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Helping People Live Safer, More Secure Lives

Liberty Insurance Pte Ltd

Registration No: 19902791D

51 Club Street
#03-00 Liberty House
Singapore 069428
Tel: (65) 6221 8611
Fax: (65) 6225 0997
www.libertyinsurance.com.sg

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LIBERTY INSURANCE PTE LTD

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Liberty House
Singapore 069428

About Us

Liberty Insurance Pte Ltd is a wholly owned business unit of the Liberty Mutual Group.

We write both Personal and Commercial insurance products including motor, personal accident, medical, bonds, property, employee benefits and marine cargo. It is our goal to have a dominant presence in Property & Casualty and Personal insurance business. In 2009, we are ranked 7th in the Singapore General Insurance industry.

The Liberty Mutual Group is one of the largest insurance companies in the world, with consolidated assets of over US\$109.5 billion as at December 2009. Liberty Mutual ranks 71st among the Fortune 500 list of largest companies in the USA and was rated "A-" (Strong) by Standard and Poor's.

Headquartered in Boston, the Liberty Mutual Group employs over 45,000 people in more than 900 offices worldwide.

For more information on the Liberty Mutual Group, please visit www.libertymutual.com

proMediCash

Liberate Your Worries



Secure a Healthy Life



Product Summary

proMediCash is specially designed to relieve your financial burden from hospital stays, arising from accidents or illnesses, by offering you cash benefits at a time when you require it most.

proMediCash pays over and above your existing medical insurance coverage and its comprehensive coverage offers:

- High cash benefits for the first day of hospitalisation
- Cash benefits following hospitalisation or quarantine due to infectious diseases
- Post hospitalisation transport reimbursements benefit
- Get Well benefit - lump sum payable following extended hospitalisation
- Lodger benefit up to 5 days for accommodation costs incurred by companion at hospital
- 24 hours worldwide coverage
- Immediate acceptance without medical examination

Summary of Benefits

Benefit Description	Plan A	Plan B	Plan C
	Sum Insured S\$	Sum Insured S\$	Sum Insured S\$
First Day Hospital Income	400	300	200
Daily Hospital Income Benefit - payable up to 500 days per Illness	300	200	100
Daily Hospital Income Benefit - payable up to 500 days per Accident	400	300	200
ICU Daily Hospital Income Benefit - payable up to 60 days per Illness/ Accident	500	400	300
Get Well Benefit - upon minimum 7 consecutive days of hospitalisation	500	300	NA
Lodger Benefit – payable daily up to 5 days per hospitalisation	100	50	NA
Inconvenience Benefit due to quarantine – payable daily up to 5 days	50	30	NA
Transport Reimbursements (Taxi and Ambulance only) – payable per visit and up to 3 visits within 90 days upon discharge	50	25	NA

Premiums

Attractive Discounts

Insured and Spouse/Child - 5% discount

Insured, Spouse and Child - 10% discount

Age Group (Next Birthday)	PREMIUMS (w/o GST)		
	Plan A	Plan B	Plan C
Child*	398	266	134
18 - 35	478	320	161
36 - 45	573	384	193
46 - 55	802	537	270
56 - 60	1,203	805	405
61 - 69 (Renewal Only)	1,503	1,006	506

Important Notes

* Child's coverage starts from 6 months to 17 years old, or up to 25 years of age if the child is enrolled in an educational institution on full time higher education.

- Maximum enrollment age is 60 years, renewable up to 69 years and subject to yearly review.
- The proposal for child must include at least one parent and the choice of plan for child must be equal or lower than that of the parent(s).

