Singlife

# GROUP HEALTH DECLARATION FORM (ICB)

For Official Use Only
Group Policy No.:

Date: _____

**IMPORTANT NOTE: Pursuant to Section 23(5) of the Insurance Act 166, you are to disclose in this form, fully and faithfully, all facts which you know or ought to know, otherwise, nothing may be payable under the Policy.**

Name & Address of Proposer: _____ Name of Company: _____

Plan Type: _____ Contact Details (Home): _____ (Work): _____ (Email): _____

## (A) EMPLOYEE'S PARTICULARS

| Full Name of Proposed Insured in Block (as shown in NRIC - underline surname) | | | | Nationality | Race<br>Asian ☐<br>Others ☐ | Country of Residence | Height (cm) | Weight (kg) |
|---|---|---|---|---|---|---|---|---|
| NRIC / Passport No. | Date of Birth | Gender<br>Male / Female # | Marital Status | Occupation - Exact Duties | | | Date of Employment | |

## (B) DEPENDANT'S INFORMATION (Please ignore this section if dependants are not covered)

| Relationship | Name | Occupation | NRIC / Passport No. | Nationality | Race | Country of Residence | Gender | Date of Birth DD / MM / YY | Height (cm) | Weight (kg) |
|---|---|---|---|---|---|---|---|---|---|---|
| Dependant 1 | | | | | Asian ☐ Others ☐ | | | | | |
| Dependant 2 | | | | | Asian ☐ Others ☐ | | | | | |
| Dependant 3 | | | | | Asian ☐ Others ☐ | | | | | |
| Dependant 4 | | | | | Asian ☐ Others ☐ | | | | | |

## (C) HEALTH QUESTIONS

(Note: Any alteration in this form must be signed.)

| | Employee | | Dependant 1 | | Dependant 2 | | Dependant 3 | | Dependant 4 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| 1. Have you ever had or been told to have or been treated for: | | | | | | | | | | |
| a. epilepsy / fits, stroke, paralysis / weakness of limb, prolonged headache, nervous breakdown, depression or any other nervous / mental disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. ear discharge, nose bleeds, double vision, impaired sight, hearing, or speech or any other disorders of ear, eye, nose and throat? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| c. asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, breathing complaints / discomfort or any other lung disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. raised cholesterol, high blood pressure, heart attack, mitral valve prolapse or other heart valve disorders, breathlessness, irregular heart rate, chest pain, or any disease or disorders of the heart or blood vessels? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| e. diabetes mellitus, thyroid disorders or any endocrine disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. jaundice, hepatitis B carrier or any form of hepatitis, liver or gallbladder disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. cancer, tumour, cyst or growth of any kind? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| j. slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| k. any sexually transmitted disease or have received any medical advice or counselling for AIDS related conditions (including HIV positive)? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| l. endometriosis, fibroids, breast and/or ovarian cysts/lumps/tumours, abnormal pap smear, irregular or painful menstruation or any other gynaecological disorders? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| m. anaemia, haemophilia or any disorders of the blood or any other congenital or hereditary disorders not listed above? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| n. Other than the conditions listed above, have you had any other health condition which led to: | | | | | | | | | | |
| - more than 10 consecutive days off work | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| - more than 5 consecutive days of hospital admission | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| - follow up consultations or treatment lasting more than a month | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Have you smoked cigarettes in the last 12 months? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| If 'Yes', please state number of sticks smoked per day and the number of years. — No. of sticks/day | | | | | | | | | | |
| No. of years | | | | | | | | | | |
| 3. Do you consume alcohol? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| If 'Yes', please state the type, quantity and frequency. — Type | | | | | | | | | | |
| Quantity | | | | | | | | | | |
| Frequency (per week) | | | | | | | | | | |

