

Proposal Form - EZCare

Please complete all sections to facilitate the processing of your application.

Statement pursuant to Section 23(5) of the Insurance Act 1966 or any subsequent amendments thereof. You are to disclose in the proposal form fully and faithfully all facts which you know or ought to know, otherwise the Policy issued hereunder may be void.

Name of Producer & Producer Code: _____

Particulars of Proposer

Name of Company: _____		Contact No.: _____
GST registered Company ¹ ? Please select	Name of Company Subsidiary: _____	
Mailing Address: _____ Postal Code ()		
Type of Business/Industry: _____	Presently Insured? If yes, name of current insurer: Please select _____	
Business Registration No.: _____	Email: _____	
Total No. of Employees: _____		

¹ If yes, please complete the GST Declaration Form

Group Eligibility

No. of Employees to be covered ² : _____	Period of Insurance: From _____ To _____
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² Minimum two (2) employees

³ Classification of Benefits – Basic Cover (Compulsory to be completed)

(e.g. Management and eligible dependents, Executives, All staff & plan)

Employee Category	No. of Employees & Dependents	Hospitalisation & Surgery (Basic)	Extended Major Medical	GP	SP	Dental	Group Personal Accident
		<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4
_____	_____						



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Name of Company: _____							
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_____	_____	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4
_____	_____	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4
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³ Notes:

- Participation of employees or eligible dependents, if taken up, is on compulsory basis. (Please complete and to submit the Employee Details Template together with this Proposal Form)
- Eligible dependent's cover should be the same as the employee's cover
- The plan selected under Extended Major Medical must follow the same plan type as the basic Hospitalisation and Surgery plan

Are there any members based outside Singapore? If yes, please provide details:			Please select
No. of Members/Age	Country Based in	Total Sum Insured/Plan	
Are there any members engaged in hazardous occupation? (e.g. welder, diver, sandblaster, offshore workers etc) If yes, please provide details:			Please select
No. of Members/Age	Country Based in	Total Sum Insured/Plan	



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Name of Company: _____		
Are there any members currently in hospital or requires frequent admission (e.g., hospital admission more than 2 times per year) to hospital? If yes, please provide details:		Please select
No. of Members/Age	Reason for Hospitalisation/ Nature of Illness	Total Sum Insured/Plan
Has any member suffered from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that cause progressive irreversible functional or physical disability? If yes, please provide details:		Please select
No. of Members/Age	Reason for Hospitalisation/ Nature of Illness	Total Sum Insured/Plan

Mode of Payment

<input type="checkbox"/> Cheque ⁴ – Annual Payment Only	Bank: _____	Cheque No.: _____
<input type="checkbox"/> Bank Transfer ⁵ – Annual Payment Only		

⁴ Please cross your cheque and make payable to "LIBERTY INSURANCE PTE LTD". Kindly indicate (1) Name of Proposer; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your cheque.

⁵ Relating to payment for SGD Singapore-related risks policies. Beneficiary details as follows:

Beneficiary Name: Liberty Insurance Pte Ltd

Beneficiary Address: One Raffles Quay #25-01 North Tower Singapore 048583

Bank Name: UOB

Bank Account No.: 451-304-455-5

Bank Address: 80 Raffles Place, #29-03 UOB Plaza 1 Singapore 048624

Bank Code: 7375

Branch Code: 001

Swift Code: UOVBSGSG

Currency: SGD

PREMIUM PAYMENT WARRANTY (CORPORATE)

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) within 60 days of the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and a pro-rata premium is to be charged for the period that the Company is on risk.



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DECLARATION

I, the Proposer, declare and warrant that:

- a) All information provided by me/us in connection with this application are true, accurate and complete
- b) I agree that this application and declaration shall be the basis of the contract between Liberty and myself
- c) I agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto
- d) If I do not fully and faithfully give the facts as I know them or ought to know them, I may receive nothing from the policy
- e) I agree to the policy terms, exclusions and conditions as expressed in the brochure, proposal form, policy wordings and endorsements
- f) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at www.libertyinsurance.com.sg/data-protection-policy, both now & in advance as it may be amended from time to time

IMPORTANT NOTICE TO SUBMITTER

If you, the submitter of this form, are submitting this form for another person who is the actual Proposer; and in consideration for Liberty processing this application upon your request:

- a) You agree that you have been validly & legally authorised by the Proposer to do so; and
- b) You warrant that you have shown this entire completed document to the intended Proposer and had obtained his/her agreement to everything; and
- c) You, in your personal capacity, agree to indemnify and keep Liberty Insurance Pte Ltd indemnified against all proceedings, costs, expenses, claims, liabilities, losses or damages if any part of this Notice turns out to be false, howsoever whatsoever, on a strict liability basis, that is, even if your state of mind was unintentional, intentional, negligent, inadvertent, accidental, unknowing, etc.

Date

Signatory of Proposer
Company Stamp (if any)

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 us (servicecenter@libertyinsurance.com.sg) or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

