Application Form

Full Medical Underwriting

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Liberty Insurance

april International
INSURANCE MADE EASY

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	DD / MM / YYYY		DD / MM / YYYY		DD / MM / YYYY		DD / MM / YYYY	
Gender	Male ◯	Female ◯	Male ◯	Female ◯	Male ◯	Female ◯	Male ◯	Female ◯
Marital Status								
Relationship to Employee								
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 family members will have the same cover as the Employee, please tick here ◯ and complete cover options for the Employee only.

MODULES	EMPLOYEE	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Hospital & Surgery	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ Essential ◯ Extensive ◯ Elite	◯ Core ◯ 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
	• 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	◯ 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	◯ ASEAN and India ◯ Worldwide excluding USA ◯ Worldwide	◯ ASEAN and India ◯ Worldwide excluding USA ◯ Worldwide	◯ ASEAN and India ◯ Worldwide excluding USA ◯ Worldwide	◯ ASEAN and India ◯ Worldwide excluding USA ◯ Worldwide	◯ ASEAN and India ◯ Worldwide excluding USA ◯ Worldwide
	• 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 SG$150,000 for Essential, SG$200,000 for Extensive and SG$250,000 for Elite 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 SG$50,000 for accidents only. • 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 family members will have the same cover as the Employee, please tick here ◯ and complete cover options for the Employee only.

Outpatient	Core with ◯ nil coinsurance	Core with ◯ nil coinsurance	Core with ◯ nil coinsurance	Core with ◯ nil coinsurance	Core with ◯ nil 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	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, sexually transmitted disease	Yes ○	No ○
8.	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ○	No ○
9.	Liver, gallbladder and pancreas: Hepatitis, fatty liver, gallstone, or other disorder of the liver, gallbladder or pancreas	Yes ○	No ○
10.	Endocrine, nutritional and metabolic diseases: Diabetes, Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid or endocrine glands	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 ○

MEDICAL DETAILS AND HISTORY – 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?			

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

○ On Acceptance ○ Another Date : DD / MM / YYYY

INTERMEDIARY ACCESS
By choosing to give any access to your intermediary, you declare that you have obtained consent from all the members.

I/We would like our insurance intermediary to have access to my/our policy details and claims transactions through their online account at **https://members.april-international.com**.	Yes ○	No ○
I/We authorise APRIL to discuss and/or share claims and medical information with my/our insurance intermediary.	Yes ○	No ○

Intermediary Name		Intermediary 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. ACKNOWLEDGEMENT & PERSONAL DATA PROTECTION ACT (PDPA)

PERSONAL DATA PROTECTION STATEMENT

I, as an individual to be insured acting on behalf of my dependants(s), if any ("members"), give consent to Liberty International Insurance Limited 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 Insurance 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. If there is any personal data relating not to myself but to the members or 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 International Insurance Limited 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:

1. I, as a corporate policyholder acting on behalf of the members, hereby confirm this declaration is correct and consent to disclose personal data to APRIL and the insurer.
2. I acknowledge that I have made my own independent decision in applying for the product selected with the premium information and key product features informed by APRIL or my intermediary. I confirm that the relevant insurance product features are suitable for my needs as well as the member's needs, and the premiums are affordable.
3. I (and the members) have read, understand, and consent to **Liberty Insurance Data Protection** and **APRIL Singapore Privacy Notice**, and if my dependents are minors, I am providing such consent as parent or legal guardian of such minors.
4. I (and the members) have read, understand, and agree to the **Brochure**, **Policy Terms and Conditions**, **Benefits Schedule**, **Statements & Authorizations**.

I declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. I further declare that I have not withheld any material fact and that except as declared herein. I will notify APRIL Singapore immediately if after signing this application and before a policy is issued if I become aware of material facts not disclosed in this form, or if the health of any person to be insured changes such that any answer on this form is not full complete, and true. If a policy is issued to me, this proposal and the statements made herein shall form the basis of the policy between me/us and Liberty International Insurance Limited. In the event that the provided information is not true or complete, I understand and further agree that the premium could be changed; the insurance contract could be declared void; or the insurance company is entitled to deny its responsibility for any material misrepresentation of non-disclosure. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

APPLICANT 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:
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