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Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

MediLite – Amendment Form

Important Notice

1. Please note that you will continue to be covered under the old plan before the effective date of the new plan.
2. Illness or conditions (accepted) contracted or diagnosed prior to upgrade will be paid previous level of benefits for 12 months from date of upgrading.
3. Additional terms may be imposed on the upgraded benefits or the application for upgraded benefits may be declined subject to declaration.
4. This form is valid for three months from date of application, after which has to be re-completed and signed

Name of Insured Member(s):

Self	:	_____	NRIC / Passport No	:	_____
Spouse	:	_____	NRIC / Passport No	:	_____
Child 1	:	_____	NRIC / Passport No	:	_____
Child 2	:	_____	NRIC / Passport No	:	_____
Child 3	:	_____	NRIC / Passport No	:	_____

Name of Applicant / Policyholder	:	_____	NRIC / Passport / ROC No	:	_____
Name of Insurance Advisor	:	_____	Code	:	_____
Policy No	:	_____	Existing Plan	:	_____

CHANGE OF PLAN - As of **NEXT** Policy Anniversary

		Self	Spouse	Child 1	Child 2	Child 3
MediLite	**Plan**	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3

ADDITION / REMOVAL OF INSURED MEMBER(S)

Name	Please select **Add (A)** or **Remove (R)**	**NRIC / Passport No.**	**Date of Birth**	**Gender**	**Relationship to Applicant**	**Effective Date**
1.	A / R					
2.	A / R					
3.	A / R					

OTHER CHANGES

☐ I/We declare that my Country of Residence has been changed as below:

Country: _____ Period of Planned Stay in Country: _____

New Address: _____

Changed since: _____

Reason for Overseas Residence: _____

If for work reasons, please provide a description of job scope: _____

☐ I/We declare that my Occupation has been changed as below:

New Occupation / Profession: _____

New Business / Trade: _____ Changed since: _____

☐ I/We declare that my *Habits / Pursuits have been changed as below:

_____ Changed since: _____

☐ Others: _____

_____

Health Declaration of Insured Member(s)

☐ I/We declare that there has been no change in my/our health condition, and that I/we have not received any medical attention, consultation or examination whatsoever, since the date of completion of the application for my/our MediLite policy; further, that all my/our answers as written in the application of my/our MediLite policy, including those relating those to my/our country of residence, business, occupation, habits or pursuits are still true.

☐ Please refer to the Health Declaration Form (applicable for **Upgrading of Plan, Addition of Cover, Review Medical Rating/Exclusion, Declaration of New Medical Condition(s)**).

DECLARATION

1. I/We hereby request that the policy stated in this form be changed in accordance with the above.
2. I/We understand and agree that no application is valid until this form is received and duly accepted by the Company during the lifetime of the insured.
3. I/We understand and agree that my application is subject to terms and conditions as stated in the Policy Contract.
4. For change of plan, I/We have received the booklet 'Your Guide to Health Insurance' as well as the MediLite brochure, which provides the Product Summary **(Version:** _____ **)** on key product information and provisions, the contents of which have been explained to my satisfaction.
5. I/We acknowledge and agree (in case of corporate policy, I represent that I have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my/our personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg
6. I/We consent to receive marketing and promotional information from Sompo (e.g. via email, mail, SMS, etc.). I/We understand that I/we can withdraw or manage my/our consent to receive marketing and promotional information at www.sompo.com.sg
7. I/We am/are aware of and agree to abide by the Policy terms, conditions and exclusions and confirm that the information given in this application/form is true, accurate and complete.

_____ _____

Signature of Applicant (on behalf of persons to be insured) Date
(Affix company stamp where applicant is a corporate entity)

_____ _____

Signature of Employee **(Where applicant is a corporate entity)** Date

_____ _____

Signature of Advisor Date