APPLICATION FOR REINSTATEMENT FOR ELDERSHIELD SUPPLEMENT / GREAT CARESHIELD

Great Eastern
A member of the OCBC Group

Reinstatement is subject to approval of underwriting by the Company and payment of outstanding premiums.

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 DETAILS OF POLICY AND POLICYHOLDER

Plan Type	ElderShield Supplement	GREAT CareShield
Policy No.		
Full Name of Policyholder		
NRIC No.		
Email Address		
Contact No.	Mobile:	Home:
Current Height and Weight	Height: ☐ • ☐☐ M	Weight: ☐☐☐ • ☐ KG

B DECLARATION OF HEALTH

Please answer the following questions relating to the Life Assured:

	Yes	No
1. Do you need assistance of another person or mechanical aids in the performance of your activities of daily living such as washing (bathing), dressing, feeding (eating), walking, transferring from bed to chair and maintaining continence; or in the past 12 months, have you stopped doing any of the following day to day activities due to your health condition(s): - housework, preparing meals, opening and sorting mails, using public transport, shopping for groceries or personal needs, participating in social activities?	☐	☐
2. Have you been diagnosed with the following condition(s): Cancer, Diabetes, Heart diseases, Stroke, Depression, Nervous breakdown, Kidney diseases, Liver diseases, Lung diseases, Dementia, Alzheimer's disease, Parkinson's disease, Motor neurone disease, Multiple Sclerosis, AIDS or HIV infection, Arthritis, Paralysis, Spinal conditions or any other serious condition(s)?	☐	☐
3. 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.		
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 the Company and other insurance company(ies) exceeds the following amounts:		
a) $3,000 per month for Long-Term Care (2 Activities of Daily Living (ADLs) and above for 6 months)	☐	☐
b) $3,000 per month for Long-Term Care (1 ADL)	☐	☐

**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

If the answer is "Yes" to any of the questions 3 a) to b), please complete separate Genetic Questionnaire.

If the answer is "Yes" to any of the questions 1 to 2, please give details below and complete the Special Health Questionnaire for each medical condition.

_____

_____

_____

_____

- Please complete the next page -

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)
Email: wecare-sg@greateasternlife.com Website: greateasternlife.com

CS604 JAN 2023

Plan Type	ElderShield Supplement	GREAT CareShield
Policy No.		

C DECLARATION

1. 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 application is accepted by the Company.
2. I confirm that I am not an undischarged bankrupt and that no Statutory Demand has been served on me and no bankruptcy order has been made against me.
3. I declare that the information given in this application and my questionnaire(s)/forms and all subsequent written notices furnished to the Company are true, correct and complete to the best of my knowledge and belief and that no material fact(s), that is, fact(s) likely to influence the assessment and acceptance of this application have been withheld. I further agree that any information that I have provided to the Financial Representative are disclosed in this application.
4. By providing the information set out above, I agree and consent to Great Eastern 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 sharing amongst themselves my personal data, for purposes reasonably required by the Companies to evaluate my proposal and to provide the products or services which I am 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"). These Purposes are set out in the 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.
5. I agree that this application form and the policy, all subsequent written notices given by the Company to me and all subsequent written statements given by me to the Company will make up the whole of the Contract of insurance between the Company and me.
6. There is no change to my existing premium payment arrangement, unless otherwise instructed by me via the Change Payment Method & Authorisation Form.

   (Note: For existing payment method on CPF MediSave / Credit Card, a deduction will be made automatically upon approval of underwriting)

Signature of Policyholder	**Date**