PRUDENTIAL

PRUBusiness Continuity

GROUP HEALTH DECLARATION FORM

Important Notes:

1) This form is applicable to the following where full underwriting is required:
   - Sum assured from S$50,000 to S$600,000 - If the applicant answers 'yes' to any of the three SIO health declaration questions
   - Sum assured from S$650,000 to S$1,500,000 per company
   - Aggregated sums assured above $600,000 per applicant across different companies for the same plan

WARNING: PURSUANT TO SECTION (25(5) OF THE INSURANCE ACT (CAP 142), YOU ARE TO DISCLOSE IN THIS FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY.

DETAILS OF LIFE ASSURED					
Full Name (as per ID)	:				
Designation	:		**Sum assured** *(multiples of S$50,000)*	:	S$
Company Name	:				
Marital Status	:	☐ Single ☐ Married ☐ Widowed ☐ Divorced			
Gender	:	☐ Male ☐ Female	**Date of Birth** *(DD-MM-YYYY)*	:	
Smoking Status	:	☐ Smoker ☐ Non-Smoker	**Age last birthday**	:	
ID Type	:	☐ NRIC ☐ Employment Pass	**Nationality**	:	
ID Number	:		**Country of Residence**	:	
Email	:		**Mobile Number**	:	
Height (cm)	:		**Weight (kg)**	:	

1. **Do you engage in any of the following?**
   - Private Flying (Pilot / Passenger) ☐ Yes ☐ No
   - Scuba Diving ☐ Yes ☐ No
   - Mountaineering / Outdoor Rock Climbing ☐ Yes ☐ No
   - Parachuting / Sky Diving ☐ Yes ☐ No
   - Racing ☐ Yes ☐ No
   - Other extreme sports (please specify:_____) ☐ Yes ☐ No

   If 'Yes' for any activity stated above, please provide details as follows:
   *Location of activity:*_____
   Frequency of activity: _____
   Depth Dived (if applicable): _____

2. **Have you taken narcotics, any habit forming drugs or ever been treated for drug or alcohol addiction?** ☐ Yes ☐ No
   If 'Yes', please provide details as follows:
   Name of substance: _____
   Date of Treatment: _____
   Type of Treatment: _____
   Name & Address of Doctor consulted: _____

3. **Do you have any health or life insurance application that has been rejected, postponed or accepted at special rates or terms by any insurance company?** ☐ Yes ☐ No
   If 'Yes', please provide details as follows:
   Date of Application: _____
   Type of Application: _____
   Reason for Special Terms: _____

Prudential Assurance Company Singapore (Pte) Limited (Reg. No.: 199002477Z)
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Tel: 1800 – 333 0 333 Website: www.prudential.com.sg

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4. **Have you in the *last 3 months* had any of the following symptoms for more than one week continuously, fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

Date: _____

Diagnosis: _____

Treatment: _____

Name & Address of Doctor consulted: _____

5. **Do you smoke any cigarettes?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

No. of years : _____

No. of sticks smoked (per day): _____

6. **Do you consume alcohol?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

*Type of Alcohol:*_____

Quantity: _____

*Frequency (per week):*_____

7. **Have you or your spouse, ever been told to have, received any medical advice, counselling or treatment in connection with sexually transmitted disease, AIDS, AIDS Related Complex or any other AIDS related conditions?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

Date: _____

Relationship: _____

Diagnosis: _____

Treatment: _____

Name & Address of Doctor consulted: _____

8. **In the past 5 years, have you attended to any tests such as X ray, ultrasound, CT scan, biopsy, electro-cardiogram (ECG), endoscopy, blood or urine test?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

Date of test(s) done: _____

Type of test(s) done: _____

Reason for the test(s) done: _____

Result of the test done: _____

*Type of treatment:*_____

Name & Address of Doctor consulted: _____

Medical Report available? No / Yes (please provide a copy)

9. **Have either of your natural parents or siblings died or suffered from cancer, heart disease, stroke, high blood pressure, diabetes, kidney disease, mental disorder, dementia, tuberculosis, Down's syndrome or any hereditary disease?** ☐ Yes ☐ No

If 'Yes', please provide details as follows:

Relationship	Condition / Cause of Death	Age of Onset	Age of Death(if deceased)

