

# Tenet Insurance Company Ltd

(A wholly owned company of Hwa Hong Corporation Limited)  
 11 Collyer Quay #09-00 The Arcade Singapore 049317 Tel: 6221 2211 Fax: 6221 3302  
 Company Registration No. 195700067Z <http://www.tenetinsurance.com>



## MEDIWELL PLUS / MEDILITE - AMENDMENT FORM

### IMPORTANT NOTES

- Please note that you will continue to be covered under the old plan before the effective date of the new plan.
- Illness or conditions (accepted) contracted or diagnosed prior to upgrade will be paid previous level of benefits for 12 months from date of upgrading.
- Additional terms may be imposed on the upgraded benefits or the application for upgraded benefits may be declined subject to declaration.
- 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   |
|--------------------------|-----------------------------|-----------|-----------|-----------|-----------|-----------|
| <input type="checkbox"/> | MediWell Plus Design & Plan | E/S _____ | E/S _____ | E/S _____ | E/S _____ | E/S _____ |
| <input type="checkbox"/> | 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                               |                     |               |        |                           |                |

### ADDITION / REMOVAL OF OPTIONAL RIDERS (Available for both *Essential* and *Surplus* Designs)

|   | Self                     | Spouse                   | Child 1                  | Child 2                  | Child 3                  |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Please select Add (A) or Remove (R)   | A / R                    | A / R                    | A / R                    | A / R                    | A / R                    |
| - Dread Disease   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - Hospital Cash Allowance   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| - Overseas Coverage for Singaporean Working in ASEAN countries, China, Hong Kong, South Korea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### ADDITION / REMOVAL OF DEDUCTIBLE (Available for MediWell Plus *Essential* Design only)

|  | Self          | Spouse | Child 1 | Child 2 | Child 3 |
|--|---------------|--------|---------|---------|---------|
| <input type="checkbox"/> Remove Deductible |               |        |         |         |         |
| <input type="checkbox"/> Add / Amend to:   | Amount (\$\$) |        |         |         |         |

**ADDITION / REMOVAL OF CO-INSURANCE** (Available for both *Essential* and *Surplus* Designs)

|  |                   |             |               |                |                |                |
|--|-------------------|-------------|---------------|----------------|----------------|----------------|
| <input type="checkbox"/> Remove Co-insurance                         |                   | <b>Self</b> | <b>Spouse</b> | <b>Child 1</b> | <b>Child 2</b> | <b>Child 3</b> |
| <input type="checkbox"/> Add / Amend to:<br>(pls select accordingly) | <b>Percentage</b> | 10 / 20     | 10 / 20       | 10 / 20        | 10 / 20        | 10 / 20        |

**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 MediWell Plus / MediLite policy; further, that all my/our answers as written in the application of my/our MediWell Plus / 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, Removal of Deductible/Co-insurance, Review Medical Rating/Exclusion, Declaration of New Medical Condition(s)**).

**DECLARATION**

1. I hereby request that the policy stated in this form be changed in accordance with the above.
2. I 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 understand and agree that my application is subject to terms and conditions as stated in the Policy Contract.
4. For change of plan, I have received the booklet 'Your Guide to Health Insurance' as well as the MediWell Plus / MediLite brochure, which provides the Product Summary (**Version:** \_\_\_\_\_ ) on key product information and provisions, the contents of which have been explained to my satisfaction.

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

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Employee (Where applicant is a corporate entity)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Advisor

\_\_\_\_\_  
 Date