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# Group Health Declaration

**Statement under section 23(5) of Insurance Act 1966 (or any future amendments to it)**
You must reveal all facts you know, or ought to know, which may affect the insurance cover you are applying for.
Otherwise, the insurance policy may not be valid.

| Name of company | Group policy number | Plan/sum assured |
|---|---|---|
| | | |

| Occupation/position of main insured | Effective date (dd/mm/yyyy) |
|---|---|
| | |

## Details of insured(s)

| **Main insured**<br>Name (as shown in NRIC/work pass) | | | NRIC number/FIN |
|---|---|---|---|
| Date of birth (dd/mm/yyyy) | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality): _____<br>☐ Others: _____ | | | Country of residence |
| **Spouse**<br>Name (as shown in NRIC/work pass) | | | NRIC number/FIN |
| Date of birth (dd/mm/yyyy) | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality): _____<br>☐ Others: _____ | | | Country of residence |
| **Child 1**<br>Name (as shown in NRIC/BC) | | | NRIC/BC number |
| Date of birth (dd/mm/yyyy) | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality): _____<br>☐ Others: _____ | | | Country of residence |

| **Child 2**<br>Name (as shown in NRIC/BC) | | | NRIC/BC number |
|---|---|---|---|
| Date of birth (dd/mm/yyyy) | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality): _____<br>☐ Others: _____ | | | Country of residence |
| **Child 3**<br>Name (as shown in NRIC/BC) | | | NRIC/BC number |
| Date of birth (dd/mm/yyyy) | Gender<br>☐ Male ☐ Female | Height (metres) | Weight (kilograms) |
| Nationality<br>☐ Singaporean<br>☐ Singapore PR (Nationality): _____<br>☐ Others: _____ | | | Country of residence |

## Questions on health

| Question | Main insured | Spouse | Child 1 | Child 2 | Child 3 |
|---|---|---|---|---|---|
| 1. Has any application for life, medical or accident insurance been declined, postponed or accepted on special terms? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. In the past five years, any medical leave of more than seven days continuously or any hospitalisation (except normal pregnancy) or surgery? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. In the past five years, have you been examined, received medical advice or treatment, or have been in hospital or clinic? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Have you been told (by a doctor) or treated for any health condition relating to: | | | | | |
| a) Heart, lungs or any respiratory disorder, kidney, liver | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b) Thyroid, nervous system, breasts, reproductive system | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c) Hereditary or congenital condition | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d) Cancer or tumour | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e) Hypertension, stroke, chest pain | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f) Diabetes | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g) Disorder of the blood, SLE (Systemic Lupus Erythematous), Hepatitis B or C, HIV (Human Immunodeficiency Virus) infection, AIDS or STD (Sexually Transmitted Diseases) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h) Any other illness, injury or disability not mentioned above? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Have you been advised to have any surgical operation? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Do you have any physical impairment, defect or deformity or mental condition or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Have you visited any General Practitioner(s) or Specialist(s) in the last six months. (For outpatient only) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. Do you or are you likely to engage in an occupation or any activities which could be considered dangerous? If "Yes", please state the activity. | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

If you have answered "Yes" to any of the above questions, please give full details including dates, name of hospital or insurer, reasons, descriptions, diagnoses, treatment, still on follow-up or fully recovered or cured and attach medical reports, if available. Please include the respective question number(s) for your answer.

## Personal Data Use Statement

By providing the information and submitting this application or transaction, I/we consent and agree to Income Insurance Limited ("Income"), its representatives, agents, relevant third parties (referred to in Income's Privacy Policy at https://www.income.com.sg/privacy-policy), Income's appointed insurance intermediaries and their respective third party service providers and representatives (collectively "Income Parties") to collect, use, and disclose any personal data in this form or obtained from other sources, including existing personal data provided, any future updates and subsequent information on my/our health or financial situation (collectively "personal data") for the purposes of processing and administering my/our insurance application or transaction, managing my/our relationship and policies with Income including providing me/us with financial advice/ financial planning services, sending me/us corporate communication and information on products and/or services related to my/our ongoing relationship with Income, conducting research and data analytics, and in the manner and for other purposes described in Income's Privacy Policy.

