Group Fact Find Form

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)		
		Out-patient 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? 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.

Q3. Is there any member based outside Singapore? Yes ☐ No ☐
If "Yes", kindly provide the following details:

Number of Members / Age	Country based in	Total Sum Insured / Plan

Q4. Is there any limitation or exclusion imposed on the cover on any member? Yes ☐ No ☐
If "Yes", kindly provide the following details:

Number of Members / Age	Limitations / Exclusions	Total Sum Insured / Plan

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

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

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

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		No. of Insured as at	Clinical GP		Specialist		Diag X-Ray/Lab Tests	
From	To		No. of Visits	Amount (S$)	No. of Visits	Amount (S$)	No. of Visits	Amount (S$)

Outstanding Claims

Period of Coverage		No. of Insured as at	Clinical GP		Specialist		Diag X-Ray/Lab Tests	
From	To		No . of Visits	Amount (S$)	No . of Visits	Amount (S$)	No . of Visits	Amount (S$)

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 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. If currently self-insured, kindly provide the following details: Please indicate “Unlimited” if there is no cap and “NA” if it is not applicable.

Benefits	Maximum Limit per Policy Year		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 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 of Authorised Officer

Name

Designation :

Company Stamp (if applicable)

NRIC / Fin No.

Date:

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.

Signature of Authorised Intermediary

Name

Designation :

Company Stamp (if applicable)

NRIC / Fin No. :

Date:

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

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.

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 and administered by:

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Co. Reg. No. 200613924G
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Singapore 069043
Tel: (+65) 6736 0057
Email: contact.sg@april.com

Liberty Insurance

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