Major Extensions

Cash benefits for hospitalisations arising from:

- Infectious diseases
- Terrorism including the use of Nuclear, Chemical and Biological weapons.
- Accidental miscarriage
- Injuries sustained in the course of motor cycling
- Injuries sustained while travelling on an unscheduled flight

Major Exclusions

We do not provide cash benefits for hospitalisations arising from:

- Any pre-existing conditions
- Any congenital conditions or deformities
- Suicides or attempted suicides
- HIV or any sexually transmitted diseases
- Cosmetic or plastic surgery
- Injuries sustained from participating in professional or competitive sports
- The use of alcohol and drugs

Key Product Provisions

- Eligibility - **proMediCash** is available only to Singaporeans and Singapore Permanent Residents.
- Scope - coverage is 24 hours worldwide, provided that the insured person is not outside of Singapore for more than 90 days at a time.
- Waiting Period - there is a 30-day waiting period (from the first inception of cover) for claims arising from hospitalisation due to illness only.
- Multiple hospitalisation stays of same or related cause shall be considered as arising from one illness / accident unless their occurrences are separated by at least 6 consecutive months.

- This is a yearly renewable policy. Coverage / Premium may be revised upon policy renewal at the full discretion of the company.

- Switching of medical policies may result in having different premium amount and different policy terms and conditions.

The information provided here is a summary. Please refer to the actual policy wordings for details of coverage.



proMediCash Proposal Form

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

1. Proposer's Particulars

Proposer's/Insured's Name:		Mailing Address:	
NRIC No./Passport No.:	Nationality:	Postal Code:	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone No: (H/P)	(O)
Occupation:	Email Address:		

2. Spouse's/Children's Particulars (if applicable)

No.	Name	Sex	Date of Birth	NRIC/Passport No.	Nationality	Relationship	Occupation

3. Coverage Required

Plan Type	Self	Spouse	Child	Premium (Per Person)	Premium
Plan A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Plan B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Plan C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Total Premium (before discount): S\$					
Total Premium (after discount): S\$					
Add 7% GST : S\$					
Total Premium Payable: S\$					

Period of Insurance: From _____ To _____

4. Mode of Payment

Cash Cheque/Bank Cheque No. _____
 Visa MasterCard Expiry Date M M Y Y
 Card No:

Cardholder's Name _____

I hereby authorise Liberty Insurance Pte Ltd to debit my credit card account as specified above.

PAYMENT BEFORE COVER WARRANTY

Please note that the total premium must be paid and actually received in full by the Company or the intermediary through whom this Policy was effected on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and no benefits whatsoever shall be payable by the Company.

5. Declaration

WE/I DO HEREBY DECLARE AND WARRANT the answers/information given above in every respect are true and correct and I have not withheld any information likely to affect the acceptance of this Proposal, and I agree that this Proposal & Declaration shall be the basis of the Contract between the Company and myself and I further agree to accept the Company's Policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto.

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 am in good health and free from any physical impairment or deformity. I will give notice to the company of any changes in health and occupation of person(s).

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 Proposer _____

6. Intermediary Use Only

Intermediary Name: _____

Code: _____

I acknowledge that I have provided the Proposer with a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to their satisfaction.

Date _____ Signature of Intermediary _____

1 PERSONAL INFORMATION

1a. Personal Details of Client

Name: Mr/Mrs/Miss/Ms/Dr _____

NRIC/ Passport No.: _____ Date of Birth: ___/___/___

Marital Status: Single / Married / Divorced / Separated / Widowed Gender: M/ F

Email Address: _____ Telephone No.: _____

1b. Employment Details

Current Occupation _____ Monthly Income Range 1. Below \$2,500
 2. \$2,501 to \$5,000
 3. \$5,001 & above

1c. Details of Spouse & Dependants (If family coverage is required)

Name / Relationship	DOB	Gender	Occupation	Monthly Income Range (see Question 1b above)
_____	___/___/___	M/F	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
_____	___/___/___	M/F	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
_____	___/___/___	M/F	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
_____	___/___/___	M/F	_____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

2 EXISTING HEALTH INSURANCE POLICIES

This covers all Health Insurance Policies you currently have (e.g. CPF-approved Medical Scheme, Personal Medical, Hospital Income, Long Term Care, Employer Sponsored Scheme etc).

