

APPLICATION FOR CORPORATISED ENTITIES GROUP INSURANCE SCHEME

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.

INSTRUCTIONS: THIS PROPOSAL FORM TOGETHER WITH THE COMPLETED "AUTHORISATION FOR SALARY DEDUCTION FORM" MUST BE SUBMITTED TO NTUC INCOME THROUGH YOUR HR/ PERSONNEL DEPARTMENT.

Please tick on appropriate box. New Application Addition of Lives

Particulars of Proposer

Name (as shown in NRIC/FIN/Passport)			NRIC/FIN/Passport No.		
Residential Address			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		
Contact No. (O)	(H)	(Hp)	PER/Payroll/Staff No.		Nationality
Employer			Department		Email

Particulars of Insured(s)

Name (as shown in NRIC/FIN/Passport/BC)	NRIC/FIN/Passport/BC No.	Nationality	Race	Gender	Date of Birth (dd/mm/yyyy)	Height (m) Weight (kg)	Occupation	Term Life Sum Assured	30 Critical Illness Rider Sum Assured (optional)
Main Insured				<input type="checkbox"/> Male <input type="checkbox"/> Female		H: _____ W: _____			
Spouse				<input type="checkbox"/> Male <input type="checkbox"/> Female		H: _____ W: _____			
Child 1				<input type="checkbox"/> Male <input type="checkbox"/> Female		H: _____ W: _____			
Child 2				<input type="checkbox"/> Male <input type="checkbox"/> Female		H: _____ W: _____			
Child 3				<input type="checkbox"/> Male <input type="checkbox"/> Female		H: _____ W: _____			

Questionnaire of Lives Insured

	Main Insured	Spouse	Child 1	Child 2	Child 3
1. 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	<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. Are you currently undergoing or have been advised to undergo any form of medical treatment, medication or 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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?	<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"/> Yes <input type="checkbox"/> No
4. 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 disease, 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?	<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"/> Yes <input type="checkbox"/> No

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Please continue with this Additional Section if you are applying for Critical Illness Rider

5. 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	<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
6. 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	<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
7a. 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	<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
7b. 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	<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
8. Do you smoke 20 (or more) sticks of cigarettes per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Except for Question 8, if you have answered "Yes" to any of the questions, please provide details. For questions 2 to 5, please provide exact diagnosis, date of onset, investigations and results, treatment and current status. Please include the respective question number(s) and name of insured for your answer. Please use extra paper if required.

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 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.

I/We have read Your Guide to Life Insurance and/or Your Guide to Health Insurance (if applicable) found on www.lia.org.sg.

I/We agree that the policy will be entered in the Register of the Singapore policies.

If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are satisfied with the information declared in this proposal.

Signature of Proposer

Signature of Spouse (If to be insured)

Date (dd/mm/yyyy)

For Official Use

Adviser's Name	Adviser's Code	Commencement Date	Remarks
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AUTHORISATION FOR SALARY DEDUCTION FORM

For Corporatised Entities Group Insurance Scheme (CEGIS)

1. This form is to be completed by the employee and submitted together with the Application Form to NTUC INCOME through the Human Resource Department.
2. If the application is accepted by NTUC INCOME, this portion will be sent to the Payroll Section of the relevant Organisation for salary deduction.

Particulars of Employee

Name (as shown in NRIC/FIN/Passport)		NRIC/FIN/Passport No.
PER/Payroll/Staff No.	Organisation	Department

Authorisation

I hereby authorise the deduction of the amount stated below from my salary, or such other amount required as payment of the premium for the Corporatised Entities Group Insurance Scheme (CEGIS).

Name (as shown in NRIC/FIN/Passport/BC)	NRIC/FIN/Passport/ BC No.	Monthly Premium	Effective Date (to be completed by NTUC Income)
Employee			
Spouse			
Child (1)			
Child (2)			
Child (3)			
Total Premium		\$	
_____ Signature of Employee		_____ Date (dd/mm/yyyy)	

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