

**proMedico Plus Plan - Proposal Form**

Intermediary: \_\_\_\_\_ Account Code: \_\_\_\_\_

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 the facts which you know or ought to know, otherwise the policy issued hereunder may be void.

**1. Applicant**

Corporate

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Tel No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Individual

Name: \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Name: \_\_\_\_\_

Nature of Employer's Business: \_\_\_\_\_

**2. Particulars of Insured Person**

Full Name: \_\_\_\_\_ NRIC/Passport No.: \_\_\_\_\_

Nationality: \_\_\_\_\_ Country of Residence: \_\_\_\_\_ Sex:  Male  Female

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Weight (Kg) \_\_\_\_\_ Height (m): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone No.: (H/P) \_\_\_\_\_ (O) \_\_\_\_\_ Email Address: \_\_\_\_\_

**3. Particulars of Additional Insured Persons (Spouse/Children)**

Full Name	Sex	Date of Birth	NRIC/Passport/B.C. No.	Relationship	Weight (Kg)	Height (m)	Country of Residence

Occupation of Spouse: \_\_\_\_\_

**4. Plan of Benefits Selected**

Plan:  Essential Plus  Economy Plus  Executive Plus  International Plus  
 Rider - Outpatient Services  Premium Saving Option:  S\$5,000/-  S\$7,500 /-  S\$10,000/-

Premium: Plan S\$ \_\_\_\_\_

Premium Saving Option (discount): \_\_\_\_\_ % S\$ \_\_\_\_\_

Rider - Outpatient Services S\$ \_\_\_\_\_

Total S\$ \_\_\_\_\_

Plus GST 5% S\$ \_\_\_\_\_

Premium plus GST S\$ \_\_\_\_\_

Period of Insurance From \_\_\_\_\_ To \_\_\_\_\_

<b>5. Health Statement of Insured Person(s)</b>							
<b>a</b>	Have you or any of the additional Insured Persons ever had any physical defects or infirmity? If Yes, please give details: _____ _____					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>b</b>	Have you or any of the additional Insured Persons ever: i) had a surgical operation? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> ii) been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please give particulars in (e) below.						
<b>c</b>	Are you or any of the additional Insured Persons 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: i) Skin, ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problems? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> ii) Stomach, intestines, liver, kidney, gall-bladder, pancreas, bladder, prostate, genio urinary system, cirrhosis, hernia, piles, diabetes, protein in urine? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> iii) Lungs, bones, joints, ligament, asthma, bronchitis, pneumonia, tuberculosis, slipped disc, fractures, arthritis, polio, muscular dystrophy? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> iv) Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> v) Lymphatic system, goiter, thyroid? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> vi) Cancer, tumors or AIDS? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> vii) Female reproductive system (for female insured), breast lumps, fibroids, cysts, menorrhagia? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> viii) Any others not listed above? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If Yes, please give particulars in (e) below.						
<b>d</b>	Have you or any of the additional Insured Persons during the past 5 years, had any treatments, examinations or advice for a recurrent complaint by a Physician or other Medical Practitioners, at a clinic, hospital, dispensary or sanatorium? If Yes, please give particulars in (e) below.					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>e</b>	State full particulars of any affirmative answers to questions (b), (c) and (d).						
	<b>Question No</b>	<b>Name of Person</b>	<b>Nature of Disability</b>	<b>Date of Disability</b>	<b>For How Long?</b>	<b>Result of Treatment</b>	<b>Name and Address of Doctors and/or Hospital</b>
	_____	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____	_____
<b>f</b>	Do you have any other medical insurance? If Yes, please give details: Name of Insurer <span style="margin-left: 200px;">Period of Insurance</span> _____ <span style="margin-left: 200px;">_____</span> _____ <span style="margin-left: 200px;">_____</span>					<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>g</b>	Has any Accident or Health policy covering you or any of the additional Insured Persons ever been declined or its renewal refused? If Yes, please give details: Name of Insurer <span style="margin-left: 100px;">Period of Insurance</span> _____ <span style="margin-left: 100px;">_____</span> _____ <span style="margin-left: 100px;">_____</span> <input type="checkbox"/> Renewal declined/refused due to _____ <input type="checkbox"/> Renewal declined/refused due to _____					<input type="checkbox"/> Yes <input type="checkbox"/> No	





## Product Summary for *proMedico* Plus Plan

Presented to : \_\_\_\_\_  
(Name of Applicant)

I/We, the Applicant, acknowledge that the Insurance Adviser has given me/us a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my/our satisfaction.

\_\_\_\_\_  
 Date                                      Signature of Applicant                                      Signature of Insurance Adviser

Name: \_\_\_\_\_

Full Name of Insured Persons	Sex	Age (next birthday)

Expiry Date of Cover: \_\_\_\_\_

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