including, without limitation, any policy renewals and policy upgrades, substitutions or replacements).

These purposes are set out in Great Eastern's Privacy Statement, which is accessible at http://www.greateasternlife.com/sg/en/privacy-and-security-policy.html and which I confirm I have read and understood.

Date: _____

Day/Month/Year
(Current Date of Completion of this form)

_____

Signature of Employee/ Eligible Member
(If this is an application for Dependant(s), the Employee will sign on behalf of the Dependant(s))

_____

Name of the Employee/ Eligible Member

*Please delete accordingly.