



Request for Changes to Individual Life Policies (Form 1)

Policy No. : _____

Name of Assured/Assignee/Trustee(s) : _____

Identity No : _____

Please tick (✓) appropriate box and complete the request accordingly.
 For items 1 to 5, this request(s) has to be completed and signed by Assured/Assignee/Trustee(s) where applicable.

Alterations on Policy :

I am aware that insurance is a long term commitment and I can seek advice from a licensed financial adviser representative before I sign this application. Should I choose not to, I take sole responsibility to ensure that this application is appropriate to meet my financial needs and insurance objectives. I understand that by making changes to my Policy, I may be losing valuable benefits and it may not be possible for me to obtain a similar level of protection on the same terms in the future.

I, the legal owner of this Policy, hereby request that this Policy to be changed as indicated below with the understanding and agreement that the change when effected shall be an amendment to and will form part of the original Policy issued and also be binding on any person who shall have or claim any interest under the above Policy.

Alterations on Premium Payments (Mode / Frequency)

1. Change frequency of premium payment to:
 Yearly Half-yearly Quarterly Monthly
 (Please note that if there is existing policy loan and interest repayment, the declaration/billing will be in accordance with the new frequency but the amount remains unchanged. If you wish to amend the repayment instalment amount, please contact our Customer Service Executive for a revised Authorisation form)

Alterations on Policy

2. Change to Reduced Paid-up Assurance
3. Change from Reduced Paid-up Assurance to Premium Paying Policy (**Applicable for CPFIS Policies only**)
 I authorise the deduction of all outstanding premiums from my CPF account and will pay any interest due by cash / cheque.
4. Deletion of Supplementary Benefit(s) / Rider(s) :- _____
 (Please specify Supplementary Benefit(s) / Rider(s) to be deleted)
5. Deletion of Insured Person(s) for Medical Policy :- _____
 (Please specify Insured Person(s) to be deleted)

 Signature of Assured(s) / Assignee(s) / Trustee(s)
 (Please note that signature / thumbprint must be consistent with our record)

 Submitted by Name & Signature of Financial
 Advisor Representative/Witness

 Date