

APPLICATION FOR REINSTATEMENT – PRUSHIELD & PRUEXTRA

Statement pursuant to Section 25(5) of the Insurance Act, (Cap 142), you are to disclose in this application form fully and faithfully, all the facts which you know or ought to know, otherwise you may receive nothing from the policy.

Policy Number(s)

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Name of Life Assured

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Q1. Have you had any changes in your health conditions since the date of application or reinstatement application for this policy? If yes, please tick "Yes" and provide details in Q5 below.	Yes	No		
a. Stroke, high blood pressure, raised cholesterol or any disease or disorders of the heart or blood vessels?	<input type="checkbox"/>	<input type="checkbox"/>		
b. Asthma, bronchitis, Pneumonia or any other lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>		
c. Kidney disease, blood, protein or sugar in urine, blood in stools or any other disorders of the genital organs?	<input type="checkbox"/>	<input type="checkbox"/>		
d. Diabetes, liver disease, Hepatitis B or any form of hepatitis or any other disorders of the thyroid?	<input type="checkbox"/>	<input type="checkbox"/>		
e. Epilepsy, fits, prolonged headache, depression, or any other nervous/mental/psychiatric disorders or disabilities?	<input type="checkbox"/>	<input type="checkbox"/>		
f. Gout, arthritis, osteoporosis, pain or deformity or disorders of the muscles, bones, spine, limbs or joints?	<input type="checkbox"/>	<input type="checkbox"/>		
g. Cancer, tumor, cysts or growths of any kind?	<input type="checkbox"/>	<input type="checkbox"/>		
h. AIDS, HIV infection or any sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>		
i. Breast lumps, endometriosis, fibroids or abnormal pap smear results or any other gynecological disorders (including the breasts)?	<input type="checkbox"/>	<input type="checkbox"/>		
Q2. Have you in the last 6 months, had any of the following symptoms for more than 1 week continuously: fatigue, weight loss, diarrhea, vomiting, giddiness, enlarged nodes or unusual skin lesions?	<input type="checkbox"/>	<input type="checkbox"/>		
Q3. Have you ever had, been told to have or received any treatment for any illness, disorder or disability not mentioned above or has had persistent symptoms or treatment for more than 7 days or are you about to undergo any consultation, treatment or surgical procedure with any doctor or other health professional?	<input type="checkbox"/>	<input type="checkbox"/>		
Q4. Has any application for medical, hospitalisation, accident or life insurance ever been declined, postponed or accepted at special rate/terms? If yes, please give details in space below:	<input type="checkbox"/>	<input type="checkbox"/>		
Q5. If any of the answers to Question 1 to 3 is "Yes", please quote the question number and provide details including dates, diagnosis, duration, name and address of doctor, place of treatment and present conditions. If space below is insufficient, please provide details on a separate piece of paper.				
Question Number	Diagnosis/ Date of diagnosis	Duration/ present condition	Reports enclosed Yes/ No	Name and Address of attending Doctor

Declaration

I/We would like to apply for the reinstatement of my/my dependant's policy. I/We declare that the information given above is true and complete to the best of my knowledge. I/We agree to inform Prudential 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 Prudential to me/us. I/We further agree that such reinstatement shall not be considered as effected by reason of any money paid or settlement made in payment of or on account of any premium/contribution, until this policy shall be duly approved by an authorized officer of the Company. I/We agree that Prudential reserves the right to call for any medical evidence or further declaration if deemed necessary.

Signature of Life Assured (17 next birthday and above)

Identity Card No:
Date (dd/mm/yyyy)

Signature of Payer/Proposer

Identity Card No:
Date (dd/mm/yyyy)

Please send us your application with this prepaid business reply folder.

1. Fold along the dotted lines.
2. Fold and insert your application form and any other required document into this prepaid business reply folder.
3. Seal along the edges of this prepaid business reply folder with clear tape (do not staple).
4. Drop your sealed prepaid business reply folder into your nearest post box.

**BUSINESS REPLY SERVICE
PERMIT NO. 00364**



PRUDENTIAL ASSURANCE COMPANY SINGAPORE (PTE) LIMITED
Robinson Road P.O. Box 492
Singapore 900942

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