

Application Form

Continuous Personal
Medical Exclusions

MyHEALTH Individual Medical Plans

Download our Easy Claim mobile app
for quicker claims reimbursement!



Please print only if necessary



INSURANCE MADE EASY

YOUR APPLICATION, STEP BY STEP.



This is your application form. Complete it, sign it, send it.



An underwriting offer will be provided in **3 working days or less**.



ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- ✓ Your full member's pack (by email)
This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- ✓ You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

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.

DECLARATION FOR PRODUCT SUMMARY

Name of Applicant : _____

I/We, the Applicant, acknowledge that the Insurance Advisor 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.

SIGNATURE OF APPLICANT (for and on behalf of all insured persons)

Date : _____

SIGNATURE OF INSURANCE ADVISOR

Name of Insurance Advisor : _____

Date : _____

1. YOUR DETAILS - CONTINUED

IMPORTANT NOTICE

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim. You are applying for **Continuous Personal Medical Exclusions (CPME)**, which means that any special terms, exclusions or loadings on your current/expiring health insurance policy will be carried over and applied to your new MyHEALTH policy.

APPLICANT'S 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

	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
	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				
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

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 dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only.					
MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Hospital & Surgery	<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
	<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
	• 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
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	<input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide	<input type="radio"/> Worldwide excluding USA <input type="radio"/> Worldwide
	• The area of cover chosen will apply to all modules selected. • Services rendered outside of the area of cover are covered up to SG\$150,000 per period of insurance under Essential and Extensive and SG\$250,000 per period of insurance under Elite, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip in the USA. • Please refer to clause 4 of the Policy Terms and Conditions.				
STEP 2					
SELECT ANY OPTIONAL MODULES THAT YOU WISH The following modules are optional. Each member has the flexibility to select the cover they want. If dependants will have the same cover as the Applicant, please tick here <input type="radio"/> and complete cover options for the Applicant only.					
MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Outpatient	Essential with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Essential with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Essential with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Essential with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Essential with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance
	Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Extensive with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance
	Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance	Elite with <input type="radio"/> nil coinsurance <input type="radio"/> 20% coinsurance
	• 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
	• 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 AND MEDICAL DETAILS

If the answer is Yes to any of the following questions, please provide full details.

Do you or any person to be insured currently have health insurance with another company?

If Yes, please provide details and attach all existing insurance certificates, schedules and endorsement relating to all persons to be insured. CPME is only available to persons currently covered by an equivalent international medical insurance policy.

Yes ☐ No ☐

Do you and any person to be insured have or have ever had any signs, symptoms, treatments, consultations, investigations, diagnostic tests for cancer?

Yes ☐ No ☐

Have you or any person to be insured been suffering from chronic conditions such as but not limited to polyps, cysts, asthma, heart conditions, cerebral infarction/stroke, brain multiple sclerosis, renal failure, liver cirrhosis, autoimmune disease, joint replacement, severe mental illness/Alzheimer's, Parkinson, Epilepsy, Down syndrome? Or ever made a claim against your insurance in relation to chronic conditions?

Yes ☐ No ☐

Chronic condition : A disease, illness or injury that has one or more of the following characteristics:

- a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests; or
- b. it needs ongoing or long-term control or relief of symptoms; or
- c. you need to be rehabilitated or specially trained to cope with it; or
- d. it continues indefinitely; or
- e. it has no known cure; or
- f. it comes back or is likely to come back.

Do you or any person to be insured have any recent (12 months) hospitalisations or plan of surgery or treatment/consultation for cancer and/or chronic conditions?

Yes ☐ No ☐

Is anyone to be covered on this plan currently pregnant?

Yes ☐ No ☐

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.

Name

Address

Telephone

Fax

Email

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.

COMMENCEMENT DATE

Date : DD / MM / YYYY

We cannot backdate cover to a date earlier than the date you accept our final offer.

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?

Yes ☐

No ☐

Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?

