

DECLARATION OF CONTINUED INSURABILITY FORM

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP. 142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You must disclose all facts as you know or ought to know which may affect the insurance cover being applied for. Otherwise, the insurance policy issued may not be valid.

Name of Proposer (as shown in NRIC)	NRIC No.
Name of Insured (as shown in NRIC)	NRIC No.
Relationship of Insured with Proposer	Policy No.
Occupation of Insured	Nature of Work

Questionnaire

1. Please state your height and weight.	___ m ___ kg
2. Have you ever taken addictive drugs, narcotics or been treated for drug addiction in the past 5 years? If "Yes", please state the name of drug(s), quantity, frequency and duration of use as well as date of last treatment.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you currently undergoing or have been advised to undergo any form of medical treatment, medication or follow-up? If "Yes", please provide exact diagnosis, date of onset, investigations and results, treatment and current status.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you ever undergone or have been advised by a doctor to undergo surgery or any tests such as X-rays, ultrasound, CT Scan, MRI Scan, electrocardiograms, blood and urine tests, biopsy, mammogram and pap smear? If "Yes", please provide exact diagnosis, date of onset, investigations and results, treatment and current status.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you had or been told (by a doctor) to have or been treated for asthma, cancers, tumours, lumps, nodules, polyps, cysts, diseases or disorders of the heart (including high blood pressure, heart attack, heart murmur, heart valve disorder, chest pain), diabetes, epilepsy, fits, hepatitis, liver diseases, raised cholesterol, kidney or urinary disorders (including protein and/or blood in urine), stroke, blood disorders, mental disorders, respiratory disorders, thyroid disorders, autoimmune diseases (eg. lupus), diseases and disorders of the eye, ear, nose or throat, musculo-skeletal disorders, gastro-intestinal disorders, HIV infection, sexually transmitted diseases, any recurring symptoms or illnesses/physical deformities not listed above? If "Yes", please provide exact diagnosis, date of onset, investigations and results, treatment and current status.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have any of your natural parents or siblings ever had or been treated for cancers, heart diseases, stroke, high blood pressure, diabetes, kidney diseases, mental disorders or any diseases which was born with or passed down from parents? If "Yes", please state the condition(s), age of onset and relationship.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you engage in aviation activities other than as a passenger on a regular airline or any other hazardous occupation (eg. commercial diver, military pilot), sports or pursuits (eg. motor racing, rock climbing)? If "Yes", please state the activity.	<input type="checkbox"/> Yes <input type="checkbox"/> No
8a. Have you had any application for life, accident or health insurance policy declined, postponed or accepted at other than normal terms? If "Yes", please advise the reason and the medical condition(s) if any.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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8b. Have you submitted any claim under any life, health and/or accident policies, whether individual or group plans, with any insurers within the last 12 months? If "Yes", please provide details accordingly.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Do you smoke 20 (or more) sticks of cigarettes per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. For female insured/spouse: Are you currently pregnant? If "Yes", please state the number of month(s) and whether there is any complication (e.g. raised blood pressure, sugar or protein in urine etc).	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please complete this additional section: For ElderShield/ElderShield Supplement application	
11. Has the insured stopped any day-to-day activities in the past one year such as doing housework, preparing meals, shopping, using public transport or any hobby due to health or disability? If "Yes", please provide details on activities affected, date of onset and reasons.	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Does the insured require any assistance of another person or mechanical aids such as a cane, crutches, wheelchair or walker in the performance of the Activities of Daily Living? If "Yes", please provide details on the reason(s) and aid(s) used.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Declaration by Proposer/Insured(s)

I/We agree to inform NTUC Income as soon as possible if there is any change in the state of my and/or the life to be insured's health or if I and/or the life to be insured plan to seek any medical consultation, investigation or treatment between the date of this application and before the date the policy is issued by NTUC Income. I/We understand that NTUC Income may impose terms, including limiting or reducing the insurance cover or sum assured of this proposal (where applicable), according to the information provided by me/us.

I/We declare and warrant that the answers given in this application are true, correct and complete and I/we accept full responsibility for them, whether written by me/us or by anyone else on my/our behalf. I/We have not withheld any information. I/We agree that this application and other written answers, statements, information or declarations made by me/us or on my/our behalf shall form the basis of the contract of insurance between me/us and NTUC Income and if anything untrue, incorrect or incomplete is stated, the insurance policy issued shall not be valid. I/We agree that NTUC Income's liability shall only commence when the proposal is accepted by them, the first premium is paid in full and written notification of the commencement of cover is made known to me/us.

I/We am/are aware that I/we can seek advice from an insurance adviser before I/we sign this application. Should I/we choose not to, I/we take sole responsibility to ensure that this product is appropriate for my/our financial needs and insurance objectives.

 Signature of Proposer
 (if different from Insured)

 Signature of Insured (If Insured's age next
 birthday is 17 years and above)

 Date (dd/mm/yyyy)