**For Health Products**

* P O L C H G *

Singlife

# HEALTH DECLARATION

**IMPORTANT NOTE:** PURSUANT TO SECTION 23(5) INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

| | | | |
|---|---|---|---|
| Policy Number(s) | | | |
| Name of Assured | | NRIC/FIN Number | |
| Name of Life Assured | | NRIC/FIN Number | |

Any disease or condition of health will not qualify for benefit unless it is fully disclosed to and accepted by us. You must ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the coverage effective date is given for consideration by us. Should you require more space for your answers, please continue on a separate sheet, sign and date it.

**If you are unsure whether any information is material or not, you are advised to disclose it.**

## TYPE OF REQUESTS

- ☐ **Reinstatement** (Please complete Sections A and D)
- ☐ **Upgrade of Plan** (For Singlife Shield / Singlife Health Plus only) - please complete Sections C and D
- ☐ **Update / Additional information on medical conditions** (Please complete Sections C and D).

## SECTION A: REINSTATEMENT

1. You are required to affirm the declaration below if your policy(ies) lapsed within a year.
   ☐ I declare that:
   a) There has been no change in the Life Assured's health* since the policy issue date.
   b) The Life Assured has not:
      • sought or been advised to seek any medical consultation, treatment or follow-up; or
      • undergone any medical tests, investigations, procedures, or surgery.
   c) The Life Assured is not currently experiencing any symptoms or health condition that may require medical consultation, advice or treatment.
      *You do not need to inform us of minor illnesses that have fully resolved and have not recurred since recovery (e.g. dengue fever, influenza, sinusitis).
2. If you are unable to affirm the declaration above, please complete:
   a) Section B and Section D for Singlife Cancer Cover Plus
   b) Section C and Section D for Singlife Shield and/or Singlife Health Plus

## SECTION B: UNDERWRITING QUESTIONS (FOR SINGLIFE CANCER COVER PLUS ONLY)

| | |
|---|---|
| 1. Have you ever had, or are you currently experiencing symptoms related to any of the following?<br>a. Cancer, carcinoma in situ of any kind, Hepatitis B (other than healthy carriers*), Hepatitis C, Cirrhosis, liver disease due to alcohol, Crohn's disease, Ulcerative Colitis, Barrett's Oesophagus or HIV/AIDS?<br>**Never been on medication and liver function normal in the last 12 months.* | ☐ Yes ☐ No |
| b. The following growth(s) which doctors have advised that no treatment nor referral to a specialist is needed - adenomyosis, cervical cyst, chalazion, dermoid cyst, endometriosis, keratinous cyst, nabothian cyst, sebaceous cyst, or spinal synovial cyst. | ☐ Yes ☐ No |
| c. Congenital brain cyst (arachnoid/colloid), endometrial polyp, gallbladder polyp, haemangioma, lipoma, ovarian cyst, pilonidal cyst, rhabdomyoma, or uterine fibroid.<br>If you answered 'Yes' to Question 1(c), please specify the growth(s) and confirm whether the growth(s) has/have been fully removed, with no recurrence and no further follow-up required. | ☐ Yes ☐ No |



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## SECTION B: UNDERWRITING QUESTIONS (FOR SINGLIFE CANCER COVER PLUS ONLY) *(continued)*

| | |
|---|---|
| d. Breast growth (fibroadenoma, fibrocystic breast disease, simple breast cyst, or other breast growth).<br>If you answered 'Yes' to Question 1(d) due to simple breast cyst ONLY, please confirm whether the simple breast cyst has been fully removed, with no recurrence and no further follow-up required. | ☐ Yes ☐ No |
| e. Colon polyp. | ☐ Yes ☐ No |
| f. Any other growth not listed above. | ☐ Yes ☐ No |
| 2. Have you been advised or intend to undergo any of the following:<br>• biopsy, tumour markers, endoscopy, colonoscopy, ultrasound, CT/MRI/PET scan, mammography, pap smear, OR<br>• had any investigations/tests?<br>*For routine screening by age and results are normal or scans done due to injury or heart disease (e.g. heart valve disorder, etc.), please answer No.<br>If you answered 'Yes' to Question 2, please select ONE option from (i) to (iii).<br>(i) No growth, suspicious or abnormality found, no treatment, follow-up or monitoring was advised. ☐<br>(ii) Abnormal result (e.g. growth found or suspected, readings out of reference range) or advised for treatment, follow-up or monitoring. ☐<br>(iii) Awaiting test completion or test result. ☐ | ☐ Yes ☐ No |
| 3. Did you have any of these symptoms in the last 6 months:<br>a. weight loss of 5 kgs or more without diet or lifestyle modification; or<br>b. coughing with blood; or<br>c. unusual bleeding or discharge from any body part for more than one week continuously; or<br>d. persistent change in bowel or bladder habits; or<br>e. a mole or skin blemish which has changed in appearance. | ☐ Yes ☐ No |

