(For Health Products)

HEALTH DECLARATION

* P O L C H G *

Singlife with AVIVA

IMPORTANT NOTE: PURSUANT TO SECTION 23(5) INSURANCE ACT 1966, YOU ARE TO DISCLOSE IN THIS APPLICATION FORM FULLY AND FAITHFULLY ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE INSURANCE EFFECTED MAY BE VOID.

Policy Number(s)			
Name of Assured		NRIC/FIN Number	
Name of Life Assured		NRIC/FIN Number	

Any disease or condition of health will not qualify for benefit unless it is fully disclosed to and accepted by us. You must ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the coverage effective date is given for consideration by us. Should you require more space for your answers, please continue on a separate sheet, sign and date it.

If you are unsure whether any information is material or not, you are advised to disclose it.

TYPE OF REQUESTS

☐ Change / Additional information on medical conditions

☐ Upgrade of Plan / Options
Please submit together with Request for Changes to Individual Health Policies (Singlife Shield / Singlife Health Plus) form.

- ☐ If your existing policy is under Full Medical Underwriting (FMU) – please complete Sections A, B and C.
- ☐ If your existing policy is under Moratorium Underwriting (MO) – please complete Sections A and C only.
  If you answer 'Yes' to any of the questions in Section A, please also complete Section B.

☐ Reinstatement

- ☐ If your existing policy is under Full Medical Underwriting (FMU) – please complete Sections A, B and C.
- ☐ If your existing policy is under Moratorium Underwriting (MO) – please complete Sections A and C only.
  If you answer 'Yes' to any of the questions in Section A, please also complete Section B.

Singapore Life Ltd. 4 Shenton Way, #01-01, SGX Centre 2 Singapore 068807 Tel: (65) 6827 9933 singlife.com
Company Reg. No. 196900499K GST Reg. No. MR-8500166-8

SECTION A: UNDERWRITING HISTORY

IMPORTANT NOTE:

- If you choose to complete Section B even though you are not required to do so, you understand and agree that your answers will be taken into consideration in processing your Singlife Shield and/or Singlife Health Plus claims.
- If you answer 'Yes' to any below questions, please complete Section B.

1. Have you had an application of a Life, Critical Illness, Health, Accident, Disability policy deferred, declined or required to pay Additional Premiums for MediShield Life? If '**Yes**', please note that your underwriting option would have to be Full Medical Underwriting and you are required to complete Section B and the information below. Change of plan/ reinstatement may be subject to new counter-offer terms by Singapore Life Ltd. after underwriting. Name of Insurer: _____ Type of Policy: _____ Reason: _____	☐ Yes ☐ No If you are required to pay Additional Premiums for MediShield Life, please also provide a copy of the CPF MediShield Life Additional Premium Letter.
2. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)? • AIDS or HIV infection • Alzheimer's disease • Angioplasty • Any form of Cancer • Atherosclerosis • Autism • Bipolar Disorder • Chronic cor pulmonale • Chronic Kidney disease • Chronic Obstructive lung disease • Coronary Artery Disease (CAD) • Dementia • Diabetes Mellitus / Impaired Glucose tolerance • Down syndrome • Heart attack • Heart bypass • Hepatitis C/D • Ischaemic Heart Disease (IHD) • Kidney failure • Liver cirrhosis • Multiple sclerosis • Muscular Dystrophy • Organ transplant • Osteoporosis • Paralysis • Polycystic Kidney disease • Pulmonary hypertension • Schizophrenia • Stroke • Systemic Lupus Erythematosus (SLE) • Thalassaemia intermediate/major	☐ Yes ☐ No

SECTION B: HEALTH QUESTIONS

1. What is your height?	metres
2. What is your weight?	kgs
3. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)?	
a) Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder?	☐ Yes ☐ No
b) High blood pressure or high cholesterol?	☐ Yes ☐ No
c) Cancer, or malignant tumour/growth/lump/nodule/polyp/cyst of any kind including cancer screening tests that were not normal?	☐ Yes ☐ No
d) Benign tumour/growth/lump/nodule/polyp/cyst?	☐ Yes ☐ No
e) Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?	☐ Yes ☐ No

