ntuc income

DECLARATION OF CONTINUED ASSURABILITY

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP. 142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You must disclose all facts as you know or ought to know which may affect the insurance cover being applied for. Otherwise, the insurance policy issued may not be valid.

Particulars of Policyholder/Assignee

Name (as shown in NRIC) of Policyholder/Assignee*				NRIC No.	Policy No.
Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Height (m)	Weight (kg)	Contact No. (O) (Hp)	(H)
Name of Company/School				Occupation/Position	Exact Nature of Work

Particulars of Insured (If different from Policyholder)

INSURED 1:
Relationship with Policyholder ☐ Child ☐ Spouse ☐ Other ______ (Please specify)

Name (as shown in NRIC)				Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Height (m)	Weight (kg)	Occupation/Position
Name of Company/School				Exact Nature of Work

INSURED 2:
Relationship with Policyholder ☐ Child ☐ Spouse ☐ Other ______ (Please specify)

Name (as shown in NRIC)				Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Height (m)	Weight (kg)	Occupation/Position
Name of Company/School				Exact Nature of Work

INSURED 3:
Relationship with Policyholder ☐ Child ☐ Spouse ☐ Other ______ (Please specify)

Name (as shown in NRIC)				Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Height (m)	Weight (kg)	Occupation/Position
Name of Company/School				Exact Nature of Work

Lifestyle

		Policyholder	Insured 1	Insured 2	Insured 3
Do you consume beer, alcohol, opium or any other stimulants? If "Yes", indicate type and quantity and frequency.	Type ______ (eg. beer, wine, other alcoholic beverages/opium or any other stimulants). Quantity ______ Frequency ______ (per day/per week/per month)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you smoke cigarettes, cigars, etc. If "Yes", indicate type and quantity per day and for how long have you been a smoker?	No of sticks per day ______. No of years ______. Type ______ (eg. cigarettes, cigars etc)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you engage or have you any prospect or intention of engaging in aviation other than as a passenger on a regular airline or any other hazardous occupation, sports or pursuits? If so, give details.		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Do you have any intention of residing abroad for more than 3 months other than for holidays or studies? If "Yes", please provide details including country, duration and reason.		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Family History

	Policyholder	Insured 1	Insured 2	Insured 3
Have any of your natural parents or siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis, dementia or any hereditary disease? If "Yes", please provide details of age(s), relationship and cause of death or condition(s).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

	Living			Deceased		
Family Record	Age	Health	Age at Onset	Age at Death	Cause of Death and Details	Duration of Illness
Wife (or Husband)						
Father						
Mother						
Brothers No. Living ______ No. Deceased ______						
Sisters No. Living ______ No. Deceased ______						

Particulars of Regular Doctor

Name and Address of Regular Doctor	
Policyholder	Insured 1
Insured 2	Insured 3

Last Date of Consultation and Reason	
Policyholder	Insured 1
Insured 2	Insured 3

Questions on Health

	Policyholder	Insured 1	Insured 2	Insured 3
1. Have you ever had or been told to have or been treated for: (a) epilepsy, fits, stroke, paralysis, weakness of limb, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(b) diabetes, thyroid disorders or any other endocrine disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(c) double vision, impaired sight, hearing or speech, ear discharge, nose bleeds or any other disorders of eye, ear, nose or throat?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(g) jaundice, hepatitis B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(h) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, or genital organs?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

	Policyholder	Insured 1	Insured 2	Insured 3
(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(j) cancer, tumour, cyst or growth of any kind?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(k) 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	☐Yes ☐No	☐Yes ☐No
(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
2. Have you or your spouse received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS Related Complex or any other AIDS related conditions?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
3. Have you had HIV testing done (please state reason and results), or in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
4. Have you had or been advised or planning to go for any appointment for surgery or any investigation or tests such as X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine tests, etc or have you had or been advised for any hospital admissions? If "Yes", please give details of condition(s) and any abnormalities.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
For Females (In addition to Questions 1-4, complete Question 5 also)	Policyholder	Insured 1	Insured 2	Insured 3
5. (a) Have you had or are you aware of or received any treatment for or intend to be treated for: (i) any disease or disorder of the breast including breast lump, cyst, fibroadenoma, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ, cancer or growth?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(ii) any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, abnormal enlargement of the abdomen, carcinoma in situ or cancer?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(iii) irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorder of the female organs?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(b) Have you been advised or have you at any time undergone a PAP smear; mammogram; biopsy; ultrasound or operation of the breasts; ultrasound of the pelvis; cone biopsy or colposcopy or any other gynaecological investigations? If "yes", please state type, reason, date of test done and results of test (copy to be submitted if available).	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(c) Are you now pregnant? If "yes", how many months?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(d) If you had previous pregnancies, (i) Were there any complications during your pregnancy or as a result of your pregnancy (e.g. ectopic pregnancy, diabetes, high blood pressure or protein in urine)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(ii) Have any of your children suffered from hereditary disorders (e.g. Spina bifida or Down's syndrome)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
(iii) Have any of your children suffered from congenital disorders (e.g. club foot, hole-in-heart or cleft lip/palate)?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

If "Yes" to the health questions, please indicate the disorder and provide the full details accordingly.				
	Policyholder	Insured 1	Insured 2	Insured 3
Name of disorder/operation/disability				
i. When did the symptoms start? (mm/yyyy)				
ii. Date of recovery, if any. (mm/yyyy)				
iii. Have you been discharged from follow-up?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
iv. Have you ever been hospitalised for this disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
v. Has the disorder occurred several times?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Option 1** For Revival of Policy (by paying the arrears of premium together with interest)

☐ **Option 2** Application to include/increase Life Insurance benefits

☐ **Option 3** Redeclaration of Health

Declaration

I/We declare that the above answers are true, correct and complete, and, whether written by me/us or by anyone else on my/our behalf, I/We accept full responsibility for them. I/We have not withheld any material information. I/We agree that:

(a) This declaration and any other written answers, statements or information made by me/us or on my/our behalf shall form the basis of the reinstatement of the policy, any variation to the policy or any supplementary contract of insurance between me/us and NTUC Income.

(b) NTUC Income is not liable until I/We have been notifed in writing that NTUC Income has reinstated the policy, effected the changes requested by me/us to the policy, or issued and delivered a supplementary contract of insurance and the premium paid in full by me/us.

(c) This application is subject to NTUC Income's underwriting and acceptance, and if accepted, may be subject to terms and conditions imposed by NTUC Income.

Signed in Singapore on the day of 20	
Signature of Policyholder/Assignee*	Signature of Insured
Signature of Witness	Name & NRIC No. of Witness

* Delete where applicable. For policies with assignee, assignee needs to complete and sign the form.

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Information to Policyholder:
Submission of Declaration of Continued Assurability (DCA) form

1. DCA form must be signed by Policyholder/Assignee and/or Insured. It must be witnessed by a person above 21 years of age.
2. For Revival of Policy – In order to revive the policy, the Policyholder and/or Insured needs to declare his/her new health conditions and may be subjected to new exclusions, loading on health and even rejection.
3. For Inclusion/Increase Life Insurance Benefits – It is compulsory for the Policyholder and/or Insured to declare his/her current state of health and/or if he/she is suffering from any medical condition. This application is subject to NTUC Income's underwriting and acceptance.