# Group Fact Find Form

*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.*

| **Kindly Complete Fully In Block Letters** (Tick boxes ☑ where appropriate) | | | |
|---|---|---|---|
| Period of Insurance from: | DD / MM / YYYY | to | DD / MM / YYYY |
| Request for Quotation was submitted on | | DD / MM / YYYY | |
| Request From: | | (Name of Insurance Company) | |

## GENERAL INFORMATION

| | | | |
|---|---|---|---|
| Company Name: | | | |
| Nature of Business: | | | |
| Presently Insured? | ◯ Yes ◯ No | If Yes, name of current insurer: | |
| Type of Policy: | | | |
| Period of Insurance from: | DD / MM / YYYY | to | DD / MM / YYYY |
| Total No. of Employees: | | No. of Employees to be Insured: | |

Participation: The insurer will assume that participation of the group insurance program is on compulsory basis unless otherwise stated.
Please tick ☑ accordingly to the choice of the insurance product that you like to have a quote from us.

| Benefits | Insurance Coverage | | | Participation | |
|---|---|---|---|---|---|
| | | | | Compulsory | Voluntary |
| Medical | 1 | Hospital & Surgical | Employee only | ☐ | ☐ |
| | | | Dependant (Spouse and/or Children) | ☐ | ☐ |
| | | Outpatient benefits | Employee only | ☐ | ☐ |
| | | | Dependant (Spouse and/or Children) | ☐ | ☐ |
| Others | 2 | Maternity | Employee only | ☐ | ☐ |
| | | | Dependant (Spouse and/or Children) | ☐ | ☐ |
| | | Dental & Optical | Employee only | ☐ | ☐ |
| | | | Dependant (Spouse and/or Children) | ☐ | ☐ |

Note: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s), subject to a minimum participation level.

| **Q1.** | **Are there any members currently in hospital or requires frequent admission (e.g. hospital admission more than 2 times per year) to hospital?** If Yes, kindly provide the following details: | Yes ◯ No ◯ |
|---|---|---|
| Number of Members / Age | Reason of Hospitalisation / Nature of Illness | Total Sum Insured / Plan |
| | | |
| | | |
| | | |

Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.

| | | |
|---|---|---|
| **Q2.** | **Has any member suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that causes progressive irreversible functional or physical disability?** f Yes, kindly provide the following details: | Yes ◯ No ◯ |

| Number of Members / Age | Reason of Hospitalisation / Nature of Illness | Total Sum Insured / Plan |
|---|---|---|
| | | |
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Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.

| | | |
|---|---|---|
| **Q3.** | **Is there any member based outside Singapore?** If Yes, kindly provide the following details: | Yes ◯ No ◯ |

| Number of Members / Age | Country based in | Total Sum Insured / Plan |
|---|---|---|
| | | |
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|---|---|---|
| **Q4.** | **Is there any limitation or exclusion imposed on the cover on any member?** If Yes, kindly provide the following details: | Yes ◯ No ◯ |

| Number of Members / Age | Limitations / Exclusions | Total Sum Insured / Plan |
|---|---|---|
| | | |
| | | |
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|---|---|---|
| **Q5.** | **Is there any member engaged in hazardous occupation? (Hazardous occupation e.g. welder, diver, sandblaster, offshore workers etc.)** If Yes, kindly provide the following details: | Yes ◯ No ◯ |

| Number of Members / Age | Nature of Work | Total Sum Insured / Plan |
|---|---|---|
| | | |
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Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application

| | | |
|---|---|---|
| **Q6.** | **To the best of your knowledge, is there any member engaged in hazardous sports? (Hazardous sports e.g. scuba diving, motor racing, bungee jumping etc.)** If Yes, kindly provide the following details: | Yes ◯ No ◯ |

| Number of Members / Age | Type of Sports | Total Sum Insured / Plan |
|---|---|---|
| | | |
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| | | |

Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application

## BENEFIT: GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

**Basis of Coverage**

| Category of Employees / Occupation | | Room & Board Benefit Plan | Currently with TMIS Yes / No | Proposal with TMIS Yes / No |
|---|---|---|---|---|
| (i) | | | | |
| (ii) | | | | |
| (iii) | | | | |
| (iv) | | | | |

Important Note:
1. Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.
2. Please provide the Deductible / Co-insurance for respective employee category or occupation, if applicable.