Policy Type*	Insured**	Type & Amount of Benefit++	Annual Premium++	Expiry Date++
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

* Individual or Group policy from employer
 ** Y = You; S = Spouse; J = Joint
 ++ Please provide benefit schedule and disability definition for disability benefit, if available

3 PERSONAL PRIORITIES

Your Health Insurance Concerns	Level of Concerns		
	Low	Medium	High
Cover for hospitalisation expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for outpatient medical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for major illnesses (e.g. cancer, kidney dialysis, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for dental expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for old age disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover for loss of income due to illness or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4 HEALTH CONDITION

Do you or any applicants have any medical condition, which requires you to receive regular attention from a doctor in a clinic or hospital? Yes No

If 'Yes', what is/are these medical condition(s)?

5 REPLACEMENT OF POLICY

Is this product intended to replace any existing health insurance policy? **Yes / No**
(If yes, Advisor should state the reasons for replacement in the "Statement by Advisor" section)

Advisor's Declaration:

I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.

Signature of Advisor: _____

Date: _____



“Our Advice and Reasons Why”

For

(Client)

BY

(Insurance Advisor)

Statement by Advisor

The recommendations in this document are based on your personal information collected in the “Know Your Client” Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the “Know Your Client” Form.

1. Analysis and calculation worksheet

	Client	Spouse	Child
1.1 Medical Expenses (also known as Hospital / Surgical Expenses)			
Type of hospital to be covered (private/public)	_____	_____	_____
Type of room to be covered (single/double/4-bedded)	_____	_____	_____
Existing type of hospital plan covered	_____	_____	_____
Existing policy type (individual/employer group)	_____	_____	_____
1.2 Critical Illnesses			
a. Total lump sum benefit to be covered	_____	_____	
b. Existing lump sum benefit covered	_____	_____	
Estimated lump sum benefit needed (a-b)	_____	_____	
1.3 Hospital Cash Income			
a. Existing amount covered	_____	_____	
b. Total Amount of Cash Income to be covered	_____	_____	
c. Total Amount of Cash Income Needed (b-a)	_____	_____	

2. Advisor analysis and recommendations

Total Health Insurance Budget (if applicable): _____ per month/per annum

Advisor’s recommendations	Reasons for recommendations	Remarks
<input type="checkbox"/> Medical Expenses (also known as Hospital/Surgical Expense Protection)		Replacement Y/N
<input type="checkbox"/> Critical Illness Protection		Replacement Y/N
<input type="checkbox"/> Hospital Cash Protection		Replacement Y/N
<input type="checkbox"/> Others		Replacement Y/N

3. Acknowledgement

I/We understand that the above recommendation(s) is/are based on the facts furnished in the “Know Your Client” Form; and I/we **agree / do not agree*** with the proposed recommendation(s).

If I/we should decide to switch from one health insurance product to another health insurance product, I/we understand that:

- A) I/We may not be insurable at standard terms
- B) I/We may have to pay a different premium
- C) Terms and conditions may defer

(*Delete as appropriate.)

Signature of client (on behalf of all applicants) :
 Date :

Signature of Advisor :
 Date :

For Office Use Only – INTERNAL

This section is to be completed by a qualified staff of the Insurer or Principal Firm of the Advisor.

4. Opinion of the Recommendation

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form; and I

agree **do not agree** with the proposed recommendation(s).

