

APPLICATION FOR REINSTATEMENT – PRUApex International Health

WARNING: PURSUANT TO THE INSURANCE ACT OF SINGAPORE - YOU ARE TO DISCLOSE IN THIS FORM FULLY AND FAITHFULLY, ALL THE FACTS WHICH YOU KNOW OR OUGHT TO KNOW, OTHERWISE YOU MAY RECEIVE NOTHING FROM THE POLICY.

Policy Number

Name of Life Assured

Relationship to Policyowner/Payer*

Health Details of Life to be Assured

You must answer these questions completely without relying or making reference(s) to any past declaration(s) that you may have made to Prudential. Failing to do so, Prudential has the right to cancel or reduce the benefits/cover provided by this policy.

If you have answered "yes" to any of the questions, give details below.

- | | | |
|---|------------------------------|-----------------------------|
| 1) Do you and your proposed life assureds have a regular doctor whom you consult for medical reasons (excluding minor illnesses such as cold or flu)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2) In the past 5 years, have you and your proposed life assureds had any tests done such as X-rays, ultrasound, CT scan, biopsy, barium meal examination, electrocardiogram (ECG), liver function test, cholesterol, blood or urine test or and other tests not mentioned? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3) In the last 5 years, have you and your proposed life assured ever been hospitalised or undergone any surgery, or had submitted any insurance claim(s), including those pending for claim(s) settlement? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4) Have you and your proposed life assureds ever had or been told to have or been treated for:-- | | |
| a. Epilepsy, fits, stroke, paralysis, weakness of limb, prolonged headache, unconsciousness, nervous breakdown, depression or any other nervous/mental disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Diabetes, thyroid disorders or any other endocrine disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Ear discharge, nose bleeds, double vision, glaucoma, impaired sight, hearing or speech or any other disorders of ear, eye, nose or throat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Asthma, bronchitis, persistent cough, coughing with blood, pneumonia, tuberculosis, chest or breathing complaints/ discomfort or any other lung disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Raised cholesterol, high blood pressure, heart attack, heart murmur, mitral valve prolapse or other heart valve disorders, breathlessness, irregular or fast heart rate, chest discomfort or pain, diseases of or any other disorders of the heart or blood vessels? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Acid reflux, gastritis, stomach or duodenal ulcer, blood in stools, piles or any other stomach or bowel disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Jaundice, abnormal liver function test, Hepatitis B carrier or any form of hepatitis, liver disorders or gall bladder disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Blood, protein or sugar in urine, kidney stones, infection or any other disorders of the kidney, bladder or urogenital organs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Slipped disc, gout, any form of arthritis, osteoporosis (weak bones), or any other disorder, pain or injury to the muscles, bones, spine, limbs or joints? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Cancer, tumour, cyst, lump or growth of any kind? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Anaemia, thalassaemia, haemophilia or any other disorders of the blood? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Systemic Lupus Erythematosus, Rheumatoid Arthritis, Kawasaki disease or any other disorders of the immune system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| m. Any other symptoms, illness, disorder, injury, disability, operation or hospitalisation not mentioned above? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5) Have you or your proposed life assureds (if applicable) been told to have, or have received any medical advice, counselling, test or treatment in connection with sexually transmitted disease, HIV, AIDS, AIDS Related Complex or any other AIDS related condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6) Have you and your proposed life assureds ever in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, shortness of breath, severe ongoing headache, enlarged nodes or unusual skin lesions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7) Have any of your and your proposed life assureds insurance application(s) with any insurers been declined, postponed, or accepted with exclusions or special terms?
This includes any moratorium underwriting or similar campaigns, in which pre-existing medical conditions are not declared upon application and are subjected to special terms and conditions. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8) Are you or any of your proposed life assureds currently undergoing, or planning to undergo, any fertility-related investigations or treatments (e.g., hormone therapy, IVF, IUI, surgical procedures, or diagnostic testing), including any assessments to determine the cause of infertility?
If yes, please provide details, such as type of treatment or investigation, and whether any symptoms or concerns were present before coverage began. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9) For proposed life assureds aged above 60, have you and your proposed life assureds undergone a health screening or medical check-up within the last 12 months?
If yes, please provide a copy of the recent health screening or check-up results with your application (conducted within the last 12 months). | | |

Health Questions for Juvenile Life only

- | | |
|---|--|
| <p>1) Is the child a premature baby (i.e., less than 37 weeks of gestation)? If yes, please provide full set of child's health booklet.</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>2) Have any of your children ever suffered from birth difficulty or complication including but not limited to "blue baby" or respiratory disorder, or congenital condition/defect/abnormality including but not limited to Spina bifida, Down's syndrome, Cleft palate, Congenital heart disease, Anal atresia, Atrial septal defect, Congenital cataract, Congenital deafness, Congenital diaphragmatic hernia, Infantile hydrocephalus, Tetralogy of fallot, Transposition of great vessel, Truncus arteriosus, Ventricular septal defect , etc?
If yes, please provide details and a full set of Child's Health Booklet for review.</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Health Questions for Female Life only