## SECTION C: UNDERWRITING QUESTIONS (FOR SINGLIFE SHIELD/SINGLIFE HEALTH PLUS ONLY)

**IMPORTANT NOTE**
By completing this section, your policy will be assessed under Full Medical Underwriting option. If your policy is under the Moratorium underwriting option, the Moratorium underwriting option will no longer apply. Additional terms including exclusions, may also be added to your policy.

| | |
|---|---|
| 1. What is your height? | ☐ metres |
| 2. What is your weight? | ☐ kgs |
| 3. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)? | |
| a. Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder | ☐ Yes ☐ No |
| b. High blood pressure or high cholesterol? | ☐ Yes ☐ No |
| c. Cancer, or malignant tumour/growth/lump/nodule/polyp/cyst of any kind including cancer screening tests that were not normal? | ☐ Yes ☐ No |
| d. Benign tumour/growth/lump/nodule/polyp/cyst? | ☐ Yes ☐ No |
| e. Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder? | ☐ Yes ☐ No |
| f. Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder? | ☐ Yes ☐ No |
| g. Depression, anxiety, stress or any other mental or nervous disorder? | ☐ Yes ☐ No |
| h. Drug or alcohol addiction or abuse? | ☐ Yes ☐ No |
| i. Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)? | ☐ Yes ☐ No |



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## SECTION C: UNDERWRITING QUESTIONS (FOR SINGLIFE SHIELD/SINGLIFE HEALTH PLUS ONLY) *(continued)*

| | | |
|---|---|---|
| 3. j. | Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder? | ☐ Yes ☐ No |
| k. | Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder? | ☐ Yes ☐ No |
| l. | Hepatitis B or C, fatty liver, jaundice, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder? | ☐ Yes ☐ No |
| m. | AIDs, HIV or sexually transmitted disease? | ☐ Yes ☐ No |
| n. | Anaemia, thalassaemia, haemophilia or any other blood disease or disorder? | ☐ Yes ☐ No |
| o. | Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder? | ☐ Yes ☐ No |
| p. | Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)? | ☐ Yes ☐ No |
| q. | Any other illness, disorder, operation, physical disability, injury or hospitalisation not mentioned above? | ☐ Yes ☐ No |

4. For application of life assured who is a dependant child (aged one year and below), please answer the following questions.

   If you answered 'Yes' to any of questions 4(a) to (c) below, please provide a full copy of the child's Health Booklet.

| | | |
|---|---|---|
| a. | Were there any significant events during pregnancy or delivery of the child including but not limited to difficulties during or at birth, congenital mental developmental issues, respiratory distress syndrome, prolonged neonatal jaundice, respiratory disorder? | ☐ Yes ☐ No |
| b. | Was the child a premature baby (i.e. less than 37 weeks of gestation)? | ☐ Yes ☐ No |
| c. | Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment? | ☐ Yes ☐ No |

**IMPORTANT NOTE:**
- If you answer 'Yes' to either Question 3 or 4 above, please complete the table below.

| Question no. | Medical condition and exact diagnosis | Date of **first** symptoms, diagnosis or recurrence |
|---|---|---|
| | | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs<br>☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs |

Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?

☐ **Yes** ☐ **No**

How long since your **full recovery**? ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs ☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs

What treatment or medication did you take?

Name and address of doctor consulted

| Question no. | Medical condition and exact diagnosis | Date of **first** symptoms, diagnosis or recurrence |
|---|---|---|
| | | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs<br>☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs |

Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?

☐ **Yes** ☐ **No**

How long since your **full recovery**? ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs ☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs

What treatment or medication did you take?

Name and address of doctor consulted



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## SECTION C: UNDERWRITING QUESTIONS (FOR SINGLIFE SHIELD/SINGLIFE HEALTH PLUS ONLY) *(continued)*

| Question no. | Medical condition and exact diagnosis | Date of **first** symptoms, diagnosis or recurrence |
|---|---|---|
| | | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs<br>☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs |

Have you made a **full recovery** with no further treatment, recurrence of condition, ongoing symptoms or complications?

☐ **Yes** ☐ **No**

How long since your **full recovery**? ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs ☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs

What treatment or medication did you take?

