# APPLICATION FOR REINSTATEMENT FORM

**NOTICE: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CHAPTER 142), YOU ARE TO DISCLOSE IN THE APPLICATION, FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.**

## 1. IMPORTANT NOTICE

- Health declaration is declared by Life Insured and Policy Owner. However, if the Life Insured age next birthday is below 16 years old, the Policy owner will be making the declaration.
- If a material fact is not disclosed in this form, 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 your Financial Advisor Representative but was not included in the form. Please check to ensure you are fully satisfied with the information declared in this form.

## 2. POLICY INFORMATION *(This section is mandatory)*

**Policy number** | | | | | | | | | | |

| **Policy owner (Life Insured 1) /Trustee/Assignee** | | |
|---|---|---|
| **Full name as shown on NRIC/Passport** | **NRIC/Passport/Entity Registration Number** | |
| **Name of Employer/Organization** | **Nature of Business/Industry** | |
| **Address of Employer/Organization** | **Occupation and Exact Nature of Work** | **Current Annual Earned Income** |
| **Life Insured 2** *(If different from Policy Owner)* | | |
| **Full name as shown on NRIC/Passport** | **NRIC/Passport Number** | |
| **Name of Employer/Organization** | **Nature of Business/Industry** | |
| **Address of Employer/Organization** | **Occupation and Exact Nature of Work** | **Current Annual Earned Income** |
| **Life Insured 3** *(If different from Policy Owner)* | | |
| **Full name as shown on NRIC/Passport** | **NRIC/Passport Number** | |
| **Name of Employer/Organization** | **Nature of Business/Industry** | |
| **Address of Employer/Organization** | **Occupation and Exact Nature of Work** | **Current Annual Earned Income** |

## 3. DETAILS OF APPLICATION *(This section is mandatory)*

| **Transaction Type (Please select accordingly)** | **To complete** |
|---|---|
| ☐ **Reinstatement for Full Medical Underwriting Plan** | ○ Application for Reinstatement Form: Sections **4**, **5** (Full Health Declaration), **7 to 11**<br>○ Tax Residency Self-certification form |
| ☐ **Reinstatement for Simplified Medical Underwriting Plan** | ○ Application for Reinstatement Form: Sections **4, 6** (Simplified Health Declaration) **to 11**<br>○ Tax Residency Self-certification form |
| ☐ **Reinstatement for Non-Medical Underwriting Plan** | ○ Application for Reinstatement Form: Section **11**<br>○ Tax Residency Self-certification form |

CTPIS/LIFE/PS-DIF/012020 092021 022023



China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909
6389 6111 6222 1033 www.sg.cntaiping.com

## 4. RESIDENCY DECLARATION *(Please select and complete the category below that reflects your residency status)*

| **Singaporean** | **Policy Owner/ Life Insured 1** | **Life Insured 2** | **Life Insured 3** |
|---|---|---|---|
| Are you currently residing in Singapore? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Have you resided outside of Singapore continuously for 5 or more years preceding the date of this application? (Even if you had returned to Singapore for one or more short visits during the period, you are still considered to have resided outside Singapore) | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Singapore PR/Work Pass** | **Policy Owner/ Life Insured 1** | **Life Insured 2** | **Life Insured 3** |
| Have you been residing in Singapore for 183 days or more in the last 12 months preceding the date of this application? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **Dependent Pass/Long Term Pass/Student Pass** | **Policy Owner/ Life Insured 1** | **Life Insured 2** | **Life Insured 3** |
| Do you have a pass or permit that has a duration longer than 90 days and you have been residing in Singapore for 90 days or more in the last 12 months preceding the date of this application? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