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SECTION B: HEALTH QUESTIONS *(continued)*

f)	Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?	☐ Yes ☐ No
g)	Depression, anxiety, stress or any other mental or nervous disorder?	☐ Yes ☐ No
h)	Drug or alcohol addiction or abuse?	☐ Yes ☐ No
i)	Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?	☐ Yes ☐ No
j)	Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?	☐ Yes ☐ No
k)	Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?	☐ Yes ☐ No
l)	Hepatitis B or C, fatty liver, jaundice, abnormal or elevated liver function, gallstones or any other liver or gallbladder disease or disorder?	☐ Yes ☐ No
m)	AIDs, HIV or sexually transmitted disease?	☐ Yes ☐ No
n)	Anaemia, thalassaemia, haemophilia or any other blood disease or disorder?	☐ Yes ☐ No
o)	Kidney stones, kidney infection, urine abnormalities or any other kidney, bladder, prostate or gynaecological disease or disorder?	☐ Yes ☐ No
p)	Eye, ear, nose or throat disease or disorder (excluding sight problems corrected by prescription lenses)?	☐ Yes ☐ No
q)	Any other illness, disorder, operation, physical disability, injury or hospitalisation not mentioned above?	☐ Yes ☐ No

4. For application of life assured who is a dependant child (aged one year and below), please answer the following questions:

a)	Were there any significant events during pregnancy or delivery of the child including but not limited to difficulties during or at birth, congenital mental developmental issues, respiratory distress syndrome, prolonged neonatal jaundice, respiratory disorder?	☐ Yes ☐ No
b)	Was the child a premature baby (i.e. less than 37 weeks of gestation)?	☐ Yes ☐ No
c)	Has the child been advised or been told to go for further follow up or further evaluation after each routine assessment?	☐ Yes ☐ No
	If you answered 'Yes' to any of questions 4(a) to (c) above, please provide a full copy of the child's Health Booklet and complete the table below.	☐ Yes ☐ No

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SECTION B: HEALTH QUESTIONS *(continued)*

IMPORTANT NOTE:

- If you answer 'Yes' to either Question 3 or 4 above, please complete the table below.

Name of Condition	Date of first symptoms, diagnosis or recurrence	Have you made a full recovery with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of doctor whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ Yes ☐ No How long has it been since your full recovery? ☐ 0 to 6 month ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more What treatment or medication are you taking?	Name: Address:
Name of Condition	Date of first symptoms, diagnosis or recurrence	Have you made a full recovery with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of doctor whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ Yes ☐ No How long has it been since your full recovery? ☐ 0 to 6 month ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more What treatment or medication are you taking?	Name: Address:
Name of Condition	Date of first symptoms, diagnosis or recurrence	Have you made a full recovery with no further treatment, recurrence of condition, ongoing symptoms or complications?	Name and address of doctor whom you consulted
Question ( ) Condition:	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more	☐ Yes ☐ No How long has it been since your full recovery? ☐ 0 to 6 month ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years ☐ 5 years or more What treatment or medication are you taking?	Name: Address:

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SECTION B: HEALTH QUESTIONS *(continued)*

5. In the **last 5 years**, have you had any **medical test(s) with abnormal results**, such as X-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, Covid-19 PCR, pap smear or mammogram?

   If '**Yes**', please complete the table below:

☐ Yes ☐ No

Name of medical test	Date of initial test	Have you had a follow-up test?	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/ monitoring?	Name and address of **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', please provide details	Name: Address:
Name of medical test	Date of initial test	Have you had a follow-up test?	Date of follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/ monitoring?	Name and address of **doctor** whom you consulted
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', what was the result? ☐ normal ☐ abnormal ☐ don't know	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ 3 to 5 years	☐ Yes ☐ No If '**Yes**', please provide details	Name: Address:

6. Are you currently experiencing symptoms or considering seeking medical advice or treatment for your health other than minor illness such as cold or flu?

   If '**Yes**', please complete the table below:

☐ Yes ☐ No

What are the symptoms or condition?	Date of first symptoms	Date of any planned medical consultation
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	
	☐ 0 to 6 months ☐ 7 to 12 months ☐ 1 year or more	

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SECTION C: DECLARATION

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

I/We declare that the information given is true and complete and that I/we have not withheld any material information that may influence the assessment of my/our application.

I/We agree that this declaration will constitute part of my/our application/policy and that failure to disclose any material known fact(s) by me/us may render the contract void from the start and nothing may be payable under the Policy.

I/We consent to 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) disclosing and 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 am/are aware that I/we can view and download a copy of Genetics Moratorium Factsheet from www.singlife.com.

I/We have read and understood Singlife's Data Protection Notice which may be found at www.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.

Signature of Assured / Policyholder (Owner) *> Your signature must be consistent with our record*	Mobile number	Date (DD/MM/YY)
	Email address	
Name of Assured / Policyholder (Owner) *> Name as in NRIC*		

Signature of Life Assured / Insured Person *> For age next birthday 16 years and above* *> Your signature must be consistent with our record*	Date (DD/MM/YY)
Name of Life Assured / Insured Person *> Name as in NRIC*	

NOTE:
Mobile number and email address provided will replace our records accordingly.

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