

**ELDERSHIELD SUPPLEMENT ALTERATION FORM**

To: Group & Health Department

Name (as shown in NRIC)

NRIC No.

Address

Policy No.

Increase monthly benefit amount to \$ \_\_\_\_\_ monthly benefit

Reduce monthly benefit amount to \$ \_\_\_\_\_ monthly benefit

Others

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Agreement**

I wish to change the above policy according to the above request(s). I understand and agree that the changes:

- (a) are subject to NTUC Income's underwriting and acceptance;
- (b) if accepted, may be subject to terms, conditions and exclusions imposed by NTUC Income;
- (c) will take effect only when NTUC Income accepts and approves my request(s) and notifies me in writing of the effective date of the change(s); and if applicable to my request(s), provided that I have paid the premium in full

I \_\_\_\_\_ (Name & Signature of Proposer) \_\_\_\_\_ (NRIC No.)

agree and authorise any medical source, insurance office or organisation to release to NTUC Income, and NTUC Income to release to any medical source, insurance office or organisation any relevant information concerning me at any time, irrespective of whether this proposal is accepted by NTUC Income. A photocopy of this authorisation shall have the same effect as the original.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Date (dd/mm/yyyy)

**IMPORTANT NOTES:**

1. Changes can only be approved for policy's duration less than 2 years from policy inception.
2. Submit Declaration of Continued Insurability form with this Alteration form.
3. Changes will be effective from next renewal date.
4. Existing payment mode for your ElderShield Supplement policy will still apply.

GH/G6113/ES/Alter/09/2011

## 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 Policyholder (as shown in NRIC)	NRIC No.
Name of Insured (as shown in NRIC)	NRIC No.
Relationship of Insured with Policyholder	Policy No.

### 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

GH/1050/Life/09/2009

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. <b>For female insured/ spouse:</b> 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
<b>Please complete this additional section: For ElderShield / ElderShield Supplement application</b>	
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 and aids used.	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Declaration

I declare that the above answers are true, correct and complete, and, whether written by me or by anyone else on my behalf, I accept full responsibility for them. I have not withheld any material information. I agree that:

(a) this declaration and any other written answers, statements or information made by me or on my behalf shall form the basis of the reinstatement of the policy, any variation to the policy or any supplementary contract of insurance between me and NTUC Income.

(b) NTUC Income is not liable until I have been notified in writing that NTUC Income has reinstated the policy, effected the changes requested by me to the policy, or issued and delivered a supplementary contract of insurance / endorsement to me and the premium paid in full by me.

(c) this application is subject to NTUC Income's underwriting and acceptance, and if accepted, may be subject to terms, conditions and exclusion imposed by NTUC Income.

\_\_\_\_\_  
 Signature of Policyholder  
 (if different from Insured)

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

\_\_\_\_\_  
 Date (dd/mm/yyyy)