

Confidential Fact-Finding form for Group Health Insurance

Kindly c	omp	lete fully ir	BLOCK	LETTER ar	d INK (Tick	boxes [√] wh	nere app	oropriate)
Period o	f ins	surance froi	m:/	/	_(dd/mm/yyyy	y) to/	_/	(dd/mm/yyyy)
		quotation v	vas subm	itted on	_//	(dd/mm/	уууу)	
Request								
		rance compa						
		formation	1					
Name of Nature of								
		red? Yes	: / No					
		of current ir						
Type of D	olicy	n						
Period of	Insu	rance: Fron	n:/_	/(0	dd/mm/yyyy)	To/	(dd/	mm/yyyy)
Total No.	of E	mployees:			No. of Emplo	yees to be in:	sured:	
program	is c	on compuls	ory basis	s unless ot	at participati herwise stat ke to have a c	ed. Please tid	ck [√]	surance accordingly to
Benefits		1 2	acurance	e Coverage		Б	articip	ation
Denents		• • • • • • • • • • • • • • • • • • • •	isui ai ice	Coverage		Compulso		Voluntary
Medical	1	Group Hos	oital &	Employee	only	Compariso	,, <u>y</u>	voidinary
		Surgical (G		Dependant (Spouse and/or Children)				
		Group Majo	or	Employee	only			
		Medical (GI	MM)	Dependar and/or Ch	nt (Spouse nildren)			
		Group Out-	Patient	Employee				
				Dependar and/or Ch	nt (Spouse nildren)			
Others	2	Dental I		Employee				
				Dependar and/or Ch	nt (Spouse nildren)			
		Maternity		Employee				
	<u> </u>		16		nt (Spouse)			
	,	tion is volunta nimum partici	,	,	endants are giv	en the choice t	o opt foi	r the cover(s),
01 Arc +	horo	any mamba	re curror	thy in bossi	tal or requires	froquent adm	niccion	(o a bosnital
		-			oital? Yes / I	•	11551011	(e.g. nospital
		provide the			ontai: 16371	40		
S/N	# o	f	Reason		alisation /Na	ture of		Sum Insured
	me age	mbers /	illness				/Plan	1

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Note: The	insurer will not rei	mburse the hospital claims for any member in hospi	ital at the time of
application			
Q.2 Has a	any member suffe	ered or is suffering from any serious condition	such as cancer,
organ fai	lure, heart diseas	se, stroke, liver disorder, arthritis or any other	disorder that
causes pi	rogressive irrever	rsible functional or physical disability? Yes / No	0
If Yes , k	indly provide the	following details:	
S/N	# of	Reason of hospitalisation / Nature of	Total Sum Insured
	members /	illness	/Plan
	age		
	,		
Note: The	insurer will not rei	mburse the hospital claims for any member in hospi	ital at the time of
application		mbarse the hospital claims for any member in hospi	tar at the time of
		based outside Singapore? Yes / No	
	3	following details:	
S/N	# of	Country based in	Total Sum Insured
37 IV	members /	Country based in	/Plan
			/ I Idii
	age		
Note: The	inauman will mat mai		ital at the times of
		mburse the hospital claims for any member in hospi	tai at the time oi
application		and or evaluations improced on the severage on	any mambara?
		ons or exclusions imposed on the coverage on a	arry members?
Voc / Nic			
Yes / No		provide the following details:	Total Come Income d
Yes / No S/N	# of	Limitations/Exclusions	Total Sum Insured
	# of members /	•	Total Sum Insured /Plan
	# of	•	
	# of members /	•	
	# of members /	•	
S/N	# of members / age	Limitations/Exclusions	/Plan
S/N Note: The	# of members / age	•	/Plan
S/N Note: The application	# of members / age	Limitations/Exclusions mburse the hospital claims for any member in hospi	/Plan
Note: The application	# of members / age insurer will not rein. ere any member	Limitations/Exclusions Imburse the hospital claims for any member in hospital engaged in hazardous occupation? Yes / No	/Plan
Note: The application Q.5 Is th (Hazardo	# of members / age insurer will not rein. ere any member ous occupation ego	Elimitations/Exclusions Imburse the hospital claims for any member in hospital engaged in hazardous occupation? Yes / Notation, welder, diver, sandblaster, offshore workers	/Plan
Note: The application Q.5 Is th (Hazardo If Yes, k	# of members / age insurer will not rein. ere any member ous occupation exindly provide the	Limitations/Exclusions mburse the hospital claims for any member in hospital engaged in hazardous occupation? Yes / Notes a g. welder, diver, sandblaster, offshore workers a following details:	/Plan
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Note: The application Q.5 Is the (Hazarde If Yes, keeps) Note: The application Q.6 To the	# of members / age insurer will not rein. ere any member ous occupation exindly provide the # of members / age insurer will not rein. e insurer will not rein. e best of your kr	Limitations/Exclusions Imburse the hospital claims for any member in hospital engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers e following details: Nature of work Imburse the hospital claims for any member in hospital claims for any member engaged in hazardous occupation?	/Plan ital at the time of etc.) Total Sum Insured /Plan ital at the time of ardous sports?
Note: The application Q.5 Is th (Hazarda If Yes, k S/N Note: The application Q.6 To th Yes / No	# of members / age insurer will not rein. ere any member ous occupation exindly provide the # of members / age insurer will not rein. e best of your kro (Hazardous spo	Elimitations/Exclusions Imburse the hospital claims for any member in hospital engaged in hazardous occupation? Yes / Notation of the second	/Plan ital at the time of etc.) Total Sum Insured /Plan ital at the time of ardous sports?
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		/Plan
Note: The	mburse the hospital claims for any member in hospital	al at the time of