## 5. FULL HEALTH DECLARATION *(Reinstatement for Full Underwriting Plan)*

| **Please complete all of the following Questions** | **Policy Owner/ Life Insured 1** | **Life Insured 2** | **Life Insured 3** |
|---|---|---|---|
| a. Please state your current height (metres) and weight (kilograms) | ……m …..kg | ……m …..kg | ……m …..kg |
| b. Do you have a regular doctor? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| *If Yes, please provide the following details:*<br>i. Name and address of clinic: .....<br>ii. Date of last consultation: .....<br>iii. Reason for consultation: .....<br>iv. Results of consultation: ..... | | | |
| c. Are you currently experiencing symptoms or are you now receiving or considering receiving medical advice/treatment from a doctor? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. In the past 5 years, have you had any surgical operation or hospital admission or had been advised to undergo or intend to have any medical test or investigations done such as X-ray, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check, electrocardiogram (ECG), blood or urine test? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. Have you EVER had or been told to have or been treated or under investigation for, | | | |
| i. Epilepsy, stroke, paralysis, weakness of limb, persistent headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ii. Diabetes, thyroid disorders or any other endocrine disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| iii. Ear discharge, nose bleeds (intermittent or continuously longer than 1 week), double vision, impaired sight, hearing impairment, or speech disorder or any other disorders of ear, eye, nose or throat? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| iv. Asthma, persistent cough (longer than 4 weeks), coughing with blood, pneumonia, bronchitis, tuberculosis, breathing complaints/discomfort or any other lung diseases? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| v. Raised cholesterol, high blood pressure, heart attack, heart murmur, cardiomyopathy, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, disease of or any other disorders of the heart or blood vessels? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| vi. Gastritis, stomach or duodenal ulcer, blood in stools, fistula, piles or any other stomach or bowel disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

## 5. FULL HEALTH DECLARATION (Cont'd)

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| e. Have you EVER had or been told to have or been treated or under investigation for, | | | |
| vii. Jaundice, Hepatitis B or Hepatitis C carrier or any form of hepatitis, liver disorder or gall bladder disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| viii. Blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or genital organs? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ix. Slipped discs, gout, arthritis, osteoporosis, chronic back pain or deformity or disorders of the muscles, spine, limbs or joints or severe injury? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| x. Cancers, tumours, cysts, polyps, fibroids, enlarged lymph nodes, unusual skin lesion, or growths of any kind? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| xi. Anaemia, thalassaemia, any other disorders of the blood, advised to abstain from donating blood or received blood transfusion or blood products on account of haemophilia or any other reason? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| xii. Systemic lupus erythematosus, rheumatic fever, rheumatic arthritis, Kawasaki's disease, vasculitis, scleroderma, or any other disorders of the immune system? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| xiii. Any other illness, disorder, operation, physical disability, or accident not mentioned above? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. Have you or your spouse been told to have, received any medical advice, counselling or treatment in connection with Sexually Transmitted Diseases (STDs), AIDS, AIDS related Complex or any other AIDS related conditions? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. Have any of your biological parents or siblings, before age of 60, died from or diagnosed with Cancer, Diabetes, Stroke, Polycystic Kidney Disease, Heart disease, Parkinson's Disease, Dementia/Alzheimer's disease, or any other hereditary Diseases? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please state condition, relationship, age at onset and age at death (if deceased).*

Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

| h. Do you drink beer, wine or other alcohol? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
|---|---|---|---|

*If yes, please indicate average daily consumption and type of alcohol.*
*(1 standard alcoholic drink equates to 330ml beer, 125ml glass of wine or 30ml of glass of spirits.)*

Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

| i. Have you ever smoked or used tobacco/nicotine products including cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches, gum or shisha during the last 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
|---|---|---|---|

*If yes, please state type and average consumption per day. If you are a former smoker, when is the last time you smoked?*

| | Policy Owner / Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| Type: | | | |
| Average consumption per day: | | | |
| Date last smoked/used: | | | |

| j. Have you ever taken addictive drugs or substances, or been treated or counselled for alcoholism or the use of addictive drug or substances? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
|---|---|---|---|

*If yes, please provide details.*
Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