Name and address of doctor consulted

5. In the **last 5 years**, have you had any **medical test(s) with abnormal results**, such as X-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, Covid-19 PCR, pap smear or mammogram? ☐ Yes ☐ No

   If '**Yes**', please complete the table below:

| Name of medical test | Date of initial test |
|---|---|
| | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs<br>☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs |

Have you had a follow-up test? ☐ Yes ☐ No

If '**Yes**', what was the result? ☐ Normal ☐ Abnormal ☐ Don't know

Date of follow-up test ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs ☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs

Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring? ☐ Yes ☐ No

If '**Yes**', please provide details

Name and address of **doctor** whom you consulted

| Name of medical test | Date of initial test |
|---|---|
| | ☐ 0 – 6 mths ☐ 7 – 12 mths<br>☐ 2 – 3 yrs ☐ 3 – 5 yrs |

Have you had a follow-up test? ☐ Yes ☐ No

If '**Yes**', what was the result? ☐ Normal ☐ Abnormal ☐ Don't know

Date of follow-up test ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 – 2 yrs ☐ 2 – 3 yrs ☐ 3 – 5 yrs ☐ > 5 yrs

Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring? ☐ Yes ☐ No

If '**Yes**', please provide details

Name and address of **doctor** whom you consulted



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## SECTION C: UNDERWRITING QUESTIONS (FOR SINGLIFE SHIELD/SINGLIFE HEALTH PLUS ONLY) *(continued)*

6. Are you currently experiencing symptoms or considering seeking medical advice or treatment for your health other than minor illness such as cold or flu? ☐ Yes ☐ No

   If '**Yes**', please complete the table below:

| | |
|---|---|
| What are the symptoms or condition? | |
| Date of first symptoms | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 yr or more |
| Date of any planned medical consultation | |
| What are the symptoms or condition? | |
| Date of first symptoms | ☐ 0 – 6 mths ☐ 7 – 12 mths ☐ 1 yr or more |
| Date of any planned medical consultation | |

## SECTION D: DECLARATION

I/We agree to inform Singapore Life Ltd. ("Singlife") if there is any change in the state of my/our health or other disclosures, statements or declarations that I/we have made in this Health Declaration between the date of this application and the date the policy includes but is not limited to any change in the state of my/the proposed life assured's health, or if I/the proposed life assured plan to seek medical consultation, investigation, or treatment, or any change to my existing insurance policies or concurrent insurance applications that I/we have. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We declare that the information given is true and complete and that I/we have not withheld any material information that may influence the assessment of my/our application.

I/We agree that this declaration will constitute part of my/our application/policy and that failure to disclose any material known fact(s) by me/us may render the contract void from the start and nothing may be payable under the Policy.

For and on behalf of myself and the Life Assured, I/we consent to Singlife collecting, processing and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies) and account(s), and for statistical, research, compliance, audit and regulatory purposes.

For and on behalf of myself and the Life Assured, I/we also consent to Singlife disclosing and/or transferring my/our personal data to Singlife related group of companies, third party service providers, reinsurers, suppliers and/or intermediaries (including my/our financial adviser, where applicable), whether located in Singapore or elsewhere, for the above purposes, and managing my/our relationship with Singlife related group of companies.

For and on behalf of myself and the Life Assured, I/we confirm that I/we have read, understood and agree to be bound by the terms of Singlife's Data Protection Notice (found on https://singlife.com/en/pdpa) as may be amended, supplemented and/or substituted by Singlife from time to time and confirm that I/we am/are aware that the latest version of such terms (amended, supplemented and/or substituted version) will be posted on Singlife's website and such version shall bind me/us upon posting and/or where I/we continue to use the relevant products and services offered by Singlife to which such terms relate to.

I/We am/are aware that I/we can view and download a copy of Genetics Moratorium Factsheet from www.singlife.com.

If Singlife accepts any Instalment Premium or any part of Instalment Premium paid after the Grace Period, it does not mean this Policy will continue or be reinstated.

Singlife shall have the right to reject any application for any other reasons.

I/We understand and agree that the changes requested in this application:

a) may require medical evidence, and I/We will pay any costs involved in providing the medical evidence Singlife needs;
b) are subject to Singlife's underwriting and acceptance;
c) if accepted, may be subjected to terms, conditions and exclusions imposed by Singlife; and
   will take effect only when Singlife has accepted and approved my/our application, notified me/us in writing of the cover start date and provided that I/we have paid the required premiums (and interest, if applicable) in full.



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## SECTION D: DECLARATION *(continued)*

| | | |
|---|---|---|
| Signature of Assured / Policyholder (Owner)<br>> *Your signature must be consistent with our record*<br><br>Name of Assured / Policyholder (Owner)<br>> *Name as in NRIC* | Mobile number<br><br>Email address | Signed Date<br>(DD/MM/YY) |
| Signature of Life Assured<br>> *For age next birthday 17 years and above*<br>> *Your signature must be consistent with our record*<br><br>Name of Life Assured<br>> *Name as in NRIC* | | Signed Date<br>(DD/MM/YY) |

**NOTE:**
Mobile number and email address provided will replace our records accordingly.



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