Application Form

Full Medical Underwriting

MyHEALTH Individual Medical Plans

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Please print only if necessary

Liberty Insurance

april International

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

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	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Gender	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯
Marital Status				
Nationality				
Smoker	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
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 ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Hospital & Surgery	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only	○ Free choice of provider ○ Specified Providers only
	• The Specified Inpatient Providers list is available at **http://healthbyapril.com/specified-hospitals**				
Annual Deductible	○ Nil ○ SGD 2,000 ○ SGD 5,000 ○ SGD 10,000	○ Nil ○ SGD 2,000 ○ SGD 5,000 ○ SGD 10,000	○ Nil ○ SGD 2,000 ○ SGD 5,000 ○ SGD 10,000	○ Nil ○ SGD 2,000 ○ SGD 5,000 ○ SGD 10,000	○ Nil ○ SGD 2,000 ○ SGD 5,000 ○ SGD 10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ Worldwide	○ Worldwide excluding USA ○ 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 ○ and complete cover options for the Applicant only.

MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Outpatient	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance	Essential with ○ nil coinsurance ○ 20% coinsurance
	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance	Extensive with ○ nil coinsurance ○ 20% coinsurance
	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance	Elite with ○ nil coinsurance ○ 20% coinsurance
	• The 20% coinsurance is waived within our Panel Network				
Dental and/or Optical Optical included with Elite plan only	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite	○ Essential ○ Extensive ○ Elite
Maternity	○ SGD 7,000 ○ SGD 13,500 ○ SGD 20,000	○ SGD 7,000 ○ SGD 13,500 ○ SGD 20,000	○ SGD 7,000 ○ SGD 13,500 ○ SGD 20,000	○ SGD 7,000 ○ SGD 13,500 ○ SGD 20,000	○ SGD 7,000 ○ SGD 13,500 ○ 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 DETAILS		
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.	Yes ○	No ○
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).	Yes ○	No ○
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.	Yes ○	No ○

MEDICAL DETAILS AND HISTORY	Please indicate if you or any person to be insured have or have ever had 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 ○	No ○
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes ○	No ○
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 ○	No ○
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes ○	No ○
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes ○	No ○
6	Tropical illness: Malaria, dengue fever	Yes ○	No ○
7	HIV/AIDS	Yes ○	No ○
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ○	No ○
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes ○	No ○
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes ○	No ○
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes ○	No ○
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes ○	No ○
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 ○	No ○
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes ○	No ○
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes ○	No ○
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes ○	No ○
17	Any other disorder/ injury	Yes ○	No ○

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 **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.

Yes ○ No ○

19 **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.)

Yes ○ No ○

20 **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.

Yes ○ No ○

21 **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			

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.

COMMENCEMENT DATE

○ On Acceptance ○ Another 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

◯ 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

◯ 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.

◯ GIRO - Quarterly Payment

Please complete the Interbank GIRO form and submit together with the Application Form

◯ Credit Card - Annual or Instalment Payment

◯ **MasterCard** ◯ **VISA**

◯ Full Payment	◯ 0% Interest Instalment Plan[1]		
	Standard Chartered	**DBS/POSB**	**United Overseas Bank**
	◯ 6 months ◯ 12 months	◯ 6 months ◯ 12 months	◯ 6 months ◯ 12 months
Name of Cardholder (as shown on card)			
Credit Card No.	– – –		
Expiry Date	MM / YY	**Card Verification Value (CVV)**	

[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:

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.

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

MH SG 2023/12

Liberty Insurance

April International

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