Example 1

| Category of Employees / Occupation | | R&B Benefit Plan |
|---|---|---|
| (i) | Senior Management (Director, General Manager, Senior Manager) | Plan 1 |
| (ii) | Manager & Executive | Plan 2 |
| (iii) | All Others | Plan 3 |

**AGE PROFILE OF EMPLOYEES**

| **Age Band** (Age Next Birthday) | | **16-30** | **31-35** | **36-40** | **41-45** | **46-50** | **51-55** | **56-60** | **61-65** | **66-70** | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Employees | Male | | | | | | | | | | |
| | Female | | | | | | | | | | |

**DETAILS OF INSURED MEMBERS**
For GHS and GMM:

| | Number of Employees (Singaporeans, SPRs*) | | | |
|---|---|---|---|---|
| | Plan 1 | Plan 2 | Plan 3 | Plan 4 |
| Employee Only | | | | |
| Employee & Spouse | | | | |
| Employee & Child(ren) | | | | |
| Employee & Family | | | | |

* refers to Singapore Permanent Residents

| | Number of Employees (Foreigners* only) | | | |
|---|---|---|---|---|
| | Plan 1 | Plan 2 | Plan 3 | Plan 4 |
| Employee Only | | | | |
| Employee & Spouse | | | | |
| Employee & Child(ren) | | | | |
| Employee & Family | | | | |

* refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore

**DETAILS OF INSURED MEMBERS - CONTINUED**
For GMM (if the basis of coverage differs from GHS):

| | Number of Employees (Singaporeans, SPRs*) | | | |
|---|---|---|---|---|
| | Plan 1 | Plan 2 | Plan 3 | Plan 4 |
| Employee Only | | | | |
| Employee & Spouse | | | | |
| Employee & Child(ren) | | | | |
| Employee & Family | | | | |

* refers to Singapore Permanent Residents

| | Number of Employees (Foreigners* only) | | | |
|---|---|---|---|---|
| | Plan 1 | Plan 2 | Plan 3 | Plan 4 |
| Employee Only | | | | |
| Employee & Spouse | | | | |
| Employee & Child(ren) | | | | |
| Employee & Family | | | | |

* refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore

**CLAIMS EXPERIENCE FOR THE PAST 3 YEARS**

| Period of Coverage GPA From / To (dd/mm/yyyy) | Number of Insured as at (dd/mm/yyyy) | Paid Claims | | Outstanding Claims | |
|---|---|---|---|---|---|
| | | Number of Claims | Amount | Number of Claims | Amount |
| | | | | | |
| | | | | | |
| | | | | | |

Note: The insurer reserves the right to request for more information.
Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis (i.e. currently insured).

## BENEFIT: GROUP OUTPATIENT INSURANCE

**CATEGORY OF EMPLOYMENT TO BE INSURED**

| Category of Employees | | Clinical GP | Specialist | Diag X-Ray/Lab Tests |
|---|---|---|---|---|
| (i) | | | | |
| (ii) | | | | |
| (iii) | | | | |
| (iv) | | | | |
| Dependant (where applicable) | | | | |
| No. of Headcounts | | | | |

**AGE PROFILE OF EMPLOYEES**

| **Age Band** (Age Next Birthday) | | **16-30** | **31-35** | **36-40** | **41-45** | **46-50** | **51-55** | **56-60** | **61-65** | **66-70** | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Employees | Male | | | | | | | | | | |
| | Female | | | | | | | | | | |

| NAME OF PROPOSER | |
|---|---|

**CLAIMS EXPERIENCE FOR THE PAST 3 YEARS**

**PAID CLAIMS**

| Period of Coverage (dd/mm/yyyy) | | No. of Insured as at (dd/mm/yyyy) | Clinical GP | | Specialist | | Diag X-Ray/Lab Tests | | Clinical GP | |
|---|---|---|---|---|---|---|---|---|---|---|
| From | To | | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) |
| | | | | | | | | | | |
| | | | | | | | | | | |
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**OUTSTANDING CLAIMS**