## 5. FULL HEALTH DECLARATION (Cont'd)

| k. Questions for Females Only | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| i. Have you suffered from or are aware of any breast lumps or any other disorders of your breasts? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ii. Have you suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any other disorders of the female organs? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| iii. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next 6 months? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| iv. Have you been advised to have a mammogram, biopsy, operation of the breasts, ultrasound pelvis, colposcopy or any other gynecological investigations? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please state type, reason, date and results (copy to be submitted if available)*
Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

| | | | |
|---|---|---|---|
| v. For females who have conceived, were there any complications during pregnancy such as gestational diabetes, high blood pressure, ectopic pregnancy, eclampsia, protein in urine, etc.? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please provide details including date and diagnosis.*
Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

| | | | |
|---|---|---|---|
| vi. Are you now pregnant? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, how many weeks?*
Policy Owner / Life Insured 1 ……
Life Insured 2 ……
Life Insured 3 ……

| l. Additional Questions for Life Insured below 18 years old | Life Insured |
|---|---|
| i. Does either of the child's parents have equivalent cover as proposed in this application? | ☐ Yes ☐ No |

*If no, please provide reason below:*
- ☐ Ineligible due to medical reasons
- ☐ Pending application with other insurers
- ☐ Others, please provide details: ……

| | |
|---|---|
| ii. Are all siblings (if any) equally insured (including pending application with other insurers)? | ☐ Yes ☐ No |

*If no, please provide reason below:*
- ☐ Ineligible due to medical reasons
- ☐ Propose Insured is the only child
- ☐ Others, please provide details: ……

| m. Additional Questions for Juvenile below 2 years old | Life Insured |
|---|---|
| i. Is the child a premature baby (i.e. less than 37 weeks of gestation)? | ☐ Yes ☐ No |

*If yes, please provide the details:*
Gestation period (weeks): ……
APGAR score at 1 minute: ……
APGAR score at 5 minutes: ……
Length at birth: …… cm
Weight at birth: …… kg
Date discharge from hospital (dd/mm/yyyy): ……

| | |
|---|---|
| ii. Were there significant events during pregnancy/delivery such as but not limited to birth difficulty, infection, congenital deformities, respiratory distress syndrome, prolonged jaundice that lasted more than 2 weeks, G6PD deficiency, respiratory disorder, intrauterine growth retardation? | ☐ Yes ☐ No |
| iii. Any special care needed after birth? | ☐ Yes ☐ No |
| iv. Has the child been advised, or been told to go for further follow up, or further evaluation, or monitoring after each routine assessment? | ☐ Yes ☐ No |
| v. Has the child had any physical, congenital or developmental defects, or shown any sign of physical or mental disorder, any growth or developmental delay or any learning difficulties? | ☐ Yes ☐ No |

## 6. SIMPLIFIED HEALTH DECLARATION *(Reinstatement for Simplified Underwriting Plan)*

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| a. Please state your current height (metres) and weight (kilograms) | ……m …..kg | ……m …..kg | ……m …..kg |
| b. Do you have a regular doctor? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| *If Yes, please provide the following details:* i. Name and address of clinic: ....…… ii. Date of last consultation: ....…… iii. Reason for consultation: ....…… iv. Results of consultation: ....…… | | | |
| c. Are you currently experiencing symptoms or are you now receiving or considering receiving medical advice/treatment from a doctor? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. In the past 5 years, have you had any surgical operation or hospital admission or had been advised to undergo or intend to have any medical test or investigations done such as X-ray, ultrasound, imaging scan, biopsy, mammogram, pap smear, prostate check, electrocardiogram (ECG), blood or urine test? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. Have you EVER had or been told to have or been treated or under investigation for: i. Heart, lung, kidney or circulatory disorder, cancer/tumour/cyst/fibroid/any growth, high blood pressure, stroke, diabetes, blood disorders, brain or nervous system disorder, liver disorder, hepatitis B or C, HIV Infection or AIDS, pregnancy complications? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ii. Any other illness, disorder, operation, physical disability, serious injury or accident not mentioned above? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. Have any of your biological parents or siblings, before age of 60, died from or diagnosed with Cancer, Diabetes, Stroke, Polycystic Kidney Disease, Heart disease, Parkinson's Disease, Dementia/Alzheimer's disease, or any other hereditary Diseases? *If yes, please state condition, relationship, age at onset and age at death (if deceased).* Policy Owner / Life Insured 1 …… Life Insured 2 …… Life Insured 3 …… | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. Do you drink beer, wine or other alcohol? *If yes, please indicate average daily consumption and type of alcohol. (1 standard alcoholic drink equates to 330ml beer, 125ml glass of wine or 30ml of glass of spirits.)* Policy Owner / Life Insured 1 …… Life Insured 2 …… Life Insured 3 …… | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h. Have you ever smoked or used tobacco/nicotine products including cigarettes, e-cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches, gum or shisha during the last 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please state type and average consumption per day. If you are a former smoker, when is the last time you smoked?*

