

**CENTRAL PROVIDENT FUND ACT**  
(CHAPTER 36)

**CENTRAL PROVIDENT FUND  
(PRIVATE MEDICAL  
INSURANCE SCHEME)  
REGULATIONS**

**Rg 26**

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**CENTRAL PROVIDENT FUND ACT  
(CHAPTER 36, SECTION 77 (1) (k))**

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**ARRANGEMENT OF REGULATIONS**

**Regulation**

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[1st July 2005]

**Citation**

**1.** These Regulations may be cited as the Central Provident Fund (Private Medical Insurance Scheme) Regulations.

**Definitions**

- 2.** In these Regulations, unless the context otherwise requires —
- “dependant”, in relation to a member, means —
- (a) a member’s spouse, child, parent or grandparent; or

- (b) any other person who is dependent on the member and whom the Board may approve for the purpose of these Regulations;

“Government premium rebate” means —

- (a) the sum of money, equivalent to the amount of premium payable under the MediShield Scheme in Division 2 of Part II of the Central Provident Fund (MediShield Scheme) Regulations 2005 (G.N. No. S 427/2005); or
- (b) the amount of premium payable after deducting any premium rebate given by the insurer,

whichever is the lower, which may be paid by the Government to a person under the MediShield Scheme for the Elderly;

“insurer” means any insurer which is registered under the Insurance Act (Cap. 142);

“integrated medical insurance plan” means any plan under which a person is insured —

- (a) under a medical insurance policy which is approved by the Minister for Health for the purposes of regulation 4 (1) (b); and
- (b) where applicable, under the MediShield Scheme in Division 2 of Part II of the Central Provident Fund (MediShield Scheme) Regulations 2005;

“MediShield Component”, in relation to a person insured under an integrated medical insurance plan, means his insurance cover under the MediShield Scheme in Division 2 of Part II of the Central Provident Fund (MediShield Scheme) Regulations 2005 which forms part of his integrated medical insurance plan;

“MediShield Scheme” means the MediShield Scheme established and maintained by the Board under section 53 of the Act;

“member” includes a member who is an undischarged bankrupt;

“policy year” means a period of 12 months from the date of the commencement or renewal of a person’s insurance cover under these Regulations;

“premium” means any premium payable under these Regulations and includes any goods and services tax thereon;

“private medical insurance plan” means a medical insurance policy which is approved by the Minister for Health for the purposes of regulation 4 (1) (a).

### **Application**

**3.** These Regulations shall apply to persons in respect of whom an application under regulation 4 is approved by the Board.

### **Application to withdraw moneys for purchase of insurance plan**

**4.—**(1) Subject to these Regulations, the Board may, upon the application of a member, or upon the transfer of liabilities relating to the insurance cover of a member or his dependant under the Central Provident Fund (MediShield Scheme — Transfer of MediShield Plus Liabilities) Regulations (Rg 33), permit the withdrawal of the whole or part of the amount standing to his credit in his medisave account for the purchase of —

- (a) a private medical insurance plan for himself or his dependant provided such application is made before 1st July 2005; or
- (b) an integrated medical insurance plan for himself or his dependant.

(2) Subject to paragraph (3), the amount that may be withdrawn under paragraph (1) (a) or (b) shall not exceed a sum of \$800 per policy year per person insured.

(3) Where the private medical insurance plan referred to in paragraph (1) (a) is the Managed Healthcare System provided by NTUC Income Insurance Co-operative Limited, the amount that may be withdrawn per person insured shall not exceed —

- (a) in the case of a person aged 30 years and below, a sum of \$90 per policy year;
- (b) in the case of a person aged 31 to 40 years, a sum of \$135 per policy year;
- (c) in the case of a person aged 41 to 50 years, a sum of \$270 per policy year;

- (d) in the case of a person aged 51 to 60 years, a sum of \$450 per policy year;
- (e) in the case of a person aged 61 years and above, a sum of \$660 per policy year;
- (f) 80% of the amount of premium payable by the member for himself or his dependant, as the case may be, under the policy; or
- (g) the total credit balance in the member's medisave account, whichever is the lowest applicable amount.