- | | |
|--|--|
| <p>1) Have you been told to repeat Pap smear within the next six months or ever had an abnormal Pap smear, mammogram, ultrasound of the pelvis or breasts, biopsy, colposcopy or any other gynaecological investigations?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>2) Have you ever had or been told to have or been treated for:</p> <p style="margin-left: 20px;">a. Any disease or disorder of the breast including breast lump, cyst, fibrocystic disease, mammary dysplasia, carcinoma in situ, cancer or growth?</p> <p style="margin-left: 20px;">b. Any disease or disorder of the cervix uteri, uterus, ovaries, vulva or fallopian tubes including ovarian cysts, abnormal uterine or vaginal bleeding, fibroid, polyp, or menstrual impairment, hormonal imbalance, carcinoma in situ, cancer or growth?</p> <p>If "yes" to questions, please provide details below.
Type, reason, date of test done and result of test (copy to be submitted if available)</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>3) Have you or any of your proposed life assureds ever experienced any complications during pregnancy or childbirth including but not limited to Gestational diabetes, Gestational hypertension, Pre-eclampsia/eclampsia, Ectopic pregnancy, Stillbirth, Miscarriage, Disseminated intravascular coagulation, Abruptio placentae, Amniotic fluid embolism?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>4) Is any of the proposed life assured's pregnancy conceived through fertility treatment or any pending such treatment?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>5) Is any of the proposed life assureds currently pregnant?
If yes, what is the expected delivery date: _____
If yes, is the proposed life assured having twins, triplets, quadruplets or more? _____</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No |

Health Questions for Dental & Vision Plus only

- | | |
|--|--|
| <p>1) Are there any dental measures, bridges, crowns, inlays, onlays, implants, etc. currently being formed or recommended?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>2) Do you are any of the proposed life assured suffer from periodontitis (extensive disorder of the gum and the tooth-supporting structures)?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Health Questions for Cancer Plus only

- | | |
|---|--|
| <p>1) Has any of the proposed life assureds been diagnosed with a hereditary cancer syndrome (e.g., BRCA-related breast/ovarian cancer, Lynch syndrome) based on clinical evaluation or diagnostic testing?
If yes, please provide please provide details of the diagnosis and any treatment received.</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>2) Do you or any of the proposed life assureds have a family history of hereditary cancers (e.g., breast, ovarian, colorectal) or has any first degree relative diagnosed with cancer before the age of 50?
If yes, please specify the type of cancer and the relation to the affected individual</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>3) Have you or any of the proposed life assureds been advised, scheduled (planned or pending), or undergone any procedures or surgeries (e.g. preventive mastectomy or oophorectomy, colon polyp removal, endometrial ablation, prostate biopsy) related to cancer prevention or risk reduction**?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>4) Are you or any of the proposed life assureds currently receiving, or have previously received, experimental or investigational cancer treatments?</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>5) Are you, any of the proposed life assureds, or any family member (including those not named in this application) currently participating in a clinical trials or research study* related to cancer therapies or cancer risk monitoring?
*A clinical trial or research study includes any structured program involving experimental or investigational drugs, procedures, or monitoring, — even if prescribed or recommended by a healthcare provider.</p> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- If "Yes", please provide details including:
- Name of the study or trial
 - Institution or sponsor conducting it
 - Type of therapy, drug, or monitoring involved
 - Reason for participation (e.g., treatment, genetic risk, surveillance)
 - Start date and expected duration

Yes No

<p>6) Have you or any of the proposed life assureds ever undergone any cancer-related screening (e.g. mammogram, colonoscopy, pap smear, CT scan, etc), biomarker testing, or received results that required follow-up imaging, specialist review, or further investigation?</p> <p>7) Are you or any of your proposed life assureds currently undergoing medical surveillance or enrolled in a cancer monitoring program*? *A cancer monitoring program refers to regular medical follow-up such as imaging, blood tests, or specialist reviews for individuals at increased risk of cancer due to personal history, family history, or genetic predisposition.</p> <p>If "Yes", please provide details including:</p> <ul style="list-style-type: none"> • Reason for surveillance (e.g., BRCA1 mutation, prior abnormal screening) • Type of monitoring (e.g., annual MRI, colonoscopy, blood markers) • Name of medical institution or specialist overseeing the program 	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Section Life to be Assured: If any of the answers above is "Yes", please provide full details including any undiagnosed symptoms for each affected Life to be Assured and attach medical reports. If necessary, please attach a separate sheet.

Proposed Medical Disclosure Layout for Life to be Assured

Name of Life to be Assured	Question & Sub-Question (e.g. a, b, etc.)	Medical Condition / Symptoms	Date of Diagnosis	Treatment or Medications (prescribed or otherwise)	Treatment Date	Treatment Duration	Name & Address of Doctor/ Hospital	Current Medical Status Full Recovery / Ongoing / Recurrent / Like to Recur / Complications / Follow-Up Needed

Declaration & Authorisation

I/We declare that material facts, that is facts likely to influence the assessment of this Application for Reinstatement have been provided and to the best of my/our knowledge the information given here is true and complete.

I/We agree to inform Prudential Assurance if there is any change in the state of health, occupation, or activity of the Life Assureds between the date of this application or medical examination and the issue of the above reinstatement. On receiving the information of any change, Prudential Assurance is entitled to accept or reject my application.

Signature of Life Assured (Age 19 next birthday and above) Signature of Policyowner/Payer

Note: Please submit a copy of NRIC/ID with current signature

Date (dd/mm/yyyy)

Date (dd/mm/yyyy)