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10.	**For Female Insured Only**				
	a) Have you ever had any abnormal pap smear test or been told by a doctor to have a repeat pap smear within the next 6 months? *If 'Yes', please provide details as follows: _____* *Date of test done: _____* *Result of the test done: _____* *Diagnosis: _____* *Type of treatment:_____* *Name & Address of Doctor consulted: _____* *Medical Report available? No / Yes (please provide a copy)*	☐	Yes	☐	No
	b) Have you had an abnormal mammogram or been advised to have mammogram, ultrasound, biopsy, operation of the breasts, ultrasound of pelvis or attended to any other gynaecological investigations? *If 'Yes', please provide details as follows:* *Date of test done: _____* *Result of the test done: _____* *Diagnosis: _____* *Type of treatment:_____* *Name & Address of Doctor consulted: _____* *Medical Report available? No / Yes (please provide a copy)*	☐	Yes	☐	No
	c) Have you ever consulted a doctor for irregular, painful menstruation or other problem(s) involving the female organs? *If 'Yes', please provide details as follows:* *Date of test done: _____* *Result of the test done: _____* *Diagnosis: _____* *Type of treatment:_____* *Name & Address of Doctor consulted: _____* *Medical Report available? No / Yes (please provide a copy)*	☐	Yes	☐	No
	d) Have you ever suffered any complication of pregnancy? *If 'Yes', please provide details as follows:* *Date of test done: _____* *Result of the test done: _____* *Diagnosis: _____* *Type of treatment:_____* *Name & Address of Doctor consulted: _____* *Medical Report available? No / Yes (please provide a copy)*	☐	Yes	☐	No
	e) Are you currently pregnant? *If 'Yes', please state no. of months _____*	☐	Yes	☐	No

11.	**Have you EVER had or been told you had or been treated for:**				
	a) asthma, bronchitis, persistent cough, tuberculosis or respiratory disorder?	☐	Yes	☐	No
	b) epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache/giddiness, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders or any disease of the brain?	☐	Yes	☐	No
	c) gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders?	☐	Yes	☐	No
	d) blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs?	☐	Yes	☐	No
	e) anaemia, diabetes, thyroid disorders or any other endocrine disorder?	☐	Yes	☐	No
	f) cancer, tumour, cyst or growth of any kind?	☐	Yes	☐	No
	g) any form of eye, hearing or speech disorder or disease?	☐	Yes	☐	No
	h) jaundice, Hepatitis B carrier or any form of hepatitis, liver or gallbladder disorders?	☐	Yes	☐	No
	i) slipped disc, gout, arthritis, pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury?	☐	Yes	☐	No

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j) raised cholesterol, high blood pressure, heart attack, heart murmur, irregular or fast heart rate, chest discomfort or pain, diseases or any other disorders of the heart, heart valves or blood vessels? ☐ Yes ☐ No

k) any other illness, disorder, injury, disability, operation or hospitalisation not mention above? ☐ Yes ☐ No

If any of the answer to the above questions is 'Yes', please provide details as follows:

Qn No.	Name of Condition	Date		Type of Test(s) done and results	Type of Treatment	Name & Address of Doctor / Clinic / Hospital
		From	To			

Please provide copy of medical report(s) of the above-mentioned condition(s) for our review (if available)

☐ No (report not available) ☐ Yes (attached for your review)

Consent, Declaration and Authorisation - Please read carefully before signing this Group Health Declaration Form.

I consent to Prudential Assurance Company (Pte) Limited ("Prudential"), its officers and employees:

a) Collecting and using at their sole discretion any and all information relating to me, including my personal particulars, in this Group Health Declaration for the purposes of underwriting; and

b) Disclosing at their sole discretion any and all information relating to me, including my personal particulars, in this Group Health Declaration to the servicing intermediary for the above group policy for the purpose of customer service.

I declare that no material facts, that are facts likely to influence the assessment and acceptance of my group application, have been withheld and the Information given above is true and complete and best to my knowledge and they shall be the basis of the issuance of my group insurance coverage.

I agree to inform Prudential if there is any change in the state of my health/activity between the date of this Health Declaration or medical examination and the date of full insurance coverage is provided by Prudential to me. I understand that the terms of accepting me as a risk for insurance coverage may vary according to such information received.

I agree and authorise any medical source (i.e. physician and hospital), insurance office or organization that has my records to release to Prudential any relevant information at any time for the purpose of underwriting this group application. A photographic copy of this authorisation shall be as valid as the original.

I further declare that I have read and understood the "Your Guide To Health Insurance" and "Product Summary" (applicable to voluntary coverage only).

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 fully satisfied with the information declared in this proposal.

Signature of Life Assured	
Date Declared	