(4) For the purpose of computing the amount that the Board may deduct under paragraph (1), the sum of \$800 referred to in paragraph (2) and the sum of \$660 referred to in paragraph (3) (e) shall include any Government premium rebate which the member may be entitled to receive.

### **Further conditions of application**

**5.—**(1) The Board shall forward to the insurer the amount withdrawn from the member's medisave account pursuant to his application under regulation 4 (1) (a) for the payment of the premiums payable for his or his dependant's private medical insurance plan, as the case may be.

(2) The Board shall, pursuant to a member's application under regulation 4 (1) (b) or upon a transfer of liabilities relating to the insurance cover of a member or his dependant under the Central Provident Fund (MediShield Scheme — Transfer of MediShield Plus Liabilities) Regulations (Rg 33), forward to the insurer such part of the amount withdrawn from the member's medisave account that does not pertain to the premiums payable for his or his dependant's MediShield Component, as the case may be.

(3) Where a person's MediShield Component has ceased, the Board shall forward to the insurer the whole amount withdrawn from that person's medisave account or, in the case where the person is a member's dependant, from that member's medisave account for the premium payable for the integrated medical insurance plan.

(4) Every application under regulation 4 shall be —

- (a) made in such form and in accordance with such procedure as the Board may require; and
  - (b) supported by such documents or evidence as the Board may require.
- (5) The Board may approve the application subject to such terms and conditions as the Board may impose.
- (6) No person shall be insured —
- (a) under more than one private medical insurance plan;
  - (b) under more than one integrated medical insurance plan;
  - (c) concurrently under a private medical insurance plan and an integrated medical insurance plan;
  - (d) concurrently under the MediShield Scheme and a private medical insurance plan; or
  - (e) concurrently under the MediShield Scheme in Division 3 of Part II of the Central Provident Fund (MediShield Scheme) Regulations 2005 (G.N. No. S 427/2005) and an integrated medical insurance plan.

### **Payment of premiums**

**6.—**(1) Subject to paragraph (3), any premium payable in respect of a member's or his dependant's private medical insurance plan or integrated medical insurance plan, as the case may be, after discounting any Government premium rebate which the member or his dependant may be entitled to receive, may be paid from the moneys standing to the member's credit in his medisave account at the time when the insurer notifies the Board that the payment of such premium is due.

(2) If —

- (a) the amount standing to the member's credit in his medisave account is insufficient to pay the premium for his or his dependant's private medical insurance plan or integrated medical insurance plan, as the case may be, after discounting any Government premium rebate which the member or his dependant may be entitled to receive; and
- (b) in the case of premium for the member's or his dependant's integrated medical insurance plan, the member has not made any arrangement for the payment of the deficiency,

the insurer shall determine whether the member or his dependant, as the case may be, may continue to be insured under the policy, but the continuance of the insurance shall be subject to such terms and conditions as the Board may impose.

(3) No premium due on or after 1st July 2007 in respect of a member's or his dependant's private medical insurance plan shall be paid from the moneys standing to the member's credit in his medisave account.

(4) Where any amount which pertains to the premium payable for a person's integrated medical insurance plan is paid to an insurer otherwise than in accordance with paragraph (1), the insurer shall transfer to the Board, in such manner as the Board may require, such part of that amount which pertains to the premium payable for the person's MediShield Component.

#### **Period of insurance cover**

7.—(1) Notwithstanding anything in these Regulations but subject to paragraph (2), a person shall, upon the payment of the premium payable for his private medical insurance plan or integrated medical insurance plan, be insured under such plan for a period of 12 months from the date the premium was due.

(2) Where a person is insured under an integrated medical insurance plan pursuant to regulation 11 (1) of the Central Provident Fund (MediShield Scheme) Regulations 2005 (G.N. No. S 427/2005), his initial period of insurance cover under the integrated medical insurance plan shall be a period of 12 months less the period calculated from the most recent date before 1st October 2005 of the renewal of his insurance cover under the Scheme in Division 3 of Part II of those Regulations to 1st October 2005.

