Liberty Insurance Pte Ltd
One Raffles Quay #25-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (542 3789)
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Fact-Find for Group – Accident & Health

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: _____	
Request from (Name of Insurer): Liberty Insurance Pte Ltd	Request for Quotation submitted on: _____
Period of Insurance: From _____ To _____	

Particulars of Proposer

Name of Proposer: _____		Business Registration No.: _____
GST registered Company[1]? Please select	Nature of Business: _____	Type of Policy: _____
Total No. of Employees: _____	No. of Employees to be insured: _____	Presently Insured: Please select
If yes, name of current insurer: _____	Period of Insurance: From _____	To _____

[1] If yes, please complete the GST Declaration Form

Participation

The insurer will assume that participation of the group insurance program is on compulsory basis unless otherwise stated. Please tick [√] accordingly to the choice of the insurance product that you like to have a quote from us.

Benefits	Insurance Coverage		Participation
1. Accident Insurance	☐ Group Personal Accident (GPA)		
2. Medical	Group Hospital & Surgical (GHS)	☐ Employee only	
		☐ Dependant (Spouse and/or Children)	

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Name of Proposer: _____			
Benefits	Insurance Coverage		Participation
2. Medical	Group Major Medical (GMM)	☐ Employee only	
		☐ Dependant (Spouse and/or Children)	
3. Others	Group Outpatient Insurance	☐ Employee only	
		☐ Dependant (Spouse and/or Children)	
4. Others	Maternity	☐ Employee only	
		☐ Dependant (Spouse and/or Children)	

Note:
Participation is voluntary if employees or dependents are given the choice to opt for the cover(s), subject to a minimum participation level.

1. 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

2. 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

3. Is there any member based outside Singapore? If yes, please provide details.	Please select

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Name of Proposer: _____		
No. of Members/Age	Country Based In	Total Sum Insured/Plan
4. Are there any limitations or exclusions imposed on the coverage on any members? If yes, please provide details.		Please select
No. of Members/Age	Limitations/Exclusions	Total Sum Insured/Plan
5. Is there any member engaged in hazardous occupation? (e.g., welder, diver, sandblaster, offshore workers etc) If yes, please provide details.		Please select
No. of Members/Age	Nature of Work	Total Sum Insured/Plan
6. To the best of your knowledge, is there any member engaged in hazardous sports? (e.g., scuba diving, motor racing, bungee jumping etc) If yes, please provide details.		Please select
No. of Members/Age	Type of Sports	Total Sum Insured/Plan

Notes (Applicable from questions 1-6):
The insurer will not reimburse the hospital claims for any member in hospital at the time of application.

1. Benefit: Group Personal Accident Insurance

For your information: Occupational Classifications

Class 1	Clerical, administrative or other similar non-hazardous occupations
Class 2	Occupations where some degree of risk is involved, e.g., supervision of manual workers, totally administrative job in an industrial environment

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Name of Proposer:	_____
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

a) Basic Coverage

	Category of Employees/Occupation	Basis of Coverage – Sum Insured	No. of Employees
GPA i)			
GPA ii)			
GPA iii)			
GPA iv)			

Example 1:
Category of Employees/Occupation — Basic Coverage
i. Senior Management (Director, General Manager, Senior Manager) — S$100,000
ii. Managers & Executive — S$50,000
iii. All Others — S$25,000

Example 2:
Category of Employees/Occupation — Basic Coverage
i. All Employees — 24x Basic Monthly Salary[2]

[2] Please provide salary information if the basis of coverage is in terms of basic monthly salary

b) Details of Employees

Age Band (Age Next Birthday)	GPA			
	No. of Employees		Total Sum Insured (S$)	
	Female	Male	Female	male
16 to 30			S$	S$
31 to 35			S$	S$
36 to 40			S$	S$
41 to 45			S$	S$
46 to 50			S$	S$
51 to 55			S$	S$
56 to 60			S$	S$

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Name of Proposer: _____

	GPA			
Age Band (Age Next Birthday)	No. of Employees		Total Sum Insured (S$)	
	Female	Male	Female	male
61 to 65			S$	S$
66 to 70			S$	S$
Total			S$	S$

c) Claims Experience for the past 3 years

				GPA			
Period of Coverage		No. of Insured as at _____		Paid Claims		Outstanding Claims	
From	To			No. of Claims	Amount (S$)	No. of Claims	Amount (S$)
					S$		S$
					S$		S$
					S$		S$

2. Benefit: Group Hospital & Surgical Insurance/Major Medical Insurance

a) Basis of Coverage

Category of Employee/ Occupation	Room & Board (R&B) Benefit Plan (S$)	Currently with TMIS	Proposal with TMIS
i.	S$	☐ No ☐ Yes	☐ No ☐ Yes
ii.	S$	☐ No ☐ Yes	☐ No ☐ Yes
iii.	S$	☐ No ☐ Yes	☐ No ☐ Yes
iv.	S$	☐ No ☐ Yes	☐ No ☐ Yes

Note:

- Dependents can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employer's cover
- Please provide the Deductible/Co-insurance for respective employee category or occupation if application

Example 1:	
Category of Employees/Occupation	R&B Benefit Plan
i. Senior Management (Director, General Manager, Senior Manager)	S$360
ii. Managers & Executive	S$200
iii. All Others	S$100

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Name of Proposer: _____

b) Age Profile of Employees

Age Band (Age Next Birthday)	No. of Employees	
	Female	Male
16 to 30		
31 to 35		
36 to 40		
41 to 45		
46 to 50		
51 to 55		
56 to 60		
61 to 65		
66 to 70		
Total		

c) Details of Insured Members

For GHS & GMM	No. of Employees (Singaporeans, SPRs[3])			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee only				
Employee and Spouse				
Employee and child(ren)				
Employee and family				
For GHS & GMM	No. of Employees (Foreigners[4] only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee only				
Employee and Spouse				

