

Please complete all sections to facilitate the processing of your application.

Statement pursuant to Section 25(5) Cap. 142 of the Insurance Act or any subsequent amendments thereof. You are to disclose in the proposal form fully and faithfully all facts which you know or ought to know, otherwise the Policy issued hereunder may be void.

Name of Producer & Producer Code: _____

Particulars of Proposer

Name of Proposer: _____		Contact No.: _____	
Mailing Address: _____ Postal Code ()			
NRIC/FIN No.: _____	Date of Birth: _____	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
Email: _____		Nationality: _____	

Details of Profession

Occupation: _____	Rank (where applicable): _____	Height (m): _____ m	Weight (kg): _____ kg
Name of Current Employer: _____		Years of Experience: _____	
Type of license Held: <input type="checkbox"/> Air Traffic Controller license <input type="checkbox"/> Airline Transport Pilot license (ATPL) <input type="checkbox"/> Commercial Pilot license (CPL) <input type="checkbox"/> Multi-crew Pilot license (MPL)		License No.: _____	
Country of Issue: _____	Licensing Authority: _____		
License Validity: From _____ To _____			
Have you ever been grounded, declared unfit to fly or had your license invalidated for medical reasons?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has any limitation ever been endorsed on any of your licenses?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been required to notify CAAS of a decreased in medical fitness?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If any of your answers are "Yes", please provide full details (please use additional paper if necessary): 			

Name of Proposer: _____

Health Declaration

1. Date of your last aviation medical _____		
2. Do you currently have any symptoms of injury or illness or are you taking prescribed medication of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever suffered from any condition which necessitated hospital attendance, admission, diagnosis or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. After or during a medical examination, have you ever:		
a) been required to take additional tests?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) been referred for specialist examination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) had the issue or renewal of your medical certificate deferred?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) had to return for examination at less than the normal interval?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) been ordered to take drugs or follow any special diet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever been investigated, diagnosed, treated or received advice from a registered medical practitioner in relation to:		
a) brain, epilepsy or disorders of the central nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) heart, arteries, cholesterol, blood pressure or disorders of the circulatory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) lungs, asthma, tuberculosis or disorders of the respiratory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) stomach, oesophagus or disorders of the digestive system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) kidney, bladder, liver, spleen, bowel or disorders of the genito-urinary system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) head, back, neck or spine or any disorders of the musculoskeletal system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) depression, psychological, psychiatric or personality disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) cancer or tumour?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j) any disorder of the eyes or ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k) any disorder of the skin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l) hepatitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m) any hernia or associated condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n) arthritis or rheumatism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
o) physical impairment or deformity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
p) drug or alcohol dependence?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
q) HIV, AIDS or AIDS related conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If any of your answers are "Yes", please provide full details (please use additional paper if necessary)		

Details of Treating Doctor(s)

Family Doctor	Last Doctor Consulted	Company's Doctor
Name of Clinic: _____	Name of Clinic: _____	Name of Clinic: _____
Name of Doctor: _____	Name of Doctor: _____	Name of Doctor: _____

Name of Proposer: _____

Health Declaration

Description of health condition(s):

Other Insurance

1. Are you entitled to any other loss of license insurance arranged by you, your association or your employer? Yes No
2. Has any insurance policy or application for loss of license insurance ever been declined, modified, accepted at an increased premium, canceled or refused renewal? Yes No
3. Have you ever claimed for benefits under any loss of license policy? Yes No

If any of your answers are "Yes", please provide full details (please use additional paper if necessary):

Selection of Cover

Sum Insured	Annual Premium (inclusive of prevailing GST)	
	Pilots, Flight Instructors and Multi-Crew Pilot	Air Traffic Controllers
S\$300,000	<input type="checkbox"/> S\$1,338	<input type="checkbox"/> S\$1,220
S\$200,000	<input type="checkbox"/> S\$960	<input type="checkbox"/> S\$835
S\$100,000	<input type="checkbox"/> S\$520	<input type="checkbox"/> S\$450
	Total Premium:	

Period of Insurance:

From _____ To _____

Mode of Payment

- Check¹** Bank: _____ Check No.: _____
- Credit Card**
- Full Payment
 - 0% Interest Instalment Plan²
 - I. Premium S\$500 and above:
 - II. Premium below S\$500 (subject to minimum premium S\$100)

Name of Proposer: _____

Mode of Payment

Name of Cardholder:
(as shown on card) _____

Credit Card No.: _____

Expiry Date: _____ / _____

Card Verification Value (CVV): _____

I hereby authorize Liberty Insurance Pte Ltd to debit my Credit Card account specified above.

¹Please cross your check & make payable to "LIBERTY INSURANCE PTE LTD". Kindly indicate (1) Name of Proposer; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your check.

²Only applicable for instalment payment through participating banks in Singapore and is subject to their Credit Card Agreement Terms & Conditions.

Automatic Renewal (Optional)

Yes, I wish to opt for auto renewal by annual GIRO payment.*

*Please complete the Interbank GIRO form and submit together with the Proposal Form.

PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and no benefits whatsoever shall be payable by the Company.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished 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 my policies, communicating with me, 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 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

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
- 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
- e) If we/I do not fully and faithfully give the facts as we/I know them or ought to know them, we/I may receive nothing from the policy

Date

Signature of Proposer