#### **Automatic termination of existing insurance cover**

8.—(1) A person who is already insured under a private medical insurance plan shall cease to be insured under that plan from the date he is insured under —

- (a) another private medical insurance plan;
- (b) an integrated medical insurance plan; or

(c) the MediShield Scheme,  
and regulation 10 shall apply accordingly.

(2) If a person who is already insured under an integrated medical insurance plan is insured under another such plan, his first plan shall terminate from the date he is insured under the second integrated medical insurance plan.

(3) If a person who is already insured under an integrated medical insurance plan is insured under the MediShield Scheme (other than through an integrated medical insurance plan), his integrated medical insurance plan shall terminate from the date he is insured under the MediShield Scheme.

### **Termination of existing insurance cover**

**9.**—(1) The termination of a private medical insurance plan or an integrated medical insurance plan may be effected by —

- (a) the insured person;
- (b) the member who insured him; or
- (c) such other person as the insurer thinks fit,

by such means as the insurer deems fit.

(2) Notwithstanding anything in this regulation, the termination of a person's integrated medical insurance plan shall not by itself cause the termination of his MediShield Component unless the termination of the MediShield Component has been effected under regulation 22 or 23 of the Central Provident Fund (MediShield Scheme) Regulations 2005 (G.N. No. S 427/2005) or any other applicable Regulations.

### **Refund of premium**

**10.**—(1) If a person insured under a private medical insurance plan ceases, under regulation 8 or 9 (1), to be insured under that plan within 2 months from the date of the commencement of the insurance plan, the insurer with whom the plan is taken out shall refund, in the manner set out in paragraph (5), the full amount of the premium paid for that policy year.

(2) If a person insured under an integrated medical insurance plan ceases, under regulation 8 or 9 (1), to be insured under that plan



within 2 months from the date of the commencement of the insurance plan, the insurer with whom the plan is taken out shall refund, in the manner set out in paragraph (6), the full amount of the premium paid for the plan.

(3) If a person insured under a private medical insurance plan ceases, under regulation 8 or 9 (1), to be insured under that plan at any time after the second month of the commencement of the insurance plan and has not, before the effective date of termination of his insurance plan, made any claim under the insurance plan, the insurer with whom the plan is taken out shall refund, in the manner set out in paragraph (5), a pro-rated amount of the premium for the unexpired period of the plan.

(4) If a person insured under an integrated medical insurance plan ceases, under regulation 8 or 9 (1), to be insured under that plan at any time after the second month of the commencement of the insurance plan, the insurer with whom the plan is taken out shall refund, in the manner set out in paragraph (6), a pro-rated amount of the premium paid for the plan less a pro-rated amount of the premium paid for the MediShield Component for the unexpired period of the plan.

(5) Any refund of any premium under paragraph (1) or (3) shall be paid in the following manner:

- (a) where the premium for the policy year was deducted entirely from the member's medisave account, the refund shall be paid into the member's medisave account;
- (b) where the premium for the policy year was paid entirely using the Government premium rebate, the refund shall be paid to the Government in cash; and
- (c) where the premium for the policy year was paid using the Government premium rebate, by deducting from the member's medisave account, by a mode of payment agreed between the member and the insurer or by any combination of these modes of payment, the proportion of the refund corresponding to the proportion of the premium paid using the Government premium rebate, if any, shall be paid to the Government in cash, and —
  - (i) where the balance remaining, after the refund of the proportionate amount of the Government premium

rebate, is less than the amount of premium paid by the agreed mode of payment, such balance shall be paid to the member in such manner as may be agreed between the member and the insurer or, if there is no agreement, in cash; and

(ii) where the balance remaining, after the refund of the proportionate amount of the Government premium rebate, is more than the amount of premium paid by the agreed mode of payment —

(A) the amount of such balance which is equal to the amount of premium paid by the agreed mode of payment shall be paid to the member in such manner as may be agreed between the member and the insurer or, if there is no agreement, in cash; and

(B) any amount remaining thereafter shall be paid to the member's medisave account.

(6) The proportion of any refund of any premium under paragraph (2) or (4) corresponding to the proportion of the premium paid by deducting from the member's medisave account shall be paid into the member's medisave account.