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*(cont'd...)*

*(cont'd...)*

| | Employee | | Dependant 1 | | Dependant 2 | | Dependant 3 | | Dependant 4 | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Yes | No | Yes | No | Yes | No | Yes | No |
| 4. Have you ever been treated for drug or alcohol addiction? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. Have you had<br>- any biopsy, CT scans, or<br>- any abnormal or pending investigations, scans, blood or urine tests?<br>If 'Yes', please provide below details such as reason, date and results of test done and the diagnosis:<br>Reason: _____<br>Date: _____<br>Type of test(s): _____<br>Result: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. Have you ever been accepted at special terms or rates, deferred or declined for any application, renewal, or reinstatement of life, accident, health disability or other insurance policy?<br>If 'Yes', please provide details on date of application and reason for special terms.<br>_____<br>_____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7. Do you engage or have any intention of engaging in hazardous activity or occupation such as private flying, scuba diving, motor racing, mountaineering etc?<br>If 'Yes', please state details such as locations, frequency, depth, etc.<br>_____<br>_____ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. Have any of your natural parents or siblings died or suffered from (a) heart disease, (b) high blood pressure, (c) stroke, (d) diabetes, (e) cancer, (f) kidney disease, (g) mental disorder, (h) muscular disorder, or any other hereditary disease?<br>If 'Yes', please state relationship, condition, age at onset of condition and age at death (if deceased). | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| Relationship | Condition/Cause of Death | Age at Onset | If Deceased, Age at Death |
|---|---|---|---|
| | | | |
| | | | |

| Relationship | Condition/Cause of Death | Age at Onset | If Deceased, Age at Death |
|---|---|---|---|
| | | | |
| | | | |

If any of the answers to Question 1 is YES, please PROVIDE COMPLETE INFORMATION and MEDICAL REPORT. If necessary, please attach a separate sheet.

| Name | Sub-Qn. (Eg. a,b) | Medical Condition | Date of Diagnosis | Treatment | | Name & Address of Doctor / Hospital | Current medical status (eg. fully recovered, follow up treatment/investigation required?) |
|---|---|---|---|---|---|---|---|
| | | | | Date | Duration | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**(D) PERSONAL DATA CONSENT(S)**

I/We consent to Singapore Life Ltd. ("Singlife") (and Singlife related group of companies) collecting, using 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), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singlife (and Singlife related group of companies) transferring my/our personal data to Singlife (and Singlife related group of companies) and their respective third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

I/We have read and understood Singlife's Data Protection Notice which may be found at singlife.com/pdpa. Singlife's Data Protection Notice may be updated from time to time without notice. I/We am/are aware that I/we should visit your website regularly to ensure that I/we am/are well informed of the updates.

**(E) DECLARATION**

I/We declare that all the information on this Application Form is true and complete to the best of my knowledge and understand that any misrepresentation or concealment of facts shall render the policy to be issued null and void. I agree that this application shall be the basis of the insurance coverage issued under the said Group Insurance Policy. I understand that the insurance coverage shall not become effective until it is accepted and confirmed in writing by Singapore Life Ltd.

I agree to inform Singapore Life Ltd if there is any change in the state of my and/or my dependants' health/activities between the date of this Health Declaration and the date full insurance coverage is provided by Singapore Life Ltd to me and/or my dependant(s). I understand that the terms of accepting me and/or my dependant(s) as a risk for insurance coverage may vary according to such information received.

I consent to Singapore Life Ltd seeking information from any doctor who has attended to me and/or my dependant(s) or from other insurance company to which I and/or my dependant(s) have at any time made a proposal for insurance and I authorise the giving of such information. I further authorise Singapore Life Ltd to give you such information obtained or information contained herein for the purpose of obtaining insurance cover under the said Group Policy to the insurance intermediary / administrator of the said Group Insurance Policy.

I/We am/are aware that the product I/We am/are applying for is authorised for sale in Singapore and I/we acknowledge that the laws and regulations applicable to my/our nationality and country of residence allows my/our purchase of this product. I/We understand that no liability can be accepted by Singapore Life Ltd for any legal consequences under the laws of any other country or any tax implications that may arise in connection with my/our purchase of this product.

**Only applicable to Group Medical products for all voluntary and flexible benefits:** I/We confirm that I/we have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these two documents.

| Signature of Employee | Signature of Dependants aged 16 years and above | | | |
|---|---|---|---|---|
| | Signature of Dependant 1 | Signature of Dependant 2 | Signature of Dependant 3 | Signature of Dependant 4 |
| Date D D M M 2 0 Y Y | Date D D M M 2 0 Y Y | Date D D M M 2 0 Y Y | Date D D M M 2 0 Y Y | Date D D M M 2 0 Y Y |

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