

Declaration/Replacement of Existing Policy(ies)

Declaration of Existing Policies

Do you have any existing policy(ies)? If "Yes", please provide details. Yes No

Name of Company	Sum Assured	Type of Policy	Year Issued

Warning: It is usually disadvantageous to replace an existing life assurance policy(ies) with a new one for the following reasons: -

- (i) insurance may not be granted on standard terms;
- (ii) a higher premium may have to be paid in view of increased age;
- (iii) the financial benefits accumulated over the years may be lost.

In your own interest, we would advise that you consult your present insurer(s) before making a final decision. Hear out both sides and make a careful comparison. You can then be sure that you are making a decision that is in your best interest.

Is the assurance now applied for intended to replace any policy(ies) listed above? If "Yes", which policy(ies)? We need the information as we are required to inform the existing insurer(s) that the policy(ies) may be replaced. Yes No

Has any proposal or application for a Life or Accident or Hospital Assurance Policy ever been declined, postponed and accepted at other than normal terms? If "Yes", please give details of company(ies) and why. Yes No

Lifestyle

		Proposer
Do you consume beer, alcohol, opium or any other stimulants? If "Yes", please indicate quantity per day.	_____ bottles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke cigarettes, cigars, etc.? If "Yes", please indicate quantity per day.	_____ sticks	<input type="checkbox"/> Yes <input type="checkbox"/> 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 "Yes", please provide particulars.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Family History On Insured

	Proposer
Has either of your natural parents or any of siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis or any hereditary disease? If "Yes", please provide details of age(s), relationship and cause of death or condition(s).	<input type="checkbox"/> Yes <input type="checkbox"/> No

Particulars of Regular Doctor

Name and Address of Regular Doctor	Proposer	Insured
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
Last Date of Consultation and Reason	Proposer	Insured
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Questions On Health

Please complete this section: **For sum assured below \$50,000**

	Proposer
1. Have you ever suffered from or received treatment for disease of the heart or circulatory system, stroke, high blood pressure, diabetes, cancer, growth or other malignancy, kidney or bladder disorders, asthma, other respiratory disorders, liver disease such as Hepatitis, epilepsy, hereditary diseases and eye disorders.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you suffered from physical or mental impairment or deformity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you undergone or are you undergoing any medical treatment/surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete this section: **For total sum assured above \$50,000**

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diabetes, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) double vision, impaired sight, hearing or speech, ear discharge, nose bleeds or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) jaundice, hepatitis B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past five years, have you had any test done such as X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram(ECG), blood or urine test? If "Yes", please provide details of any abnormalities detected.	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Females only

5. (a) Have you had or are you aware of any breast lumps or any other disorders of your breasts?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Have you had irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Have you had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to the above health questions, please indicate disorder and provide the full details accordingly.

	Proposer 1	Proposer 2
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Have you ever been hospitalised for this disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Has the disorder occurred several times?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declaration and Authorisation

I hereby declare that the foregoing answers are true and whether written by me or by anyone else on my behalf I accept full responsibility for them; and that I have not withheld any material information; and that this assurance is to be taken out by me and the premiums to be paid thereon are to be paid by me. I agree that there shall be no liability upon NTUC Income until a policy has been issued and delivered to me and the first premium paid in full. And I, the Life to be Assured, agree and authorise :

(a) Any medical source, insurance office, or organisation to release to NTUC Income, and

(b) NTUC Income to release to any medical source, insurance office,

any relevant information concerning me at the time, irrespective of whether the proposal is accepted by NTUC Income or not. A photographic copy is as valid as an original copy.

I understand that it is usually disadvantageous to replace an existing investment product e.g. unit trust, with a new investment product, whether from the same/different financial institution.

I have been given the following documents, the contents of which were explained to my satisfaction :

(a) Your Guide to Life Insurance, (b) Products Summary, and (c) Benefit Illustration.

I also wish to apply for admission as a member of NTUC Income and if accepted, I agree to be bound by the By-Laws of NTUC Income.

If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the adviser but was not included in the proposal. Please check to ensure you are fully satisfied with the information declared in this proposal.

Signed in Singapore on the _____ day of _____ 20____	Signature of Witness
Signature of Proposer/Insured	Name & NRIC No. of Witness

CPFIS Special Account

TO: THE CENTRAL PROVIDENT FUND BOARD

I hereby irrevocably authorise the Board to:

1. Debit my CPF Special Account the sum of monies specified by NTUC Income or the amount determined by the Board for the purchase/placement of life insurance policy(ies) approved under the CPFIS-SA including any related fees, expenses and charges under the CPF Investment Scheme - Special Account (CPFIS-SA).
2. Credit my CPF Special Account with any income or any proceeds from the liquidation of life insurance policy(ies) approved under the CPFIS-SA that are received from NTUC Income.
3. Disclose any particulars or information whatsoever relating to or in connection with my investment with NTUC Income to facilitate any transactions that cannot be settled due to data discrepancies, insufficient funds or any other reasons that the board deems fit.

I understand that the above transactions shall be made, subject to the provisions of the Central Provident Fund Act and the Central Provident Fund (Investment Schemes) Regulations as may be amended from time to time and also to all such terms and conditions as may be imposed by the Board from time to time.

I hereby agree to indemnify the Board and shall keep the Board indemnified against all actions, proceedings, liabilities, claims, damages, expenses or legal costs whatsoever arising out of in connection with the Board accepting and acting upon this authorisation.

Signature of Proposer	Name (as shown in NRIC)	Date (dd/mm/yyyy)
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Adviser's Declaration

1. I declare that all the answers given to me by the Proposer/Insured are declared in the proposal. I have not withheld any other information which may influence the acceptance of this proposal by NTUC Income.
2. I am aware that NTUC Income takes a serious view of non-disclosure and action will be taken against me if I am deemed a party to the non-disclosure.
3. I have personally SEEN the Proposer/Life Insured and have explained the terms of the policy to the Proposer.
4. I have seen the original identification documents and attached a photocopy herewith. I confirm that the attached is a photocopy of the original.

	Proposer	Insured	Signature of Adviser & Date
NRIC/Passport No.			
Date of Birth (dd/mm/yyyy)			
5. Is the life assurance intended to replace an existing policy? If "Yes", please give details.			<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is the proposed life assured related to any other NTUC Income's representative? If "Yes", why is this insurance being proposed?			<input type="checkbox"/> Yes <input type="checkbox"/> No