| | Policy Owner / Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| Type | | | |
| Average consumption per day | | | |
| Date last smoked/used | | | |

## 6. SIMPLIFIED HEALTH DECLARATION (Cont'd)

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| i. Have you ever taken addictive drugs or substances, or been treated or counselled for alcoholism or the use of addictive drug or substances? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please provide details.*

Policy Owner / Life Insured 1 ……

Life Insured 2 ……

Life Insured 3 ……

## 7. INSURANCE HISTORY

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| a. Has any application or reinstatement for a life, critical illness, disability, accident or hospital insurance policy ever been refused, postponed or accepted at special terms by any insurance company? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please provide details below.*

| | Insurance Company | Type of Policy | Reasons |
|---|---|---|---|
| Policy Owner / Life Insured 1 | | | |
| Life Insured 2 | | | |
| Life Insured 3 | | | |

| | | | |
|---|---|---|---|
| b. Have you ever made any claims or are you intending to make any claims on any policy with any insurance company? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please provide details below.*

| | Insurance Company | Nature of claim | Year of claim | Reasons |
|---|---|---|---|---|
| Policy Owner / Life Insured 1 | | | | |
| Life Insured 2 | | | | |
| Life Insured 3 | | | | |

## 8. ADDITIONAL DETAILS

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| a. Do you travel or live away from your residence city location? *If yes, please provide details over the last 12 months.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. Do you anticipate the pattern of frequency of travel will change substantially over the next 12 months? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. Do you engage or expect to engage in any hazardous or potentially hazardous activity, such as automobile or motorcycle racing, power boat racing, scuba diving, parachuting and sky diving, professional sports or flying other than as a fare-paying passenger on a scheduled airline route? *If yes, please complete the Hazardous Pursuits Questionnaire.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. Does your job nature involve working at heights (over 25 feet) or underground, handling explosives, commercial diving, armed with weapons (exclude police forces), working with or maintaining high voltage power lines and cables? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

**Policy owner**

| Location Visited | **Purpose** (business or pleasure) | Duration of each stay (days) | Frequency per year |
|---|---|---|---|
| | | | |

**Insured**

| Location Visited | **Purpose** (business or pleasure) | Duration of each stay (days) | Frequency per year |
|---|---|---|---|
| | | | |

*If yes, please provide details*.

