

## Group Application Form

# MyHEALTH Business & YourHEALTH Benefits

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 [april-international.com](http://april-international.com)

Please print only if necessary



# 1. PLAN SPONSOR 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](http://www.gia.org.sg) or [www.sdic.org.sg](http://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.

### REQUESTED POLICY START DATE

Policy Start Date : DD / MM / YYYY

### PLAN SPONSOR DETAILS

Company Name : \_\_\_\_\_

Subsidiary Company Name(s): \_\_\_\_\_

Type of Business/Industry: \_\_\_\_\_

Company Address : \_\_\_\_\_

Postal Code : \_\_\_\_\_ Country : \_\_\_\_\_

Telephone : \_\_\_\_\_ Fax : \_\_\_\_\_

### PLAN SPONSOR ADMINISTRATOR

First Name : \_\_\_\_\_ Family Name : \_\_\_\_\_

Job Title : \_\_\_\_\_

Mailing Address : \_\_\_\_\_

If different from Company Address

Postal Code : \_\_\_\_\_ Country : \_\_\_\_\_

Tel. : \_\_\_\_\_ Mobile : \_\_\_\_\_

Email : \_\_\_\_\_

### INTERMEDIARY DETAILS (for intermediary only )

Intermediary Name : \_\_\_\_\_

Company Name : \_\_\_\_\_

Telephone : \_\_\_\_\_

Email : \_\_\_\_\_

Or Stamp Above :

# 1. PLAN SPONSOR DETAILS - CONTINUED

GROUP ELIGIBILITY - EMPLOYEES	
<b>Employee enrolment requirement :</b> Compulsory enrolment is required for all Medical History Disregarded (MHD) policies.	<input type="radio"/> Compulsory <input type="radio"/> Voluntary (Please provide details)
<b>Are all employees to be enrolled permanent staff and actively at work?</b>	<input type="radio"/> Yes <input type="radio"/> No (Please provide details)
<b>Are you aware of any pending hospitalisations, serious illnesses and/or any ongoing treatment for chronic conditions in respect of the employees and dependants to be enrolled?</b>	<input type="radio"/> Yes (Please provide details) <input type="radio"/> No
UNDERWRITING BASIS AT ENTRY	
<input type="radio"/> Full Medical Underwriting <input type="radio"/> Moratorium <input type="radio"/> Medical History Disregarded <input type="radio"/> CPME	
GROUP ELIGIBILITY - DEPENDANTS	
<b>Are dependants eligible for coverage?</b> Compulsory enrolment is required for all Medical History Disregarded (MHD) policies.	<input type="radio"/> Yes (Please complete Dependant Enrolment Basis below) <input type="radio"/> No
<b>Spouse Enrolment Basis</b>	<input type="radio"/> Compulsory <input type="radio"/> Voluntary (Please provide details)
<b>Children Enrolment Basis</b>	<input type="radio"/> Compulsory <input type="radio"/> Voluntary (Please provide details)
ONLINE ACCESS	
<b>As a group administrator, would you like access to your policy details online at <a href="https://myapril-business.april.asia/">https://myapril-business.april.asia/</a>?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>Would you like your insurance intermediary to have access to your <u>group policy details and claims</u> through their online account?</b>	<input type="radio"/> Yes <input type="radio"/> No
<b>May we share information about member claims and benefits paid with your insurance intermediary?</b>	<input type="radio"/> Yes <input type="radio"/> No

## 2. PAYMENT METHODS

### PREMIUM PAYMENT FREQUENCY

Annually

Semi-Annually (4% surcharge)

Quarterly (5% surcharge)

### PAYMENT METHOD

Bank Transfer

### BANK TRANSFER

- Please send full payment (inclusive of all bank charges) to:

#### Singapore Dollar (SGD) Account

##### 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 and Debit Note number as a payment detail to your banker.
3. Please email ops.sg@april.com the bank remittance advice or instruction slip with your Policy Number, Company name and Debit Note number.

### 3. 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/](http://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 PROPOSER

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 OF AUTHORISED PERSON

Authorised Person

Name : \_\_\_\_\_

Title : \_\_\_\_\_

#### DECLARATION BY PLAN SPONSOR

You declare that the statements contained in this application form are correctly recorded, and that they are full, complete and true. You further declare that you have not withheld any material fact and that except as declared herein, all persons to be insured are currently in good health. You will notify us immediately if after signing this application and before a policy is issued if you 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 you, this proposal and the statements made herein shall form the basis of the policy between you and Liberty International Insurance Limited (Hong Kong). You understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

Date : \_\_\_\_\_

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](mailto:contact.sg@april.com)

