NTUC Income Insurance Co-operative Limited
Income Centre 75 Bras Basah Road Singapore 189557
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an NTUC Social Enterprise

For office use (Policy number)

Dependants' Protection Scheme

Health declaration

Statement under section 25(5) of Insurance Act, Cap. 142 (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.

Section A: Your details

Name (as shown in NRIC)		NRIC number	Policy number
Contact number (Handphone) (Office) (Home)		Email	
Occupation	Exact duties involved	Height (metres)	Weight (kilograms)

The contact number and email in Section A are for us to use to contact you and check on any requests for changes (if needed). We will not add the details to our records. To change your home address, contact number and email, please fill in the 'Change of personal particulars form'.

Section B: Medical underwriting questions

It is necessary for you to declare the condition of your health for your Dependants' Protection Scheme (DPS) cover. If you are suffering from any undisclosed pre-existing serious illness, claims will not be admitted. Please refer to our website www.income.com.sg/dps-list-of-serious-illness.pdf for the list of serious illnesses.

1. Have you ever had or been told to have or been treated for any of the following medical conditions: (a) ischaemic heart disease/coronary heart disease, heart valves disorders or arrhythmia (irregular heartbeats), (b) cancer, (c) stroke/cerebrovascular disorders, tumour of the brain or arteriovenous malformation, (d) renal failure or renal dialysis, (e) diabetes with complications, (f) chronic liver disorders, liver cirrhosis, hepatic encephalopathy or liver failure, (g) AIDS/HIV infection, (h) dementia/Alzheimer's disease, (i) severe psychiatric or mental illness, (j) motor neuron disease, (k) muscular dystrophy, (l) paralysis (hemiplegia/paraplegia/quadriplegia), (m) chronic lung disease, (n) rheumatoid arthritis with complications, (o) multiple sclerosis, (p) systemic lupus erythematosus with complications, (q) parkinson disease with complications, (r) pulmonary hypertension, (s) aplastic anaemia, thalassaemia major or severe blood disorders, or (t) any other illness, disorder, injury, physical disability or abnormality not listed above?	☐ Yes ☐ No

If the answer to any of the above medical conditions is Yes, please provide details below.

Medical condition	Date/symptoms/ signs	Date of investigation/ type of tests done and results/ name of clinic or hospital	Treatment (name of drug)/ surgery (period of hospital admission)	Present condition (eg. still on follow up, receiving treatment, fully recovered & discharged)

2. Other than for the medical conditions or symptoms that you have already told us about, have you had or been advised by a doctor to have surgery or any medical tests/investigations (for example blood test, urine test, X-ray, ECG, Ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check) during the last 5 years? Or do you intend to have any surgery or tests or investigations in the coming year?	☐ Yes ☐ No

If yes, please provide details below.

Date	Type of test(s)/ surgery done	Reason for test(s)/ surgery done	Results	Name of clinic or hospital	Follow up/treatment required (Yes/No) If yes, please provide details including type of treatment and name of drug.

3. Have you ever used drugs or substances in an illegal way or drug addiction or had alcoholism?	☐ Yes ☐ No

If yes, please provide details below.

Type of substance/ alcohol used	Period of usage	Date of completion of treatment	Name of clinic or hospital	Date of complete abstinence	Fully discharged (Yes/No)

4. Have any of your applications or reinstatement of a life insurance or health insurance policy ever been declined, postponed or accepted with special conditions (for example loading or exclusions)?	☐ Yes ☐ No

If yes, please provide the details below.

Name of insurer	Type of policy/loading/exclusion	Reasons

5. Have you ever made any claims or are you intending to make any claims under any life, health or accident policies, whether individual or group plans, with us or any other insurer?	☐ Yes ☐ No

If yes, please provide details below.

Type of claim(s) (eg. critical illness, hospitalisation, disability, accident)	Details of claim(s)	Date of claim(s)	Name of insurer

Section C: Preferred payment method

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, correct and complete and I have not withheld any material information, whether entered in by me or on my behalf.

I confirm that I understand and agree to the 'Personal data collection statement'.

I agree and authorise any medical source, insurance office and/or organisation to release to Income, and 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 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 or thumb print of policyholder	Date (dd/mm/yyyy)

For official use

Age	Status ☐ Standard-accept ☐ Manual-accept ☐ Reject

Standard-underwritten by	Manual-underwritten by	Date underwritten