Policy Owner / Life Insured 1 ……

Life Insured 2 ……

Life Insured 3 ……

**Note:**

If the answer to any of the questions in **Section 4 to 8** is **YES**, please provide full details below and include (where applicable):

- Name of condition and date of diagnosis
- Name and address of each doctor and hospital
- Duration of illness/injury and date of recovery as appropriate
- Nature of tests done, dates, results and reason(s) for tests
- Copy of the above test(s) result(s), if any
- Details of treatment, if any

Please request from your Financial Advisor Representative the relevant ***Questionnaires*** and/or ***Medical Consent Form***.

| Qn. No. | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| | | | |

## 9. DECLARATION OF EXISTING POLICY(IES) AND CONCURRENT APPLICATION

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| a. Do you have any existing policy(ies) or applications pending approval? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

*If yes, please provide details below.(including applications pending approval from other company(ies).*

**Policy Owner / Life Insured 1**

| Name of Company | Sum Assured ($) | | | | Annual Premium ($) | Year Issued |
|---|---|---|---|---|---|---|
| | Life | TPD | Critical Illness | Others (Please specify type) | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Insured 2**

| Name of Company | Sum Assured ($) | | | | Annual Premium ($) | Year Issued |
|---|---|---|---|---|---|---|
| | Life | TPD | Critical Illness | Others (Please specify type) | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

**Insured 3**

| Name of Company | Sum Assured ($) | | | | Annual Premium ($) | Year Issued |
|---|---|---|---|---|---|---|
| | Life | TPD | Critical Illness | Others (Please specify type) | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

## 10. Additional Questions on Genetic Testing *(Please complete the following according to your residency status)*

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| **For Singapore Residents:** If your total cover including current, concurrent, pending applications and inforce policies (including multiplier benefit) with China Taiping Insurance (Singapore) Pte. Ltd. (CTPIS) and other insurers exceed the following amounts, please indicate accordingly: | | | |
| a. $2,000,000 for Life Protection | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. $2,000,000 for Total and Permanent Disability | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. $500,000 for Critical Illness | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "Yes" to one or more under (a) to (c), have you undergone a genetic test for Huntington's Disease? *If yes, please provide details (including date done) and all copies of results.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Policy Owner / Life Insured 1 .....

Life Insured 2 .....

Life Insured 3 .....

| | | | |
|---|---|---|---|
| If "Yes" to (c), have you undergone a genetic test for breast cancer (BRCA1 or BRCA2)? *If yes, please provide details (including date done) and all copies of results.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Policy Owner / Life Insured 1 .....

Life Insured 2 .....

Life Insured 3 .....

## 10. Additional Questions on Genetic Testing (Cont'd)

| Please complete all of the following Questions | Policy Owner/ Life Insured 1 | Life Insured 2 | Life Insured 3 |
|---|---|---|---|
| **For Non-Singapore Residents:**<br>Have you undergone a genetic test for Huntington's Disease and breast cancer (i.e. BRCA1 and BRCA2)?<br>*If yes, please provide details (including date done) and all copies of results.* | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

Policy Owner / Life Insured 1 .....

Life Insured 2 .....

Life Insured 3 .....

## 11. DECLARATION AND AUTHORISATION

1. I/We understand the contents of this Application for Reinstatement Form and confirm that I/We wish to perform the transaction selected above.
2. I/We agree to inform China Taiping Insurance (Singapore) Pte. Ltd ("CTPIS") if there is any change in the state of health, occupation or activity of the Insured between the date of this Application for Reinstatement Form or medical examination and the issue of the above benefit. On receiving the information of any change, CTPIS is entitled to accept or reject this transaction.
3. I/We confirm that this Policy is not assigned to any other party or is assigned only to the assignee who has signed this form.
4. I/We/The beneficiaries are not undischarged bankrupt(s). There are currently no pending or threatened bankruptcy proceedings against me/us.
5. Save as provided in this form, information provided on the Life Insured's health, occupation and engagement of hazardous activities is complete and remains accurate.
6. I/We confirm that the above information is true and correct, and I/We authorise CTPIS to effect the change(s) requested on my Policy(ies).
7. I/We agree to indemnify and hold CTPIS harmless against any and all losses (whether direct, indirect, special or consequential) suffered by me/us or any third party arising from or in connection with CTPIS accepting and acting on my/our instructions (including where relevant, the use of the Electronic Services).
8. I/We are aware that the changes set out in this Application for Reinstatement Form will not be effective until it is formally accepted by CTPIS.
9. I/We confirm that I/we have read and understood and hereby consent to the collection, use, processing and disclosure of my/our personal data in accordance with and agree to be bound by CTPIS Privacy Policy which is made available on our website at https://www.sg.cntaiping.com/en/privacypolicy, as may be amended from time to time.
10. I/We agree on my/our behalf and on behalf of every life insured person that in addition to the release of information to any medical source, or other entity mentioned in this Application for Reinstatement Form, CTPIS is authorized to collect, retain, use and/or disclose as it reasonably deems fit, any information in respect of me/us/any life insured person, that is received by CTPIS to its Representatives and relevant third parties, companies within China Taiping Insurance Group, reinsurers, medical organisations, my/our adviser, financial institutions, CPF agent banks, credit agencies, investigators, service providers (who may have to disclose my/our data to their service providers such as medical providers, reinsurers, medical evacuation agencies), judicial, regulatory, government, statutory authorities, dispute resolution parties and industry entities) whether within or outside Singapore. As far as reasonably possible, CTPIS will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with relevant law.

