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)

Name of Life Assured

Relationship to Policyowner/Payer#

	Yes	No
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.		
a. Stroke, high blood pressure, raised cholesterol or any disease or disorders of the heart or blood vessels?	☐	☐
b. Asthma, bronchitis, Pneumonia or any other lung disorders?	☐	☐
c. Kidney disease, blood, protein or sugar in urine, blood in stools or any other disorders of the genital organs?	☐	☐
d. Diabetes, liver disease, Hepatitis B or any form of hepatitis or any other disorders of the thyroid?	☐	☐
e. Epilepsy, fits, prolonged headache, depression, or any other nervous/mental/psychiatric disorders or disabilities?	☐	☐
f. Gout, arthritis, osteoporosis, pain or deformity or disorders of the muscles, bones, spine, limbs or joints?	☐	☐
g. Cancer, tumor, cysts or growths of any kind?	☐	☐
h. AIDS, HIV infection or any sexually transmitted disease?	☐	☐
i. Breast lumps, endometriosis, fibroids or abnormal pap smear results or any other gynecological disorders (including the breasts)?	☐	☐
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?	☐	☐
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?	☐	☐
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:	☐	☐

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

#*The grandparent or sibling must be a citizen of Singapore or permanent resident of Singapore to be applicable.*

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.

Note: If no payment is received upon receipt of the form, unpaid premiums will be billed to existing credit card or DBS/POSB GIRO arrangement (if any).

Signature of Life Assured (17 next birthday and above)

Last 4 digit of
Identity Card No:

Date (dd/mm/yyyy)

Signature of Policyowner/Payer

Last 4 digit of
Identity Card No:

Date (dd/mm/yyyy)

P06122021