Benefit: Group Hospital & Surgical Insurance/Major Medical Insurance								
a. Basis of C	Coverage							
Category of Employees / Occupation	Employees / Benefit Plan Yes / No							
(i)								
(ii)								
(iii)								
(iv)								

Important Note:

- (1) Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover
- (2) Please provide the Deductible /Co-insurance for respective employee category or occupation, if applicable.

Example 1

Category of Employees / Occupation	R&B Benefit Plan (S\$)
(i)Senior Management (Director, General Manager, Senior	360
Manager)	
(ii)Manager & Executive	200
(iii)All others	100

b. Age profile of employees						
Age band (Age next birthday)		# of employees				
	Male	Female				
16-30						
31-35						
36-40						
41-45						
46-50						
51-55						
56-60						
61-65						
66-70						
Total						

c. Details of Insured Members						
For GHS and GMM						
		# of employees (Sing	gaporeans & SPRs*)			
	Plan 1	Plan 2	Plan 3	Plan 4		
Employee Only						
Employee &						
Spouse						

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ŀ	HEALTH INTERNATIONAL		O		
Employee &					
Child(ren)					
Employee &					
Family					
* refers to Singapo	ore Permanent Reside	nts			
		# of emplo	oyees (Foreigne	rs* only)	
	Plan 1	Plan 2	PI	an 3	Plan 4
Employee Only					
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family					
* refers to all fore	igners holding Employ	ment Pass, S Pas	s and Work Perm	<u>it, working in Si</u>	ingapore
For GMM (if the	basis of coverage				
			<u>es (Singaporear</u>		
	Plan 1	Plan 2	PI	an 3	Plan 4
Employee Only					
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family					
* refers to Singapo	ore Permanent Reside	nts			
	1		··		
	DI 4		oyees (Foreigne		B
	Plan 1	Plan 2	PI	an 3	Plan 4
Employee Only					
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family			/ 14/- / 5	!t	·
^ reters to all forei	igners holding Employ	ment Pass, S Pas	s and vvork Perm	it, working in Si	ngapore
d 01-!	rmaniamas familis	maat 2			
	xperience for the			0	dina Claire
Period of	# of Insured as		Claims		ding Claims

d. Claims experience for the past 3 years								
Period of	# of Insured as	Paid (Claims	Outstanding Claims				
coverage	at	# of Claims	Amount (S\$)	# of Claims	Amount (S\$)			
From/To	(dd/mm/yyyy)							
(dd/mm/yyyy)								
Note: The insurer i	Note: The insurer reserves the right to request for more information.							

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e.Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis (i.e. currently insured).

