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|--|--------------------------|--------------------------|
| d) Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine ? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Lymphatic system, goitre, thyroid ? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Cancer, tumors or AIDS ? | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Female reproductive system (for female insureds), breast lumps, fibroids, cysts, menorrhagia ? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Any others not listed above. | <input type="checkbox"/> | <input type="checkbox"/> |

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 ?

(Please give particulars of each such instance in question 5 below.) Yes No

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application made by you or any of your dependants for Life, Accident and Health insurance been declined, postponed, withdrawn or subject to special terms and conditions ?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



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.