



DECLARATION FORM

Important Note: Pursuant to the Insurance Act 1966, you are to disclose in this form fully and faithfully, all facts which you know or ought to know, otherwise, nothing may be payable under the policy.

Contract Number			
Name of Assured		NRIC/FIN Number	
Name of Life Assured		NRIC/FIN Number	

Any disease or condition of health will not qualify for benefit unless it is fully disclosed to and accepted by us. You must ensure that each question below is answered clearly and fully and that all material information, including any new disease or condition of health or any change in state of health, which arises or becomes known to you prior to the coverage effective date is given for consideration by us. Should you require more space for your answers, please continue on a separate sheet, sign and date it.

If you are unsure whether any information is material or not, you are advised to disclose it.

SECTION A: HEALTH QUESTIONS *(Applicable for Singlife Shield and Singlife Health Plus only)*

1. What is your height?	<input style="width: 80px;" type="text"/> metres
2. What is your weight?	<input style="width: 80px;" type="text"/> kg
<p>3. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)?</p> <p>a) Heart attack, chest pain or discomfort, irregular heart beat, heart valve disorder, heart murmur, palpitations or any other blood vessel or heart disease or disorder?</p> <p>b) High blood pressure or high cholesterol?</p> <p>c) Cancer, or malignant tumour/growth/lump/nodule/polyp/cyst of any kind including cancer screening tests that were not normal?</p> <p>d) Benign tumour/growth/lump/nodule/polyp/cyst?</p> <p>e) Diabetes, elevated or raised blood sugar, thyroid disorders or any other endocrine disease or disorder?</p> <p>f) Asthma, bronchitis, pneumonia, tuberculosis, emphysema or any other breathing or lung disease or disorder?</p> <p>g) Depression, anxiety, stress or any other mental or nervous disorder?</p> <p>h) Drug or alcohol addiction or abuse?</p> <p>i) Arthritis, gout or any other disorder, pain or injury to the muscles, bones, tendons, limbs, joints, spine (back or neck)?</p> <p>j) Stroke, epilepsy, fits, paralysis or weakness of limb, head injury or any other neurological disease or disorder?</p> <p>k) Crohn's disease, ulcerative colitis, stomach or duodenal ulcers, or any other bowel, stomach or intestinal disease or disorder?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION A: HEALTH QUESTIONS (Applicable for Singlife Shield and Singlife Health Plus only) (continued)

Name of Condition	Date of first symptoms, diagnosis or recurrence	Have you made a full recovery with no further treatment, recurrence of condition, ongoing symptoms or complications?		Name and address of doctor whom you consulted	
Question () Condition:	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> Yes How long has it been since your full recovery ? <input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years <input type="checkbox"/> 5 years or more	<input type="checkbox"/> No What treatment or medication are you taking? <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	Name <input type="text"/> Address <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
5. In the last 5 years , have you had any medical test(s) with abnormal results , such as x-ray, ultrasound, imaging scan, biopsy, electrocardiogram (ECG), blood or urine test, Covid-19 PCR, pap smear or mammogram? If ' Yes ', please complete the table below:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of medical test	Date of initial test	Have you had a follow-up test?	Date since last follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring?	Name and address of doctor whom you consulted
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No If ' Yes ', what was the result? <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No If ' Yes ', please provide details <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	Name <input type="text"/> Address <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Name of medical test	Date of initial test	Have you had a follow-up test?	Date since last follow-up test	Have you been prescribed treatment or been advised to have any further test or required follow-up/monitoring?	Name and address of doctor whom you consulted
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No If ' Yes ', what was the result? <input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> don't know	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 to 2 years <input type="checkbox"/> 2 to 3 years <input type="checkbox"/> 3 to 5 years	<input type="checkbox"/> Yes <input type="checkbox"/> No If ' Yes ', please provide details <div style="border: 1px solid black; height: 60px; width: 100%;"></div>	Name <input type="text"/> Address <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
6. Are you currently experiencing symptoms or considering seeking medical advice or treatment for your health other than minor illness such as cold or flu? If ' Yes ', please complete the table below:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
What are the symptoms or conditions?	Date of first symptoms			Date of any planned medical consultation	
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more				
	<input type="checkbox"/> 0 to 6 months <input type="checkbox"/> 7 to 12 months <input type="checkbox"/> 1 year or more				