| | |
|---|---|
| **Signature of Policy Owner (Life Insured 1) /Trustee/Assignee**[1] | **Date** (dd/mm/yyyy) |
| **Signature of Life Insured 2**<br>*Only Life Insured age next birthday 16 years old and above must sign* | **Date** (dd/mm/yyyy) |
| **Signature of Life Insured 3**<br>*Only Life Insured age next birthday 16 years old and above must sign* | **Date** (dd/mm/yyyy) |

[1] *For policies that are assigned, the assignee needs to fill in and sign this form.*

*For entities, form must be signed by the authorised signatory of the company and company stamp is required.*

***Please remember to...***

- ✓ ***Countersign on any amendments.***
- ✓ ***Ensure that the appropriate sections have been completed.***
- ✓ ***Ensure that all signature(s) are consistent with our records.***
- ✓ ***Submit this form and any relevant documents to us within 30 days from your date of signing.***

**Completed?** You may submit this form to us via MAIL or Email.

**MAIL** – 3 Anson Road #16-00 Springleaf Tower Singapore 079909

**EMAIL** – Customer.Service@sg.cntaiping.com (Form submission must be received from your email address registered with CTPIS)

# Individual Tax Residency Self-certification form

**NOTICE: PURSUANT TO SECTION 25(5) OF THE INSURANCE ACT (CHAPTER 142), YOU ARE TO DISCLOSE IN THE APPLICATION, FULLY AND FAITHFULLY, ALL FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE THE POLICY MAY BE VOID.**

## 1. POLICY INFORMATION

**Policy Number** | | | | | | | | | | |

## 2. INDIVIDUAL DETAILS

### A. Personal Details

| | |
|---|---|
| **Full Name of Account Holder** *(Please underline surname or last name)* | |
| **NRIC/Passport No.** | |
| **Gender** | |
| **Date of Birth** | |
| **Nationality** | |
| **Citizenship** *(Please specify all if more than one)* | |
| **Contact Details** *(Please provide at least one number)* | Home No. : + _____ - _____<br>Office No. : + _____ - _____<br>Mobile No. : + _____ - _____ |

### B. Address

| | |
|---|---|
| **Residential Address** | ♦ *Please submit the following document(s) to show **proof of the Residential Address** (i.e. front and back of your NRIC/ Letters from government or banks, or utility or telephone bills (dated within the last 3 months)* |
| **Mailing address** *(If different from Residential Address)* | |

## 3. TAX RESIDENCY DECLARATION

### A. Common Reporting Standards (CRS) Tax Residency Self-Certification

**WARNING**: Singapore Income Tax Act imposes a penalty of a fine not exceeding $10,000 and / or imprisonment of up to 2 years, on individual that is known to provide false or misleading information. For more information, please refer to Section 105M of Income Tax (Amendment No. 2) Bill 2016.

