



# Central Provident Fund Board

MSH8

79 Robinson Road, CPF Building, Singapore 068897  
Website: [www.cpf.gov.sg](http://www.cpf.gov.sg) CPF Call Centre: 1800-227 1188

## Stop Premium Payment for Dependant(s)' MediShield Cover

This form may take you 3 minutes to complete.

### Important Notes:

1. Please complete this form if you wish to stop premium payment for your dependant(s)' MediShield cover(s) but want them to continue coverage under the Scheme.
2. Upon approval of this application, premium payment from your Medisave for your dependant(s) will be ceased.
3. Dependant(s) who are above 16 years old will take over the premium payment of their own MediShield cover when their policy is renewed.
4. Please provide the dependant(s)' residential address if it is different from yours. **This is only applicable if dependant(s) is below 16 years old.**
5. Please do not use correction fluid/tape. Please **sign against any amendment** you have made on the form.

### PART I: PARTICULARS OF CPF MEMBER (PAYER)

(As in NRIC)		*Delete where applicable									
Name:	NRIC/CPF Account: <b>S/T*</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										
Contact No.:	(Home)	(Office)						(Mobile)			

### PART II: STOP PREMIUM PAYMENT FOR DEPENDANT(S)

I wish to stop paying MediShield premium for the following Dependant(s) listed below:

**Name of Dependant**  
(As in NRIC / Birth Certificate)

**NRIC / Birth Certificate Number(s)**

\*Delete where applicable

- |          |  |   |                      |
|----------|--|---|----------------------|
| 1. _____ | <b>S/T*</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | - | <input type="text"/> |
| 2. _____ | <b>S/T*</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | - | <input type="text"/> |
| 3. _____ | <b>S/T*</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | - | <input type="text"/> |
| 4. _____ | <b>S/T*</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | - | <input type="text"/> |

# The residential address of the above dependant(s) is :

\_\_\_\_\_

\_\_\_\_\_

**Signature/Right Thumb Print of CPF Member (Payer)**

**Date**

# please fill only if his/her registered address is different from yours

### For Official Use

Checked By :