Product Summary for Hospital & Surgical Plan

Presented to : ____________________ ____________________
(Name of Applicant) (Signature of Applicant)

Covered Member : ____________________
(Name of Insured)

Age (next birthday)____________ Gender ________
(Covered Member)

Name & Signature of Financial Services Consultant : ____________________

Date : ____________________

Expiry Date of Cover : ____________________

*A duly signed copy must be filed with Liberty Insurance Pte Ltd for record purpose.

PROPOSAL FORM

Statement pursuant to Section 25(5) of the Insurance Act (Cap. 142) (or any subsequent amendments thereof) - You are to disclose in this proposal form fully and faithfully all the facts which you know or ought to know, otherwise the policy issued hereunder may be void.

Intermediary : ______________________

Please complete in BLOCK CAPITAL and return to the Company

I PARTICULARS OF PROPOSER

Name : [ ] NRIC/Passport No. : [ ] Sex : [ ]

Address : [ ]

Occupation : [ ] DOB : [ ] Weight : [kg] Height : [m]

Marital Status : [ ] Nationality : [ ] Country of Residence : [ ]

Employer's Name : [ ]

Address : [ ] Tel. No. : [ ]

II PARTICULARS OF SPOUSE/CHILDREN TO BE INSURED

Full Name	Relationship	Date of Birth	NRIC/ Passport No.	Sex	Height (m)	Weight (kg)

Occupation of Spouse: ______________________

III PLAN OF BENEFITS SELECTED (Please tick the appropriate box)

PLAN: Essential [ ] Economy [ ] Executive [ ] International [ ]

Optional Outpatient Services [ ] available for Economy, Executive and International Plan

Total Premium (before GST) : ______________________

Total Number of person(s) to be insured: ______________________

IV HEALTH STATEMENT

1. Have you or any of your dependants had any physical defects or infirmity Yes [ ] No [ ]

   If "Yes", give details : [ ]

2. Have you or any dependants ever:

   a) had a surgical operation ? Yes [ ] No [ ]

   b) been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed? Yes [ ] No [ ]

   If "Yes" in either case, give particulars in question 5 overleaf.

3. Are you or any of your dependants currently undergoing any medical treatment, ever been treated, under observation for, or told that you or they had, any disorder or disease of the following :

	Yes	No
a) Skin, ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problems?	[ ]	[ ]
b) Stomach, intestines, liver, kidney, gall-bladder, pancreas, bladder, prostate, genio urinary system, cirrhosis, hernia, piles, diabetes, protein in urine ?	[ ]	[ ]

		Yes	No
c)	Lungs, bones, joints, ligament, asthma, bronchitis, pneumonia, tuberculosis, slipped disc, fractures, arthritis, polio, muscular dystrophy ?	☐	☐
d)	Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine ?	☐	☐
e)	Lymphatic system, goitre, thyroid ?	☐	☐
f)	Cancer, tumors or AIDS ?	☐	☐
g)	Female reproductive system (for female insureds), breast lumps, fibroids, cysts, menorrhagia ?	☐	☐
h)	Any others not listed above.	☐	☐

If your answer to any of the above is "Yes" give particulars in question 5.

4. Have you or any of your dependants during the past 5 years, had any treatments, examinations or advices for a recurrent complaint by a physician or other medical practioners, at a clinic, hospital, dispensary, or sanitorium ? Yes ☐ No ☐

   (Please give particulars of each such instance in question 5 below.)

5. State full particulars of any affirmative answers to questions 2, 3 and 4

Question No.	**Name of Person**	**Nature of Disability**	**Date of Disability**	**For How Long**	**Result of Treatment**	**Name and Address of Doctors and/or Hospital**

6. Do you have any other medical insurance ?

   Yes ☐ No ☐ If "Yes" give details :

7. Has any Accident or Health policy covering you or any of your dependants ever been cancelled or its renewal refused ?

   Yes ☐ No ☐ If "Yes" give details :

8. Has any application made by you or any of your dependants for Life, Accident and Health insurance been declined, postponed, withdrawn or subject to special terms and conditions ?

   Yes ☐ No ☐ If "Yes" give details :

9. Have you ever made a claim against any insurer in respect of bodily injury or sickness ?

   Yes ☐ No ☐ If "Yes" give details :

My usual family/last doctor consulted :

Company doctor :

Address :

I hereby declared that the foregoing statement and particulars are true and complete and I have not withheld any information that may influence the acceptance of this insurance, and I agree that this declaration shall be the basis of the contract between Persons Insured and the Company and I agree to accept the Company's policy subject to the terms and conditions contained therein or endorsed thereon.

I further understand that this Proposal will only be effective on acceptance by the Company and my paying up the premium applicable to Liberty Insurance Pte Ltd; and that until then no liability will attach to the company under this Policy.

I have been given a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my satisfaction.

Date

Signature of Employee/Proposer

FOR OFFICIAL USE ONLY