**i. Details of Tax Residency**

Please provide information on your Tax Residency (This will be applicable to where you are liable to pay income taxes).If you have any questions on how to define your Tax Residency status, please visit **http://www.oecd.org/tax/automatic-exchange/crs-implementation-and-assistance** or speak to a professional tax adviser.

| CRS Declaration of Tax Residency (Tick where applicable. You may select more than 1) | |
|---|---|
| 1. I am a tax resident of **Singapore**<br>**Taxpayer Identification Number (TIN):** _____ | ☐ Please complete **Part iii** |
| 2. I am a tax resident of other country(ies) / jurisdiction(s) | ☐ Please complete both **Part ii & iii** |

CTPIS/LIFE/CRS-FATCA-I/082021



China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 6389 6111 6222 1033 www.sg.cntaiping.com

## A. Common Reporting Standards (CRS) Tax Residency Self-Certification (Cont'd)

**ii. Details of Foreign Tax Residency(ies)**

Please provide ALL the country(ies) (excluding Singapore) in which you are a tax resident and the associated Taxpayer Identification Number (TIN).

| | Country/Jurisdiction of Tax Residency | Taxpayer Identification Number (TIN) | If you are unable to provide the TIN, Please tick one of the reasons* | | | If Reason B has been selected, please indicate why TIN is not available |
|---|---|---|---|---|---|---|
| 1 | | | ☐ A | ☐ B | ☐ C | |
| 2 | | | ☐ A | ☐ B | ☐ C | |
| 3 | | | ☐ A | ☐ B | ☐ C | |

| *Reason | Description |
|---|---|
| A | The country where the Account Holder (Assignee) is liable to pay tax does not issue TINs to its residents. |
| B | The Account Holder (Proposer) is otherwise unable to obtain a TIN or equivalent number. (Please explain why you are unable to obtain a TIN if you have selected this reason) |
| C | No TIN is required. (Note: Only select this reason if the authorities of the country of tax residency entered above do not require the TIN to be disclosed.) |

**Clarification of Tax Residency**

If your declared country(ies)/jurisdiction(s) of tax residency does not include the country of your **residential/mailing address, contact number, country of birth, nationality or citizenship**, please provide the reason below.

_____

_____

**iii. Acknowledgement of Tax Residency**

☐ I confirm that I am not a tax resident of any country(ies) other than the one(s) that I have declared above. I shall notify CTPIS within 30 days from date of change.

## B. DECLARATION ON U.S STATUS

☐ I am not a U.S. Person / Person with U.S. Indicia and I am not acting for / on behalf of a U.S Person / Person with U.S Indicia. If my tax status changes and I become a U.S Person / Person with U.S Indicia. I shall notify CTPIS within 30 days from date of change.

☐ I am a U.S. Person / Person with U.S. Indicia (please delete accordingly) and I have submitted the Declaration for U.S Person and U.S Indicia Form.

**Please specify Tax Payor Identification No. (TIN)** ☐☐☐ - ☐☐ - ☐☐☐☐

♦ For definition of U.S Person under/or U.S Indicia, please visit https://www.irs.gov
Please note that Form W-9 / Form W-8BEN need to be completed for U.S Person or Person with U.S Indicia respectively.

## 4. DECLARATION AND AUTHORISATION

a) I declare that the information provided in this form is, to the best of my knowledge and belief, correct and complete.

b) I acknowledge and understand that the information contained in this self-certification and any reportable account(s) may be reported to the tax authorities of the country/jurisdiction in which this account(s) is/are maintained and exchanged with tax authorities of another country/jurisdiction or countries/jurisdictions in which I may be tax resident pursuant to intergovernmental agreements to exchange financial account information.

c) I agree to notify China Taiping Insurance (Singapore) Pte. Ltd. within 30 days of any errors, omissions or changes in the information provided in this form.

| | |
|---|---|
| _____ **Signature of Account Holder** | _____ **Date** |