



1. Are there any members currently in hospital or requires frequent admission (e.g. hospital admission more than 2 times per year) to hospital ? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*

2. Has any member suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that causes progressive irreversible functional or physical disability?  
**Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*

3. If there any member based outside Singapore? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Country based in	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*

4. Are there any limitations or exclusions imposed on the coverage on any members? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Limitations / Exclusions	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*



5 Is there any member engaged in hazardous occupation? **Yes / No**  
 (Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Nature of work	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*

6 To the best of your knowledge, is there any member engaged in hazardous sports? **Yes / No**  
 (Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.)

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Type of sports	Total Sum Insured / Plan

*Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.*



**1. BENEFIT: GROUP PERSONAL ACCIDENT INSURANCE**

For your information: **Occupational Classifications**

Class 1	Clerical, administrative or other similar non-hazardous occupations
Class 2	Occupations where some degree of risk is involved, e.g. supervision of manual workers, totally administrative job in an industrial environment
Class 3	Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident
Class 4	High risk occupations involving heavy manual work including hot works

a) Basis of Coverage

		Category of Employees/Occupation (refer to the examples)	Basis of Coverage - Sum Insured (refer to the examples)	# of Employees
<b>GPA</b>	(i)			
	(ii)			
	(iii)			
	(iv)			

**Example 1**

Category of Employees / Occupation	Basis of Coverage
(i) Senior Management (Director, General Manager, Senior Manager)	100,000
(ii) Manager & Executive	50,000
(iii) All Others	25,000

**Example 2**

Category of Employees / Occupation	Basis of Coverage
(i) All Employees	24 x Basic Monthly Salary

*\*Please provide salary information if the basis of coverage is in terms of basic monthly salary.*

b) Details of Employees

Age Band (Age Next Birthday)	GPA			
	# of Employees		Total Sum Insured (\$\$)	
	Male	Female	Male	Female
<b>16-30</b>				
<b>31-35</b>				
<b>36-40</b>				
<b>41-45</b>				
<b>46-50</b>				
<b>51-55</b>				
<b>56-60</b>				
<b>61-65</b>				
<b>66-70</b>				
<b>Total</b>				



c) Claims Experience for the past 3 years

**Paid Claims**

Period of Coverage From / To  (mm/dd/yyyy)	# of Insured as at  (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S\$)

*Note : The insurer reserves the right to request for more information*

**Outstanding Claims**

Period of Coverage From / To  (mm/dd/yyyy)	# of Insured as at  (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S\$)

*Note: The insurer reserves the right to request for more information.*



**2 BENEFIT: GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE**

a) Basis of Coverage

Category of Employees / Occupation	Room & Board Benefit Plan (\$\$)	Currently with TMIS Yes / No	Proposal with TMIS 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 (\$\$)
(i) Senior Management (Director, General Manager, Senior Manager)	360
(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 (Singaporeans, SPRs)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
<i>* refers to Singapore Permanent Residents</i>				

	# of Employees (Foreigners* only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
<i>* refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore</i>				

**For GMM (if the basis of coverage differs from GHS):**

	# of Employees (Singaporeans, SPRs)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
<i>* refers to Singapore Permanent Residents</i>				

	# of Employees (Foreigners* only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
<i>* refers to all foreigners holding Employee Pass, S Pass and Work Permit, working in Singapore</i>				



d) Claims Experience for the past 3 years

Period of Coverage From / To  (dd/mm/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		# of Claims	Amount (S\$)	# of Claims	Amount (S\$)

*Note: The insurer reserves the right to request for more information.*

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

**3 BENEFIT: MATERNITY INSURANCE**

a) Basis of Coverage

Category of Employees (refer to the example)	# of Headcount
(i)	
(ii)	
(iii)	

**Example 1**

**Category of Employees/Occupation**

- (i) Senior Management (Director, General Manager, Senior Manager)
- (ii) Manager & Executive
- (iii) All Others

**Example 2**

- (i) All Employees

b) Claims Experience for past 3 years

Period of Coverage From / To  (dd/mm/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		# of Claims	Amount (S\$)	# of Claims	Amount (S\$)

*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 Limit per Policy Year (\$\$)		Deductible / Co-insurance (\$\$)	
Normal Delivery				
Caesarian Delivery				
Others:				

4 **NEEDS ANALYSIS & PRODUCT RECOMMENDATION**

Please tick the appropriate box to indicate the priority of your company's needs:

<b><u>Company's Priorities</u></b>	<b><u>Low</u></b>	<b><u>Med</u></b>	<b><u>High</u></b>	<b><u>Advisor's Recommendation</u></b>
Cover for Outpatient medical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Hospital & Surgical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Dental expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Major illnesses (e.g. cancer, kidney failure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Loss of Income due to sickness or accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for long term medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others :	_____			

5 **DECLARATION**

I / We hereby declare that, to the best of my / our knowledge 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:  
NRIC/ Fin No.  
Designation:  
Date:

Company Stamp (if applicable):

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  
Name :  
NRIC/ Fin No.  
Designation:  
Date

Company Stamp (if applicable):