| Period of Coverage (dd/mm/yyyy) | | No. of Insured as at (dd/mm/yyyy) | Clinical GP | | Specialist | | Diag X-Ray/Lab Tests | | Clinical GP | |
|---|---|---|---|---|---|---|---|---|---|---|
| From | To | | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) | No. of Visits | Amount (S$) |
| | | | | | | | | | | |
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**Please attach a copy of the Schedule of Benefits if the benefits are on insured basis. If currently self-insured, kindly provide the following details:**
(Please indicate "Unlimited" if there is no cap and "N.A" if it is not applicable)

| Benefits | Maximum Limit per Visit (S$) | | Maximum Limit per Policy Year (S$) | | Co-Payment (S$)/Co-Insurance (%) | | | |
|---|---|---|---|---|---|---|---|---|
| | Panel Clinic | Non-Panel Clinic | Panel Clinic | Non-Panel Clinic | Panel Clinic | Non-Panel Clinic | Panel Clinic | Non-Panel Clinic |
| Clinical GP | | | | | | | | |
| Specialist | | | | | | | | |
| Diag X- Ray/ Lab Tests | | | | | | | | |

**BENEFIT: MATERNITY INSURANCE**

**Basis of Coverage**

| Category of Employees (refer to the example) | | Number of Headcount |
|---|---|---|
| (i) | | |
| (ii) | | |
| (iii) | | |

| Example 1 | |
|---|---|
| Category of Employees / Occupation | |
| (i) | Senior Management (Director, General Manager, Senior Manager) |
| (ii) | Manager & Executive |
| (iii) | All Others |
| Example 2 | |
| (i) | All Employees |

| CLAIMS EXPERIENCE FOR THE PAST 3 YEARS | | | | | |
|---|---|---|---|---|---|
| Period of Coverage GPA From / To (dd/mm/yyyy) | Number of Insured as at (dd/mm/yyyy) | Paid Claims | | Outstanding Claims | |
| | | Number of Claims | Amount | Number of Claims | Amount |
| | | | | | |
| | | | | | |
| | | | | | |

Note: The insurer reserves the right to request for more information.

**Please attach a copy of the Schedule of Benefits if the benefits are on insured basis. If currently self-insured, kindly provide the following details:**
(Please indicate "Unlimited" if there is no cap and "N.A" if it is not applicable)

| Benefits | Maximum Limit per Visit (S$) | | Deductible / Co-insurance | |
|---|---|---|---|---|
| Normal Delivery | | | | |
| Caesarian Delivery | | | | |
| Others: | | | | |

## NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box ☑ to indicate the priority of your company's needs: Nature of Business:

| Company's Priorities | Low | Medium | High | Advisor's Recommendation |
|---|---|---|---|---|
| Cover for Outpatient medical expenses | ☐ | ☐ | ☐ | |
| Cover for Hospital & Surgical expenses | ☐ | ☐ | ☐ | |
| Cover for Dental expenses | ☐ | ☐ | ☐ | |
| Cover for Major illnesses (e.g. cancer, kidney failure, etc.) | ☐ | ☐ | ☐ | |
| Cover for Loss of Income due to sickness or accident | ☐ | ☐ | ☐ | |
| Cover for long term medical treatment | ☐ | ☐ | ☐ | |
| Others: | | | | |

## ACKNOWLEDGMENT & PERSONAL DATA PROTECTION ACT (PDPA)

**PERSONAL DATA PROTECTION STATEMENT**

I, as a corporate policyholder acting on behalf of my employees or other individuals who will be insured ("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:

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.

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.

## SIGNATURE OF AUTHORISED OFFICER

I declare that the statements contained in this 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 Limited immediately if after signing this form and before a policy is issued 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, 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.

| | | | |
|---|---|---|---|
| | Name : | | |
| | Designation : | | |
| | NRIC / Fin No. | | |
| | Date : | | Company Stamp (if applicable) |

## SIGNATURE OF AUTHORISED INTERMEDIARY

I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the requirements of this Fact-Finding form to him / her.

| | | | |
|---|---|---|---|
| | Name : | | |
| | Designation : | | |
| | NRIC / Fin No. | | |
| | Date : | | Company Stamp (if applicable) |

| | |
|---|---|
| Policyholder or Applicant Name: | |
| Passport / ID Number: | |
| Policy Number (if Applicable): | |

*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.*

MH SG 2025/01

Underwritten by:
**Liberty Insurance Pte Ltd**
Registration No. 199002791D
GST Registration No. M2-0093571-3
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