

LIFE POLICY ALTERATION FORM

To: Life Insurance Department

Name (as shown in NRIC) & NRIC No. of Policyholder / Assignee*:

Name (as shown in NRIC) & NRIC No. of Life Insured:

Relationship of Life Insured with Policyholder / Assignee*

Policy Number/s:

Type of Request/s	Details	Remarks	For Official Use (Scan under CS Type)
<input type="checkbox"/> Conversion of Plan	From _____ To _____	Applicable for LV Refund/LVGift/Convertible Term/Student Plan	<i>Product Transfer</i>
<input type="checkbox"/> Change of Plan	From _____ To _____	1. Policies must be in-force for less than 2 years. 2. Changing to a plan which is not launched on the original plan's inception date is not allowed. 3. Investment-linked policies (ILPs) cannot be changed to other policies and vice versa.	<i>Product Transfer</i>
<input type="checkbox"/> Increase Sum Assured	From _____ To _____	1. Policies must be in-force for less than 2 years. 2. Complete the 4-page Declaration of Continued Assurability (DCA) form overleaf.	<i>Increase Sum Assured</i>
<input type="checkbox"/> Decrease Sum Assured	From _____ To _____	1. Changes will be effective from next premium due date. 2. For policies with cash values, please attach a copy of policyholder/assignee's NRIC (front and back)	<i>Decrease Sum Assured</i>
<input type="checkbox"/> Increase Policy Term	From _____ To _____	1. Policies must be in-force for less than 2 years. 2. Complete the 4-page Declaration of Continued Assurability (DCA) form overleaf.	<i>Premium Payment Term Change</i>
<input type="checkbox"/> Decrease Policy Term	From _____ To _____	Policies must be in-force for less than 2 years.	<i>Premium Payment Term Change</i>
<input type="checkbox"/> Add Rider	Type of Rider (please circle): Hospital Benefit/Term/Enhanced Waiver/ Special Waiver/Waiver of Premium Other Rider/s to add: _____ Sum Assured: _____ Cover Term: _____	Complete the 4-page Declaration of Continued Assurability (DCA) form overleaf.	<i>Add Rider</i>
<input type="checkbox"/> Delete Rider	Type of Rider: _____ _____	Changes will be effective from next premium due date.	<i>Precontract Terminating Rider</i>
<input type="checkbox"/> Freelook/Other Requests	_____ _____		<i>Cooling Period Withdrawal</i>

Agreement

I wish to change the above policy/ies 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 I have paid the premium in full; and the rider issued and delivered to me.

Signature of Policyholder/Assignee*

Date (dd/mm/yyyy)

*Delete where applicable. For policies with assignee, assignee needs to complete and sign the form.

LI/MISC/11/2010

DECLARATION OF CONTINUED ASSURABILITY

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.

Particulars of Policyholder/Assignee

Name (as shown in NRIC) of Policyholder/Assignee*				NRIC No.	Policy No.
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (m)	Weight (kg)	Contact No. (O) (Hp)	(H)
Name of Company/School				Occupation/Position	Exact Nature of Work

Particulars of Insured (If different from Policyholder)

INSURED 1:					
Relationship with Policyholder <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please specify)					
Name (as shown in NRIC)					Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (m)	Weight (kg)	Occupation/Position	
Name of Company/School				Exact Nature of Work	
INSURED 2:					
Relationship with Policyholder <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please specify)					
Name (as shown in NRIC)					Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (m)	Weight (kg)	Occupation/Position	
Name of Company/School				Exact Nature of Work	
INSURED 3:					
Relationship with Policyholder <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ (Please specify)					
Name (as shown in NRIC)					Birth Cert/NRIC No.
Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (m)	Weight (kg)	Occupation/Position	
Name of Company/School				Exact Nature of Work	

Lifestyle

		Policyholder	Insured 1	Insured 2	Insured 3
Do you consume beer, alcohol, opium or any other stimulants? If "Yes", indicate type and quantity and frequency.	Type _____ (eg. beer, wine, other alcoholic beverages/opium or any other stimulants). Quantity _____ Frequency _____ (per day/per week/per month)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke cigarettes, cigars, etc. If "Yes", indicate type and quantity per day and for how long have you been a smoker?	No of sticks per day _____. No of years _____. Type _____ (eg. cigarettes, cigars etc)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you engage or have you any prospect or intention of engaging in aviation other than as a passenger on a regular airline or any other hazardous occupation, sports or pursuits? If so, give details.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any intention of residing abroad for more than 3 months other than for holidays or studies? If "Yes", please provide details including country, duration and reason.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Family History

Family History							
				Policyholder	Insured 1	Insured 2	Insured 3
Have any of your natural parents or siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney diseases, mental disorder, tuberculosis, dementia or any hereditary disease? If "Yes", please provide details of age(s), relationship and cause of death or condition(s).				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Living			Deceased		
Family Record	Age	Health	Age at Onset	Age at Death	Cause of Death and Details	Duration of Illness	
Wife (or Husband)							
Father							
Mother							
Brothers							
No. Living _____							
No. Deceased _____							
Sisters							
No. Living _____							
No. Deceased _____							