Benefit: Group Ou	utpatie	nt Ins	suranc	е						
a. Category of en					se tick a	as ap	ppropr	iate)		
Category of Employees		Clinica	I GP	Specia	Specialist		Diag X-I Tests	Ray/Lab	Denta	al
(i)										
(ii)										
(iii										
Dependant (where app	licable)									
# of headcount	iioabio)									
b. (i)Age profile	of emplo	vees							L	
Age band (Age next bi					# of (empl	loyees			
	3,			Male				Fen	nale	
16-30										
31-35										
36-40										
41-45										
46-50										
51-55										
56-60										
61-65										
66-70										
Total										
(ii)Claims expe	rience to	or the p	past 3	years						
Paid Claims										
		Cli	nical	Spec	ialist*	r	Diagnost ay/lab t		Der	ntal*
Period of # of Ir coverage at	nsured as	# of visits	Amt (S\$)	# of visits	Amt (S\$)	# o		nt (S\$)	# of visits	Amt (S\$)
From/To (dd/mi	m/yyyy)									
(dd/mm/yyyy)										
					1					
* inclusive of visits to nor	n-panel clii	nics Not	e: The ir	surer res	erves the	rjah	nt to rea	uest for	more info	rmation.
Outstanding (
		Clir	nical	Spe	cialist*			ostics X- o tests*	De	ental*
coverage at	sured as n/yyyy)	# of visits	Amt (S\$)	# of visits	Amt (S		# of visits	Amt (S\$)	# of visits	Amt (S\$)





* inclusive of visits to non-panel clinics Note: The insurer reserves the right to request for more information.

c. Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis. If currently insured, kindly provide the following details:

Please indicate "Unlimite	d" if there is no cap and	"NA" if it is not applicable.

Benefits	Maximum limit per visit (S\$)		Maximum lin (S\$)	nit per policy	Co-payment (S\$)/Co-insurance (%)	
	Clinic on Company's panel	Non-panel clinic	Clinic on Company's panel	Non-panel clinic	Clinic on Company's panel	Non-panel clinic
Clinical GP						
Specialist						
Diagonistic X-Ray/Lab						
Tests						
Dental						
Others						

Benefit: Maternity Insurance					
a. Basis of coverage					
Category of Employees (refer to the example)	# of headcount				
(i)					
(ii)					
(iii)					

Example 1

Example 2

- (i) Senior Management (Director, General Manager, Senior Manager)
- (i) All Employees

- (ii) Manager & Executive
- (iii) All Others

b. Claims experience for past 3 years							
Period of	# of Insured as	Paid Claims		Outstanding Claims			
coverage	at	# of Claims	Amount (S\$)	# of Claims	Amount (S\$)		
From/To	(dd/mm/yyyy)						
(dd/mm/yyyy)							
Note: The insurer reserves the right to request for more information.							
c. Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured							
basis. If currently self-insured, kindly provide the following details:							
Please indicate "Unlimited" if there is no cap and "NA" if it is not applicable.							
Benefits	Maximum Limi	Maximum Limit per Policy Year Dedu			eductible / Co-insurance (S\$)		
	(S\$)	(S\$)					
Normal Delivery							
Caesarian							
Delivery							
Others							

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Needs analysis & product recommendation						
Please tick the appropriate box to indicate the priority of your company's needs:						
Company's Priorities	Low	Med	High	Advisor's recommendation		
Cover for Outpatient medical						
expenses						
Cover for Hospital & Surgical						
expenses						
Cover for Dental expenses						
Cover for Major illnesses						
(e.g. cancer, kidney failure, etc.)						
Cover for Loss of Income due to sickness or accident						
Cover for long term medical						
treatment						
Others:						
Declaration						
I / We hereby declare that, to the	best o	f my / o	our knov	vledge and belief, the information given		
here are true and complete, and agree that if a contract of insurance is effected, all information						
submitted in connection with this application shall form the basis of such contract between the						
Company and the Insurer.						
Signature of Authorised Officer:						
Name:		1 '	Company stamp (if applicable):			
NRIC/ Fin No.						
Designation:						
Date:						
I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the						
requirements of this Fact-Finding form to him / her.						
Signature of Insurance Representative:						
Signature of modifice Representative.						
Name:			Compan	y stamp (if applicable):		
NRIC/ Fin No.			- · ···	2 r x - 1.1 1 1.		
Designation:						
Date:						

Plan Owners' Protection Scheme

This plan is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your plan is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the General Insurance Association of Singapore (GIA)/Life Insurance Association of Singapore (LIA) or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

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