Yes ☐

No ☐

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

☐ SGD ☐ USD ☐ EUR ☐ 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. PAYMENT METHODS

<input type="radio"/>	Cheque - Annual Payment Only		
Cheques should be drawn on a Singapore clearing bank and made payable to “ Liberty Insurance Pte Ltd ”. Kindly indicate (1) Name of Applicant or policyholder ; (2) Contact No. ; (3) Name of Product ; (4) Producer Code at the back of your cheque			
<input type="radio"/>	Bank Transfer - Annual Payment Only		
Relating to payment for SGD Singapore-related risks policies: Beneficiary Bank Beneficiary Name : Liberty Insurance Pte Ltd. Beneficiary Address : One Raffles Quay, #25-01 North Tower, Singapore 048583 Bank Name : UOB Bank Account No : 4513142581 Bank Address : 80 Raffles Place, #29-03 UOB Plaza 1, Singapore 048624 Bank Code : 7375 Branch Code : 001 Swift Code : UOVBSGSG Currency : SGD			
1. All bank charges will be borne by the remitter. 2. Please indicate your Policy Number as a payment detail to your bank. 3. Please email contact.sg@april.com the bank remittance advice or instruction slip with your Policy Number to us for our accounting records and to issue an Official Receipt.			
<input type="radio"/>	GIRO - Quarterly Payment		
Please complete the Interbank GIRO form and submit together with the Application Form			
<input type="radio"/>	Credit Card - Annual or Instalment Payment		
<input type="radio"/>	MasterCard	<input type="radio"/>	VISA
<input type="radio"/>	Full Payment	<input type="radio"/> 0% Interest Instalment Plan ¹	
		Standard Chartered	DBS/POSB
		<input type="radio"/> 6 months	<input type="radio"/> 6 months
		<input type="radio"/> 12 months	<input type="radio"/> 12 months
	United Overseas Bank		
	<input type="radio"/> 6 months		
	<input type="radio"/> 12 months		
Name of Cardholder (as shown on card)			
Credit Card No.		<div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> </div>	
Expiry Date		Card Verification Value (CVV)	
		MM / YY	
¹ Only applicable for instalment payment through participating banks in Singapore and is subject to their Credit Card Agreement Terms & Conditions.			

SIGNATURE OF CARDHOLDER

PERSONAL DATA PROTECTION

I/We give consent to Liberty Insurance Pte Ltd (“Liberty”) and its employees, related companies, agents and service providers to collect, use and disclose all personal and credit card data for one or more of the purposes described in Liberty’s Data Protection Policy, including but not limited to premium payment, collection, accounting, audit, compliance, regulatory, research, analysis, verification, and dispute resolution. I/We have read and agreed to the terms of the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If any personal data furnished is not about me/us, I/we warrant that I/we have obtained consent from the data subject (or if lacking in legal capacity, his/her legal representatives, guardians or parents as the case may be) for Liberty to collect, use and disclose his/her personal data for the above purposes and on the terms in this document, and as if the said data are about me/us. I/We warrant that all personal data I/we have provided are accurate and complete, and I/we will inform Liberty of any changes to the data as soon as practicable.

Notes: The liability of the Company (Liberty Insurance Pte Ltd) commences only when the proposal/renewal has been accepted by the Company and premium successfully deducted. Acceptance of premium does not constitute acceptance of liability

5. 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:

- 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.
- 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.
- I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.
- 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.
- 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.

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
One Raffles Quay #25-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY(5423 789)

Arranged by:

APRIL Singapore Pte Ltd
Co. Reg. No. 200613924G
2A McCallum Street
Singapore 069043
Tel: (+65) 6736 0057
Email: contact.sg@april.com



SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT



Save this file and
send it to
asia.app@april.com

OR

PRINT, SIGN, EMAIL

PRINT



Send the scanned copy to
asia.app@april.com



Mail to
**APRIL Singapore Pte Ltd
2A McCallum Street
Singapore 069043**