

DEPENDANTS' PROTECTION SCHEME

HEALTH DECLARATION FORM

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP142 (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.

Section A: Particulars of Policyholder

Name (as shown in NRIC) Please underline surname		NRIC/CPF Account No.	Policy No.
Contact No. (Hp) _____ (O) _____ (H) _____	Email _____		
Occupation _____	Exact Duties Involved _____		

Section B: Medical Underwriting Questions

		If 'Yes', please specify
<p>It is necessary for you to declare the condition of your health for your Dependants' Protection Scheme (DPS) cover. Otherwise, future claims for DPS benefits arising from undisclosed pre-existing serious illness(es) or physical/mental impairment will not be admitted. Serious illness refers to cancer, ischaemic heart disease, coronary artery disease, chronic renal disease, kidney failure, stroke, chronic liver cirrhosis or systemic lupus erythematosus, psychiatric or mental illness and any other illness which in the opinion of our panel of independent medical practitioners, constitutes a life threatening condition. Please complete this form and return it to us within 60 days from your risk commencement date.</p> <p>1. Have you ever had or been told to have or been treated for any</p> <ul style="list-style-type: none"> (a) cancer, growth or tumour, (b) diabetes, thyroid or endocrine disease, (c) blood, lupus or other immune disease, (d) high blood pressure, heart disease or chest pain, (e) stroke, epilepsy or mental conditions, (f) kidney disease or blood or protein in urine, (g) hepatitis or liver disease, (h) lung disease or persistent cough, (i) AIDS or HIV infection or test, (j) hereditary disease or congenital abnormalities, (k) other illness, disorder, injury, physical disability or abnormality, or (l) been hospitalised or undergone surgery in the last 5 years? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you considering, for any reason, to seek consultation, investigation or treatment of any kind by any medical or healthcare professional or institution?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever used drugs or substances in an illegal way or suffered from alcoholism or drug addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Has any of your proposals for life, critical illness or medical insurance on your life to any insurance company ever been declined, postponed or accepted at other than normal terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Please state Height and Weight.		
Height _____ (m) Weight _____ (kg)		

Section C: Preferred Payment Method (Please complete this section if you wish to top-up.)

Please choose a preferred premium payment method by ticking on one of the boxes below.

- Cash/Cheque made payable to "NTUC Income".
- Deduction from CPF Ordinary Account and/or Special Account. I have ensured there is sufficient fund in my CPF OA/SA.

Section D: Declaration and Authorisation

I authorise the Central Provident Fund Board to deduct premium(s) from my Ordinary/Special account in accordance with the provisions of the Central Provident Fund Act (Chapter 36), and the regulations made thereunder and as amended from time to time and subject to all terms and conditions as may be imposed by the Central Provident Fund Board from time to time.

I authorise the Central Provident Fund Board to disclose/seek information on a confidential basis to/from my insurer(s) such information relating to:

- i) payment of premiums due under this proposal, including the deduction of premiums from my Ordinary/Special Account; and
- ii) the making of refunds under this proposal, as Central Provident Fund Board shall reasonably consider appropriate.

I declare that the information provided by me in this form is true and correct and I have not withheld any material information, whether entered in by me or on my behalf.

I agree and authorise any medical source, insurance office and/or organisation to release to NTUC Income, and NTUC Income to release to any medical source and/or insurance office any relevant information concerning me at any time, irrespective of whether the proposal is accepted by NTUC Income.

Without prejudice to the generality of the above statement, I consent to the transfer and disclosure, at any time and without notice or liability to me of any medical information on me in the insurer's possession to the Central Provident Fund Board for:

- (a) the purpose of making of a claim under the DPS or any other insurance scheme referred to in the Central Provident Fund Act (Chapter 36) which I may be insured under; or
- (b) any purpose connected with the administration or operation of the accounts maintained by the Board for me under the Central Provident Fund Act (Chapter 36).

I agree that this consent shall not be affected by any subsequent physical or mental disorder, disability or incapacitation which I may suffer from. In addition, I agree that this consent shall remain valid notwithstanding my death.

Signature/Thumb Print of Policyholder

Date (dd/mm/yyyy)

For Official Use

Age	Status	
	<input type="checkbox"/> Standard-Accept <input type="checkbox"/> Manual-Accept <input type="checkbox"/> Reject	
Standard-Underwritten by	Manual-Underwritten by	Date Underwritten