SECTION A: HEALTH QUESTIONS (Applicable for Singlife Shield and Singlife Health Plus only) (continued)

<p>7. Have you had an application of a Life, Critical Illness, Health, Accident, Disability policy deferred, declined or required to pay Additional Premiums for MediShield Life?</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'Yes', please complete the information in the box below:</p> <p>Note: If you are required to pay Additional Premiums for MediShield Life, please also provide a copy of the CPF MediShield Life Additional Premium Letter.</p>			
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> Name of Insurer <input style="width: 90%;" type="text"/> Type of Policy <input style="width: 90%;" type="text"/> Reason <input style="width: 90%;" type="text"/> </td> <td style="width: 50%; border: none;"> Name of Insurer <input style="width: 90%;" type="text"/> Type of Policy <input style="width: 90%;" type="text"/> Reason <input style="width: 90%;" type="text"/> </td> </tr> </table>	Name of Insurer <input style="width: 90%;" type="text"/> Type of Policy <input style="width: 90%;" type="text"/> Reason <input style="width: 90%;" type="text"/>	Name of Insurer <input style="width: 90%;" type="text"/> Type of Policy <input style="width: 90%;" type="text"/> Reason <input style="width: 90%;" type="text"/>	
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<p>8. Have you ever experienced symptoms or received medical advice or had treatment for any of the following conditions (whether diagnosed or not)?</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> • AIDS or HIV infection • Alzheimer's disease • Angioplasty • Any form of Cancer • Atherosclerosis • Autism • Bipolar Disorder • Chronic cor pulmonale • Chronic Kidney disease • Chronic Obstructive lung disease • Coronary Artery Disease (CAD) • Dementia • Diabetes Mellitus/Impaired Glucose tolerance • Down syndrome • Heart attack • Heart bypass </td> <td style="width: 50%; border: none;"> <ul style="list-style-type: none"> • Hepatitis C/D • Ischaemic Heart Disease (IHD) • Kidney failure • Liver cirrhosis • Multiple sclerosis • Muscular Dystrophy • Organ transplant • Osteoporosis • Paralysis • Polycystic Kidney disease • Pulmonary hypertension • Schizophrenia • Stroke • Systemic Lupus Erythematosus (SLE) • Thalassaemia intermediate/major </td> </tr> </table>	<ul style="list-style-type: none"> • AIDS or HIV infection • Alzheimer's disease • Angioplasty • Any form of Cancer • Atherosclerosis • Autism • Bipolar Disorder • Chronic cor pulmonale • Chronic Kidney disease • Chronic Obstructive lung disease • Coronary Artery Disease (CAD) • Dementia • Diabetes Mellitus/Impaired Glucose tolerance • Down syndrome • Heart attack • Heart bypass 	<ul style="list-style-type: none"> • Hepatitis C/D • Ischaemic Heart Disease (IHD) • Kidney failure • Liver cirrhosis • Multiple sclerosis • Muscular Dystrophy • Organ transplant • Osteoporosis • Paralysis • Polycystic Kidney disease • Pulmonary hypertension • Schizophrenia • Stroke • Systemic Lupus Erythematosus (SLE) • Thalassaemia intermediate/major 	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<ul style="list-style-type: none"> • AIDS or HIV infection • Alzheimer's disease • Angioplasty • Any form of Cancer • Atherosclerosis • Autism • Bipolar Disorder • Chronic cor pulmonale • Chronic Kidney disease • Chronic Obstructive lung disease • Coronary Artery Disease (CAD) • Dementia • Diabetes Mellitus/Impaired Glucose tolerance • Down syndrome • Heart attack • Heart bypass 	<ul style="list-style-type: none"> • Hepatitis C/D • Ischaemic Heart Disease (IHD) • Kidney failure • Liver cirrhosis • Multiple sclerosis • Muscular Dystrophy • Organ transplant • Osteoporosis • Paralysis • Polycystic Kidney disease • Pulmonary hypertension • Schizophrenia • Stroke • Systemic Lupus Erythematosus (SLE) • Thalassaemia intermediate/major 		