Where the personal data of another person(s) (for example, personal data of the insured person, my family, employee, payee/payer or beneficiary) is provided by me/us (whether in this or subsequent submissions) or from other sources to Income Parties, I/we represent and warrant that:

- I/we have obtained their consent for the collection, use and disclosure of their personal data; and
- I am/we are authorised to give any authorization and approval on their behalf for the purposes as set out in this Personal Data Use Statement.

Please refer to Income's Privacy Policy (https://www.income.com.sg/privacy-policy) for more information, including access and correction to personal data and consent withdrawal.

## Declaration by main insured

I cannot alter any of the wordings in this application form. Any attempt to do so will have no effect.

I confirm (a) that I understand and agree to the collection, use and disclosure of the personal data as stated in the "Personal Data Use Statement" (PDUS) above and (b) on the representation and warranty made in the PDUS.

I authorise, consent and agree to the following:

- Income Parties to collect from and/or disclose to the group policyholder, the personal data for all the relevant purposes listed above and in Income's Privacy Policy including to respond to enquiries from the group policyholder for the purposes of this application and policy servicing matters, including confirmation of eligibility for the cover; and
- The group policyholder to disclose the personal data to Income Parties for all the relevant purposes listed above and in Income's Privacy Policy.

For the purpose of this application, I authorise, consent and agree to:

a. the medical source, insurance office, reinsurer, organisation to release to Income any medical or relevant information to do with me or the Insured whether Income accepts this application or not;
b. Income and its relevant third parties stated in Income's Privacy Policy to collect from, use and/or disclose to any medical source, insurance office, reinsurer, or organisation any medical or relevant information to do with me or the Insured; and
c. Income or any of its approved medical examiners or laboratories to perform the necessary medical assessment and tests for Income to underwrite and evaluate me or the Insured's health status or condition in relation to this application.

I agree that a copy of this authorization is valid and binding as an original copy.

I declare that the statements and answers given in this form are true, correct and complete. I accept full responsibility for them, whether written by me or by anyone else on my behalf. I have not withheld any information. If it is discovered later that I or the other insured suffer from a medical condition that is not disclosed in this form, I will not be entitled to rely on the defence that the information was disclosed for or in the records of other policies with Income. I agree that this form and other written answers, statements, information or declarations I have made or which have been made on my behalf will form the basis of the contract of insurance between my employer and Income. If anything is untrue, incorrect or incomplete, I understand that my insurance cover shall be absolutely void.

I confirm that there has been no change in my heath or the Insured's health since the completion of the application and all additional declarations made in connection with the application. I will notify Income immediately if there is any change in the state of my health or the Insured's health, or if I or the Insured plan to seek medical consultation, investigation, or treatment between the date of this application and the date this policy is in force. I am aware that Income may add special terms to my cover including limiting or reducing the insurance cover or sum assured of this application according to the information provided by me. I understand and agree that Income may declare my insurance cover as void according to the information provided or if I fail to notify Income of any change in the state of my health or the Insured's health.

I acknowledge and agree that this form will constitute part of my employer's application for Group Insurance, and will form the basis of the contract of insurance.

I agree that this form may be signed by electronic or digital signature, whether encrypted or not, which will be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Electronic signature may include electronically scanned and transmitted versions (e.g., via pdf) of an original signature.

**I agree that if I do not reveal any significant facts in this application (which would have affected Income's decision to accept my application on standard terms), any policy issued may be invalid. This includes any fact I may not be sure is significant, and any information I have given to my employer or the intermediary but was not included in this form.**

| Signature of main insured | Name of main insured | Date (dd/mm/yyyy) |
|---|---|---|