Particulars of Regular Doctor

Name and Address of Regular Doctor	
Policyholder	Insured 1
Insured 2	Insured 3
Last Date of Consultation and Reason	
Policyholder	Insured 1
Insured 2	Insured 3

Questions on Health

Questions on Health				
	Policyholder	Insured 1	Insured 2	Insured 3
1. Have you ever had or been told to have or been treated for:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) epilepsy, fits, stroke, paralysis, weakness of limb, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) diabetes, thyroid disorders or any other endocrine disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) double vision, impaired sight, hearing or speech, ear discharge, nose bleeds or any other disorders of eye, ear, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/discomfort or any other lung disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorder of the heart or blood vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(f) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(g) jaundice, hepatitis B carrier or any other form of hepatitis, liver disorder or gall bladder disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(h) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder, or genital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

	Policyholder	Insured 1	Insured 2	Insured 3
(i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(j) cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(k) anaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(l) any other illness, disorder, operation, physical disability or accident not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or your spouse received any medical advice, counselling or treatment in connection with sexually transmitted diseases, AIDS, AIDS Related Complex or any other AIDS related conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you had HIV testing done (please state reason and results), or in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you had or been advised or planning to go for any appointment for surgery or any investigation or tests such as X-ray, ultrasound, CT scan, biopsy, pap smear, electrocardiogram (ECG), blood or urine tests, etc or have you had or been advised for any hospital admissions? If "Yes", please give details of condition(s) and any abnormalities.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
For Females (In addition to Questions 1-4, complete Question 5 also)	Policyholder	Insured 1	Insured 2	Insured 3
5. (a) Have you had or are you aware of or received any treatment for or intend to be treated for:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) any disease or disorder of the breast including breast lump, cyst, fibroadenoma, fibrocystic disease, nipple changes or discharge, mammary dysplasia, Paget's disease of the nipple or breast, carcinoma in situ, cancer or growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) any disease or disorder of the cervix uteri, uterus or ovaries including ovarian cysts, abnormal uterine or vaginal bleeding, abnormal enlargement of the abdomen, carcinoma in situ or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorder of the female organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Have you been advised or have you at any time undergone a PAP smear; mammogram; biopsy; ultrasound or operation of the breasts; ultrasound of the pelvis; cone biopsy or colposcopy or any other gynaecological investigations? If "yes", please state type, reason, date of test done and results of test (copy to be submitted if available).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) Are you now pregnant? If "yes", how many months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If you had previous pregnancies,	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(i) Were there any complications during your pregnancy or as a result of your pregnancy (e.g. ectopic pregnancy, diabetes, high blood pressure or protein in urine)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(ii) Have any of your children suffered from hereditary disorders (e.g. Spina bifida or Down's syndrome)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(iii) Have any of your children suffered from congenital disorders (e.g. club foot, hole-in-heart or cleft lip/palate)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes" to the health questions, please indicate the disorder and provide the full details accordingly.				
	Policyholder	Insured 1	Insured 2	Insured 3
Name of disorder/operation/disability				
i. When did the symptoms start? (mm/yyyy)				
ii. Date of recovery, if any. (mm/yyyy)				
iii. Have you been discharged from follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv. Have you ever been hospitalised for this disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Has the disorder occurred several times?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Option 1 For Revival of Policy (by paying the arrears of premium together with interest) <input type="checkbox"/> Option 2 Application to include/increase Life Insurance benefits <input type="checkbox"/> Option 3 Redecclaration of Health				

Declaration

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

- (a) This declaration and any other written answers, statements or information made by me/us or on my/our behalf shall form the basis of the reinstatement of the policy, any variation to the policy or any supplementary contract of insurance between me/us and NTUC Income.
- (b) NTUC Income is not liable until I/We have been notified in writing that NTUC Income has reinstated the policy, effected the changes requested by me/us to the policy, or issued and delivered a supplementary contract of insurance and the premium paid in full by me/us.
- (c) This application is subject to NTUC Income's underwriting and acceptance, and if accepted, may be subject to terms and conditions imposed by NTUC Income.

Signed in Singapore on the _____ day of _____ 20____

Signature of Policyholder/Assignee*

Signature of Insured

Signature of Witness

Name & NRIC No. of Witness

* Delete where applicable. For policies with assignee, assignee needs to complete and sign the form.

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Information to Policyholder:

Submission of Declaration of Continued Assurability (DCA) form

1. DCA form must be signed by Policyholder/Assignee and/or Insured. It must be witnessed by a person above 21 years of age.
2. For Revival of Policy – In order to revive the policy, the Policyholder and/or Insured needs to declare his/her new health conditions and may be subjected to new exclusions, loading on health and even rejection.
3. For Inclusion/Increase Life Insurance Benefits – It is compulsory for the Policyholder and/or Insured to declare his/her current state of health and/or if he/she is suffering from any medical condition. This application is subject to NTUC Income's underwriting and acceptance.