Comments (necessary if in disagreement with recommendation) :

Remedial Action

Signature

Name :
Position :
Date :



GIA version for use from 1 April 2004

GROUP INSURANCE FACT-FINDING FORM

KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK

Kindly tick boxes [✓] where appropriate

PERIOD OF INSURANCE from _____ to _____
 (dd/mm/yyyy) (dd/mm/yyyy)

REQUEST FOR QUOTATION was submitted on _____
 (dd/mm/yyyy)

REQUEST FROM _____
 (Name of Insurance Company)

1. GENERAL INFORMATION

a) Name of Company: _____

b) Nature of Business: _____

c) Presently Insured: Yes / No
 If **Yes**, Name of Current Insurer: _____

d) Type of Policy: _____
 Period of Insurance: From _____ to _____
 (dd/mm/yyyy) (dd/mm/yyyy)

e) Total Number of Employees: _____ No. of Employees to be insured: _____

f) Participation:
*The Insurer would assume that participation of the group insurance program is on compulsory basis, unless otherwise **indicated with a tick here** below under "Participation - Voluntary".*

Insurance Coverage	Participation	
	Compulsory	Voluntary
Group Hospital & Surgical		
- for employees only		
- for dependants only		
Group Personal Accident		

Please note:
Voluntary: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s).

2. GROUP HOSPITAL & SURGICAL 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: *Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.*

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) **Details of Insured Members**

	No. of Employees				
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Employee Only					
Employee & Spouse					
Employee & Child(ren)					
Employee & Family					

c) **Claims Experience for the past 3 years**

Period of Coverage From / To (dd/mm/yyyy)	Number of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		Number	Amount	Number	Amount

The Insurer reserves the right to request for more information.

d) Kindly attach a copy of the Schedule of Benefits (if currently insured).

- e) Is there any member seriously ill (e.g. cancer, kidney failure, etc) or in hospital? Yes / No
If **Yes**, kindly provide the following details

Number of members: _____

Reason for hospitalisation: _____

Nature of illness: _____

Kindly note that insurer would not reimburse the claim for any member in the hospital at the time of application.

- f) Is there any member based outside Singapore? Yes / No
If **Yes**, kindly provide the following details

Number of members: _____

Country based in: _____

- g) Is there any member engaged in hazardous occupation? Yes / No
(Hazardous occupation e.g. welder, diver, rigger, sandblaster, offshore workers, etc)

If **Yes**, what is the nature of work? _____

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

If **Yes**, what kind of sports? _____

3. GROUP PERSONAL ACCIDENT INSURANCE

a. Basis of Coverage

<u>Category of Employees / Occupation</u>		<u>Basis of Coverage</u> Sum Insured (S\$)
(i)		
(ii)		
(iii)		
(iv)		

Example 1

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

Example 2

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

b. Details of Employees

<u>Category of Employees / Occupation</u>		No of Employees		Sum Insured	
		Male	Female	Male	Female
(i)					
(ii)					
(iii)					
(iv)					
Total					

c. Claims Experience for the past 3 years

Period of Coverage From / To (dd/mm/yyyy)	Number of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		Number	Amount	Number	Amount

The Insurer reserves the right to request for more information

- d. Is there any member engaged in hazardous occupation? Yes / No
(Hazardous occupation e.g. welder, driver, rigger, sandblaster, offshore workers, etc)

If **Yes**, what is the nature of work? _____

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

If **Yes**, what kind of sports? _____

FOR YOUR INFORMATION – Occupational Classifications

Class 1	Clerical, administrative or other non-hazardous occupation
Class 2	Occupations where some degree of risks is involved e.g. supervision of manual workers, totally administrative job in a 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

4. NEEDS ANALYSIS & PRODUCT RECOMMENDATION

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

<u>Company's Priorities</u>	<u>Low</u>	<u>Med</u>	<u>High</u>	<u>Advisor's Recommendation</u>
<u>Cover for outpatient medical expenses</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cover for hospitals & surgical expenses</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cover for dental expenses</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cover for major illnesses</u> (e.g. cancer, kidney failure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cover for loss of income due to</u> sickness or accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cover for long term medical treatment</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Others : _____

5. DECLARATION

[This section must be printed at the end of each form for all the types of applicable business.]

I / We hereby declare that, to the best of my / our knowledge and belief, the information given here is 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:
Designation:
Company Stamp (if applicable):
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

Name / NRIC:
Designation:
Company Stamp (if applicable):
Date: