Application Form

Continuous Personal Medical Exclusions

MyHEALTH Employee and Family

Download our Easy Claim mobile app
for quicker claims reimbursement!

april-international.com

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

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.

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 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	
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
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