SECTION B: HEALTH QUESTIONS (Applicable for Singlife Cancer Cover Plus II only)

<p>1. Have you ever had or are you currently under investigation for:</p> <p>a. Cancer, carcinoma in situ of any kind, Hepatitis B (other than healthy carriers*), Hepatitis C, Cirrhosis, liver disease due to alcohol, Crohn's disease, Ulcerative Colitis, Barrett's Oesophagus or HIV/AIDS? <i>*Never been on medication and liver function normal in the last 12 months.</i></p> <p>b. Benign growth(s)? (Please complete the following):</p> <p>i. The following growth(s) which doctors have advised that no treatment or referral to a specialist is needed - adenomyosis, cervical cyst, chalazion, dermoid cyst, endometriosis, keratinous cyst, nabothian cyst, sebaceous cyst, or spinal synovial cyst. <i>For simple breast cyst, please refer to (ii).</i></p> <p>ii. The following growth(s) which has been removed with no recurrence and no further follow-up needed - simple breast cyst, congenital brain cyst (arachnoid/colloid), endometrial polyp, gallbladder polyp, hemangioma, lipoma, ovarian cyst, pilonidal cyst, rhabdomyoma, or uterine fibroid.</p> <p>iii. Breast growth (fibroadenoma, fibrocystic breast disease, etc.)</p> <p>iv. Colon polyp (removed, no recurrence and no further treatment or follow-up needed)</p> <p>v. Other than the above</p>	<p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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SECTION B: HEALTH QUESTIONS (Applicable for Singlife Cancer Cover Plus II only) (continued)

<p>2. Have you been advised (other than routine screening by age, where results are normal) or intend to undergo any of the following: biopsy, tumour markers, endoscopy, colonoscopy, ultrasound, CT/MRI/PET scan, mammography, pap smear OR had any investigations/tests which were abnormal and/or required monitoring? *For scans done due to injury or heart disease (e.g. heart valve disorder, etc.), please answer No.</p> <p>If you answer 'Yes' to Q2, please select ONE option from (a) to (c).</p> <p>a. Result is normal b. Abnormal result or require monitoring c. Awaiting result</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> a <input type="checkbox"/> b <input type="checkbox"/> c</p>
<p>3. Did you have any of these symptoms in the last 6 months: a. weight loss of more than 5 kgs without diet or lifestyle modification; or b. coughing with blood; or c. unusual bleeding or discharge from any body part for more than one week continuously; or d. persistent change in bowel or bladder habits; or e. a mole or skin blemish which has changed in appearance.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

SECTION C: DECLARATION

I/We agree to inform Singapore Life Ltd. ("Singlife") if there is any change in the state of my/our health or my/our activities between the date of this Health Declaration and the date full insurance coverage is provided by Singapore Life Ltd. to me/us. I/We understand that the terms of accepting me/us as a risk for insurance coverage may vary according to such information received.

I/We declare that the information given is true and complete and that I/we have not withheld any material information that may influence the assessment of my/our application.

I/We agree that this declaration will constitute part of my/our application/policy and that failure to disclose any material known fact(s) by me/us may render the contract void from the start and nothing may be payable under the Policy.

I/We consent to Singapore Life Ltd. (and Singlife related group of companies) collecting, using and/or disclosing my/our personal data for the processing of the above transaction and such other purposes ancillary or related to the administering of the policy(ies), account(s) and/or managing my/our relationship with Singlife.

I/We also consent to Singapore Life Ltd. (and Singlife related group of companies) transferring my/our personal data to Singlife related group of companies and/or third party service providers, reinsurers, suppliers or intermediaries, whether located in Singapore or elsewhere, for the above purposes.

For full details of the purposes of collection, use and disclosure of your personal data, please visit <http://www.singlife.com.sg/pdpa.html>.

Signature of Assured & Date

Signature of Life Assured & Date
(who is 16 years old and above)