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Name of Proposer:	_____			
For GHS & GMM	No. of Employees (Foreigners[4] only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee and child(ren)				
Employee and family				
For GMM (if the basis of coverage differs from GHS)	No. of Employees (Singaporeans, SPRs[3])			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee only				
Employee and Spouse				
Employee and child(ren)				
Employee and family				
For GMM (if the basis of coverage differs from GHS)	No. of Employees (Foreigners[4] only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee only				
Employee and Spouse				
Employee and child(ren)				
Employee and family				

[3] Refers to Singapore Permanent Residents
[4] Refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore

d) Claims Experience for the past 3 years

Period of Coverage		No. of Insured as at	Paid Claims		Outstanding Claims	
From	To	_____	No. of Claims	Amount (S$)	No. of Claims	Amount (S$)
				S$		S$
				S$		S$
				S$		S$

Note: The insurer reserves the rights to request for more information.

e) Please attached a copy of Schedule of Benefits, if the benefits are on insured basis (i.e., currently insured)

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Name of Proposer: _____

3. Benefit: Group Outpatient Insurance

a) Category of employment to be insured

Category of Employees	Clinical GP	Specialist	Diag X-Ray/Lab Tests
i.	■	■	■
ii.	■	■	■
iii.	■	■	■
iv.	■	■	■
Dependant (where applicable)	■	■	■
No. of Headcounts			

b) Age profile of employees

Age Band (Age Next Birthday)	No. of Employees	
	Female	Male
16 to 30		
31 to 35		
36 to 40		
41 to 45		
46 to 50		
51 to 55		
56 to 60		
61 to 65		
66 to 70		
Total		

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Name of Proposer:	_____

c) Claims experience for the past 3 years - Paid claims

Period of Coverage		No. of Insured as at	Clinical GP		Specialist		Diag X-Ray/Lab Tests	
From	To	_____	No. of Claims	Amount (S$)	No. of Claims	Amount (S$)	No. of Claims	Amount (S$)
				S$		S$		S$
				S$		S$		S$
				S$		S$		S$

d) Claims experience for the past 3 years - Outstanding claims

Period of Coverage		No. of Insured as at	Clinical GP		Specialist		Diag X-Ray/Lab Tests	
From	To	_____	No. of Claims	Amount (S$)	No. of Claims	Amount (S$)	No. of Claims	Amount (S$)
				S$		S$		S$
				S$		S$		S$
				S$		S$		S$

e) Please attach a copy of the Schedule of Benefits if the benefits are on insured basis. If currently self-insured, kindly provide the following details:
(Please indicate "Unlimited" if there is no cap and "N.A" if it is not applicable)

Benefits	Maximum Limit per Visit (S$)		Maximum Limit per Policy Year (S$)		Co-payment (S$)/Co-insurance (%)			
	Panel clinic	Non-panel clinic	Panel clinic	Non-panel clinic	Panel clinic	Non-panel clinic	Panel clinic	Non-panel clinic
Clinical GP	S$	S$	S$	S$	S$	S$	0%	0%
Specialist	S$	S$	S$	S$	S$	S$	0%	0%
Diag X-Ray/Lab Test	S$	S$	S$	S$	S$	S$	0%	0%

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4. Benefit: Maternity Insurance

a) Basis of Coverage

Category of Employees	No. of Headcount

Example 1:
Category of Employees/Occupation

i. Senior Management (Director, General Manager, Senior Manager)
ii. Managers & Executive
iii. All Others

Example 2:

i. Senior Management (Director, General Manager, Senior Manager)

b) Claims Experience for the past 3 years

Period of Coverage		No. of Insured as at _____	Paid Claims		Outstanding Claims	
From	To		No. of Claims	Amount (S$)	No. of Claims	Amount (S$)
				S$		S$
				S$		S$
				S$		S$

Note: The insurer reserves the rights to request for more information

c) Please attached a copy of Schedule of Benefits, if the benefits are on insured basis (i.e., currently insured). If currently self-insured, kindly provide the following details (Please indicate unlimited if there is no cap and N.A. if it is not applicable).

Benefits	Maximum Limit per Policy Year (S$)	Deductible (S$)/Co-Insurance (%)
Normal Delivery	S$	
Caesarian Delivery	S$	
Others:	S$	

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Name of Proposer:	_____

Needs Analysis & Product Recommendation
Please select the priority of your company's needs:

Company's Priorities	Level of Priority	Advisor's Recommendations
Cover for Outpatient Medical expenses	Please select	
Cover for Hospital & Surgical expenses	Please select	
Cover for Dental expenses	Please select	
Cover for major illnesses (e.g., Cancer, Kidney failure etc)	Please select	
Cover for Loss of Income due to sickness or accident	Please select	
Cover for long-term medical treatment	Please select	
Others:		

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, et

_____
Date

_____
Signatory of Authorised Officer &
Company Stamp

_____
Name

Fact-Find for Group – Accident & Health

Name of Proposer: _____

_____
NRIC/FIN No.

_____
Designation

DECLARATION – INSURANCE REPRESENTATIVE

I/We hereby declare that I/we have reviewed this Fact-Find Group form with the authorised officer of the Company, and that I/we have explained all the requirements of this Fact-Find to him/her.

_____
Date

_____
Signatory of Authorised Officer & Company Stamp

_____
Name

_____
NRIC/FIN No.

_____
Designation