(7) Where any premium to be refunded for the MediShield Component has been forwarded by the Board to the insurer, the insurer shall pay out the premium refunded —

(a) to the person from whom, and in the mode of payment by which, the premium was received by the insurer; or

(b) if the Board directs otherwise, in accordance with the directions of the Board.

### **Cancellation of insurance cover**

**11.**—(1) If the insurer has reason to believe that any person who is insured, or any member whose dependant is insured, under an integrated medical insurance plan has, in connection with the application for himself or his dependant to be insured under the plan, made or furnished to the insurer any statement or fact that is false or misleading in a material particular or failed to disclose to the

insurer any material facts, which if known to the insurer, would have reasonably affected the decision of the insurer to issue the integrated medical insurance plan to the person or the member's dependant, the insurer may cancel the integrated medical insurance plan and refund all premiums paid in accordance with paragraph (2), and upon such cancellation, that person or that member's dependant, as the case may be, shall be deemed never to have been insured under that plan.

(2) The proportion of any refund of any premium under paragraph (1) corresponding to the proportion of the premium paid by deducting from the member's medisave account shall be paid into the member's medisave account.

(3) Where a claim has been made against the insurer before the date of cancellation of the integrated medical insurance plan under paragraph (1), the premium to be refunded shall be calculated from the first policy year immediately following the policy year in which the last claim was made against the insurer.

### **Termination of insurance cover under MediShield Scheme**

**12.** Where a person who is insured under an integrated medical insurance plan attains the age of 85 years or has claimed the total amount that he may claim under his MediShield Component, any termination of his MediShield Component shall not by itself result in the termination of his integrated medical insurance plan.

### **Reimbursement of medical expenses by person other than insurer and Board**

**13.—**(1) Where another person is under an obligation, contractual or otherwise, to pay or reimburse a person insured under an integrated medical insurance plan for charges incurred in respect of any medical treatment in an approved hospital received by such insured person, there shall become due and payable to the insurer or the MediShield Fund or both, as the case may be, on the date that the insured person receives such payment or reimbursement from that other person, the total amount received by the insured person from the insurer or the MediShield Fund or both, as the case may be, under the integrated medical insurance plan or the prescribed balance, whichever is the lower.

(2) For the purposes of paragraph (1), the prescribed balance shall be ascertained in accordance with the formula  $X + Y - Z$  —

where X is the total sum received by the insured person from that other person as payment or reimbursement of any medical treatment received by the insured person;

Y is the total amount of payment received from the insurer or the Board or both, as the case may be, by an insured person under the integrated medical insurance plan;

Z is the total amount of the medical expenses incurred by an insured person in respect of the medical treatment in an approved hospital.

(3) Where the insurer had received from the insured person the reimbursement amount under the integrated medical insurance plan pursuant to paragraph (1), the insurer shall retain the amount paid by the insurer under the integrated medical insurance plan, excluding the amount paid from the MediShield Fund, and shall transfer the remaining balance, or the full amount paid from the MediShield Fund, whichever is the lower, to the Board in such manner as the Board thinks fit.

### **Breach of Regulations**

**14.** If a member who has purchased a private medical insurance plan or an integrated medical insurance plan for himself or his dependant is in breach of any of these Regulations or if for any purpose connected with these Regulations, he makes a false representation to the Board or furnishes the Board with any false information, the Board may require the member to refund to his medisave account all moneys withdrawn by him therefrom under these Regulations together with interest that would have accrued thereto if the withdrawal had not been made.

### **Transitional provision**

**15.** Without limiting the provisions of the Interpretation Act (Cap. 1), the revocation of the Central Provident Fund (Private Medical Insurance Scheme) Regulations (Rg 26, 1998 Ed.) shall not affect anything whatsoever done under any provision of the revoked Regulations, and every such thing so far as it is subsisting or in force at the time of the revocation shall continue and have effect as if it had

been done under the corresponding provision of these Regulations  
and as if that provision had been in force when the thing was done.

*[G.N. Nos. S 428/2005; S631/2005; S 771/2005; S 889/2005; S 115/2006]*

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