

# ACCIDENT & HEALTH PLANS APPLICATION FOR REINSTATEMENT



**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) Please note that policy reinstatement is subject to satisfactory health underwriting.  
 3) Upon underwriting, we may require medical information, the costs of which will be payable by the policyholder.

**POLICY NUMBER:** \_\_\_\_\_

**NAME OF POLICYHOLDER:** \_\_\_\_\_ **NRIC OF POLICYHOLDER:** \_\_\_\_\_

**NAME OF LIFE ASSURED:** \_\_\_\_\_ **NRIC OF LIFE ASSURED:** \_\_\_\_\_

I request to reinstate the above expired Policy for all Lives under my Policy except for Lives whose insurance has been terminated and may not be renewed under the terms and conditions of my Policy; and on the terms and conditions of the latest Version of the Policy issued by The Great Eastern Life Assurance Company (the Company) for the Plan Type issued under my Policy subject to the terms of the Reinstatement. I declare that all Lives Insured under my policy:

		Please tick	
		Yes	No
1.	Has changed occupation as last declared in this policy and are engaged in any occupation, sport or pastime activity of a hazardous nature;	<input type="checkbox"/>	<input type="checkbox"/>
2.	Has ever sought medical advice or treatment during the period since the Termination Date of my policy and are intending to seek medical advice or treatment in the foreseeable future for any medical condition, symptom or injury;	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has been diagnosed to suffer from osteoporosis, any mobility problems and physical disabilities;	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has resided outside the Country of Issue.	<input type="checkbox"/>	<input type="checkbox"/>

If any of the above statements is 'Yes', please give details below:

I understand and agree that if my application for reinstatement is accepted:

- I shall pay the premium for reinstatement to the Company within 15 days of the acceptance of the application for reinstatement by the Company or before the end of the reinstatement period; whichever is earlier (the date of payment of the premium for reinstatement Date).
- Any endorsement(s) or variations on my Policy authorized by the Company, will apply to the policy issued upon reinstatement of insurance.
- The insurance shall exclude any claim that occurs after the termination date of my Policy and before the Reinstatement Date which is the date in which the application for reinstatement has been approved and the required premium is paid to and accepted by the Company.
- The Policy issued upon reinstatement shall exclude any claims for expenses incurred as described in my Policy under the heading "Reinstatement of Policy" for which I have understood.
- I understand that if the life assured has been diagnosed with any cancer (including any carcinoma\_in\_situ) before or within 90 days from the date of reinstatement of this Policy, I am not entitled to claim from this Policy. (Applicable for Early Cancer Care Policies Only)
- I understand that if the life assured has been diagnosed with any cancer (early, intermediate or major) or undergoing of such medical procedure which is regarded as a cancer (early, intermediate or major) within 90 days from the date of reinstatement of this Policy, I am not entitled to claim from this Policy. (Applicable for GREAT Cancer Guard Policies Only)

I agree to inform the Company if there is any change in my health between the date of the application for reinstatement and the Reinstatement Date. On receiving the information, the Company is entitled to accept or reject my application for reinstatement.

**I declare that the statements made and particulars given in this application are true, correct and complete.**

Signature of Policyholder (and Company Stamp, if applicable) \_\_\_\_\_

Date (DD/MM/YY) \_\_\_\_\_

### PAYMENT METHOD

Yes, I want to stay protected!

Choose your most convenient way to pay your premium.

( ) CHEQUE / BANK DRAFT  
 (Please cross your cheque, make it make it payable to "Great Eastern Life" and write your policy number and NRIC number on the reverse)

( ) CREDIT CARD  Visa or  MasterCard

One time deduction  Current and Future Premiums

Number:

Expiry Date:

Name of Cardholder\*: \_\_\_\_\_

Signature of Cardholder: \_\_\_\_\_

**Note:**

**Cardholder must be the Policyholder to complete this form.**

**To complete credit card authorisation form CS243 if using 3rd party credit card.**

Contact No: