

APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH EMPLOYEE AND FAMILY

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Insurance.



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international

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1. YOUR DETAILS

IMPORTANT NOTICE

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 about the risk that is being proposed, otherwise the policy issued hereunder may be void.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Liberty Insurance or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

This is a short-term accident and health policy and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you 30 days notice in writing.

1. YOUR DETAILS - CONTINUED

EMPLOYEE DETAILS

Family Name : _____

First Name(s) : _____

Date of Birth : DD / MM / YYYY Gender : Male Female

Height (cm) : _____ Weight (kg) : _____

Occupation : _____
(Specify nature of duties)

Smoker : Yes No Marital Status : _____

Nationality : _____ ID/Passport No. : _____

Residential Address : _____

Postal Code : _____ Country : _____

Usual Country of Residence : _____
If you wish to use a different mailing address please advise us

Tel. : _____ Mobile : _____

Email : _____

Important : this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information.

FAMILY MEMBERS TO BE INSURED

	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
	Unmarried children proposed for insurance must be aged 18 or under. Unmarried children over 18 in full-time education can be covered up to 23 years old.			
Family Name				
First Name(s)				
Date of Birth	<u>DD / MM / YYYY</u>	<u>DD / MM / YYYY</u>	<u>DD / MM / YYYY</u>	<u>DD / MM / YYYY</u>
Gender	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>	Male <input type="radio"/> Female <input type="radio"/>
Marital Status				
Relationship to Employee				
Nationality				
Smoker	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>	Yes <input type="radio"/> No <input type="radio"/>
ID/Passport No.				
Occupation (Specify nature of duties)				
Height & Weight	cm kg	cm kg	cm kg	cm kg

Please use separate sheet if necessary. Please advise us if any family members to be insured do not live at the employee's Residential Address.

2. YOUR COVER

STEP 1					
SELECT YOUR COVER					
The following modules form the base of your policy. Each member has the flexibility to select the cover they want.					
If family members will have the same cover as the Employee, please tick here <input type="radio"/> and complete cover options for the Employee only.					
MODULES	EMPLOYEE	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	<input type="radio"/> Core <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Core <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Core <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Core <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Core <input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite
	<input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only	<input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only	<input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only	<input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only	<input type="radio"/> Free choice of provider <input type="radio"/> Specified Providers only
<ul style="list-style-type: none"> • If you selected Core, you will have access to Specified Providers only by default. • If you selected Essential, Extensive or Elite, Specified Providers Only will be available with Worldwide excluding USA only. • The Specified Inpatient Providers list is available at http://healthbyapril.com/specified-hospitals 					
Annual Deductible	<input type="radio"/> Nil <input type="radio"/> SGD 2,000 <input type="radio"/> SGD 5,000 <input type="radio"/> SGD 10,000	<input type="radio"/> Nil <input type="radio"/> SGD 2,000 <input type="radio"/> SGD 5,000 <input type="radio"/> SGD 10,000	<input type="radio"/> Nil <input type="radio"/> SGD 2,000 <input type="radio"/> SGD 5,000 <input type="radio"/> SGD 10,000	<input type="radio"/> Nil <input type="radio"/> SGD 2,000 <input type="radio"/> SGD 5,000 <input type="radio"/> SGD 10,000	<input type="radio"/> Nil <input type="radio"/> SGD 2,000 <input type="radio"/> SGD 5,000 <input type="radio"/> SGD 10,000
	<ul style="list-style-type: none"> • Your selected deductible applies to the Hospital and Surgery module only. 				
Area of Cover	<input type="radio"/> ASEAN and India <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> ASEAN and India <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> ASEAN and India <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> ASEAN and India <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> ASEAN and India <input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide
	<ul style="list-style-type: none"> • The area of cover chosen will apply to all modules selected. • If you selected Core, your area of cover will be ASEAN and India by default. ASEAN and India cannot be selected with Essential, Extensive or Elite. • Services rendered outside of the area of cover are covered up to US\$150,000 per period of insurance, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip in the USA. If you selected Core, you will be covered up to US\$50,000 for accidents only. • Please refer to clause 4 of the Policy Terms and Conditions. 				
STEP 2					
SELECT YOUR OPTIONAL MODULES					
The following modules are optional. Each member has the flexibility to select the cover they want.					
If family members will have the same cover as the Employee, please tick here <input type="radio"/> and complete cover options for the Employee only.					
MODULES	EMPLOYEE	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Outpatient	<input type="radio"/> Core with nil coinsurance	<input type="radio"/> Core with nil coinsurance	<input type="radio"/> Core with nil coinsurance	<input type="radio"/> Core with nil coinsurance	<input type="radio"/> Core with nil coinsurance
	<input type="radio"/> Essential with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Essential with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Essential with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Essential with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Essential with nil coinsurance <input type="radio"/> 20% coinsurance
	<input type="radio"/> Extensive with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Extensive with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Extensive with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Extensive with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Extensive with nil coinsurance <input type="radio"/> 20% coinsurance
	<input type="radio"/> Elite with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Elite with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Elite with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Elite with nil coinsurance <input type="radio"/> 20% coinsurance	<input type="radio"/> Elite with nil coinsurance <input type="radio"/> 20% coinsurance
<ul style="list-style-type: none"> • The 20% coinsurance is waived within our Panel Network 					
Dental and/or Optical <small>Optical included with Elite plan only</small>	<input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite	<input type="radio"/> Essential <input type="radio"/> Extensive <input type="radio"/> Elite
Maternity	<input type="radio"/> SGD 7,000 <input type="radio"/> SGD 13,500 <input type="radio"/> SGD 20,000	<input type="radio"/> SGD 7,000 <input type="radio"/> SGD 13,500 <input type="radio"/> SGD 20,000	<input type="radio"/> SGD 7,000 <input type="radio"/> SGD 13,500 <input type="radio"/> SGD 20,000	<input type="radio"/> SGD 7,000 <input type="radio"/> SGD 13,500 <input type="radio"/> SGD 20,000	<input type="radio"/> SGD 7,000 <input type="radio"/> SGD 13,500 <input type="radio"/> SGD 20,000
	<ul style="list-style-type: none"> • Important: Available to women between 19 to 45 years of age who have selected at minimum an Extensive or Elite Hospital and Surgery on a NIL deductible basis, plus an optional Outpatient module. 				

3. UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS		
<p>Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.</p>		
		Yes <input type="radio"/> No <input type="radio"/>
<p>Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).</p>		
		Yes <input type="radio"/> No <input type="radio"/>
<p>Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.</p>		
		Yes <input type="radio"/> No <input type="radio"/>
MEDICAL DETAILS AND HISTORY	Please indicate if you or any person to be insured <u>have or have ever had</u> any of the signs, symptoms, illnesses or disorders below by ticking the appropriate box.	
1	Cancer, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind	Yes <input type="radio"/> No <input type="radio"/>
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes <input type="radio"/> No <input type="radio"/>
3	Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood	Yes <input type="radio"/> No <input type="radio"/>
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes <input type="radio"/> No <input type="radio"/>
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes <input type="radio"/> No <input type="radio"/>
6	Tropical illness: Malaria, dengue fever	Yes <input type="radio"/> No <input type="radio"/>
7	HIV/AIDS	Yes <input type="radio"/> No <input type="radio"/>
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes <input type="radio"/> No <input type="radio"/>
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes <input type="radio"/> No <input type="radio"/>
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes <input type="radio"/> No <input type="radio"/>
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes <input type="radio"/> No <input type="radio"/>
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes <input type="radio"/> No <input type="radio"/>
13	Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system	Yes <input type="radio"/> No <input type="radio"/>
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes <input type="radio"/> No <input type="radio"/>
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes <input type="radio"/> No <input type="radio"/>
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes <input type="radio"/> No <input type="radio"/>
17	Any other disorder/ injury	Yes <input type="radio"/> No <input type="radio"/>

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured			
Question No.			
Disease/ Medical Condition/ Sign & Symptom			
Date of first occurrence of sign & symptom	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Frequency of sign & symptom			
Treatment Details (including name, date, duration of medication, surgery etc.)			
Date of last follow-up medical consultation/ treatment	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Any on-going, regular, planned or preventive treatment required?			
Any on-going sign or symptom?			

MEDICAL DETAILS AND HISTORY - CONTINUED

18	<p>Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient? If Yes, please give details.</p>			Yes <input type="radio"/>	No <input type="radio"/>
19	<p>In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)? Please also answer "yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)</p>			Yes <input type="radio"/>	No <input type="radio"/>
20	<p>In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month? If Yes, please state the medicine name, dosage and the approximate cost.</p>			Yes <input type="radio"/>	No <input type="radio"/>
21	<p>Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. If you have never seen a doctor in the past 3 years, please indicate that below.</p>				
	Name				
	Address				
	Telephone		Fax		
	Email				

Please provide more details on a separate sheet if required.

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

ADDITIONAL SPACE FOR FURTHER REMARKS

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?		Yes <input type="radio"/>	No <input type="radio"/>
Do you authorise us to discuss and/or share claims and medical information with the insurance intermediary of this group plan?		Yes <input type="radio"/>	No <input type="radio"/>
Producer Name		Producer Code	
Company Name		Telephone	
Email			

CLAIM REIMBURSEMENT

Please provide your banking details for claim reimbursement.

Bank Name			
Bank Address			
A/C Name		A/C No.	
Currency	<input type="radio"/> SGD <input type="radio"/> USD <input type="radio"/> EUR <input type="radio"/> GBP	For all other currencies, please check with APRIL Singapore. For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear.	
The following information must be provided for bank accounts outside of Singapore :			
Sort Code		BIC (Swift) Code	
Corresponding Bank Details (if applicable)			

4. ACKNOWLEDGEMENT & PERSONAL DATA PROTECTION ACT (PDPA)

PERSONAL DATA PROTECTION STATEMENT

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION BY APPLICANT

I/We do hereby declare and warrant that:

- a. All information provided by me/us in connection with this application is true, accurate and complete. I/We have not withheld any material fact and except as declared herein all persons to be insured are currently in good health to the best of my/our knowledge and belief.
- b. I/We understand that any inaccurate, incomplete or false information given or any omission of information required, may at Liberty Insurance Pte Ltd's ("Liberty", the "Company") discretion, render this application invalid.
- c. I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.
- d. I/We agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.
- e. I/We agree to inform if there is any change in any of the details I have provided to Liberty in this application. I understand and agree that it is my sole responsibility to inform and update Liberty of any changes to the health or personal information of any person to be insured. I hereby agree to indemnify and absolve Liberty of any liability arising out of any use and/or disclosure by Liberty of any inaccurate or incomplete information due to my failure to update Liberty promptly of any changes to the health or personal information of any person to be insured.

SIGNATURE

Name : _____

Title : _____

Date : _____

Important : The application form must be sent to us **within 30 days** from this date for your application to be valid.

For more information, contact your insurance consultant :

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
51 Club Street #03-00 Liberty House
Singapore 069428
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