Liberty Insurance Pte Ltd
One Raffles Quay #25-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (542 3789)
Reg. No. 199002791D | GST Reg. No. M2-0093571-3
www.libertyinsurance.com.sg

Proposal Form - proMedico

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

Statement pursuant to Section 23(5) of the Insurance Act 1966 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

☐ Corporate

Name of Company: _____	Contact No.: _____
Mailing Address: _____ Postal Code ( )	
Nature of Business: _____	Email: _____
GST registered company[1]? Please select _____	

[1] If yes, please complete the GST Declaration Form

☐ Individual

Name of Individual: _____	Occupation: _____
Name of Employer: _____	Nature of Employer's Business: _____

Particulars of Insured Person

Name of Insured Person: _____	NRIC/FIN No.: _____
Mailing Address: _____ Postal Code ( )	
Email: _____	Contact No.: _____

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Name of Proposer:	_____

Particulars of Insured Person (cont'd)

Nationality: _____	Country of Residence: _____	Gender: Please select	
Date of Birth: _____	Marital Status: Please select _____	Height (m): _____m	Weight (kg): _____kg
Occupation: _____			

Particulars of Additional Insured Person(s) (Spouse/Children/Employee)

Name	Relationship	Date of Birth	NRIC/FIN No.	Country of Residence	Gender	Occupation	Weight (kg)/ Height (m)
					Please selec		
					Please selec		
					Please selec		
					Please selec		
					Please selec		
					Please selec		
					Please selec		
					Please selec		

Selection of Plan

Period of Insurance: From _____ To _____				Area of Coverage: Please select	
Basic Hospital & Surgical Coverage: Overall Annual Limit	☐ Premier: S$100,000 ☐ Premier Plus: S$250,000 ☐ Prime: S$500,000			☐ Prestige: S$1,000,000 ☐ Prestige Plus: S$1,500,000	
Premium Saving Options: Deductible limits per person per disability		Premier	Premier Plus	Prime	Prestige	Prestige Plus
NIL	0% discount	☐	☐	☐	☐	☐
S$2,500	15% discount	☐	☐	☐	☐	☐
S$5,000	30% discount	☐	☐	☐	☐	☐

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Name of Proposer:	_____

Selection of Plan (cont'd)

Premium Saving Options: Deductible limits per person per disability		Premier	Premier Plus	Prime	Prestige	Prestige Plus
S$7,500	40% discount	☐	☐	☐	☐	☐
S$10,000	50% discount	☐	☐	☐	☐	☐
Optional riders:		Plan 1	Plan 1	Plan 1	Plan 2	Plan 2
Outpatient Services		☐	☐	☐	☐	☐
Dental Care (must be taken in conjunction with Outpatient Services)		☐	☐	☐	☐	☐
Maternity Care[2]				☐	☐	☐

Important Notes
Proposal for children must include at least one parent under the same plan and coverage level.
Dependent's cover must be under the same plan and coverage level as the proposed Insured Member except Maternity Care benefit
[2] Maternity Care benefit only applicable to women between 19-45 years of age who have selected a proMedico Prime/ Prestige/Prestige Plus Basic Hospital and Surgical coverage on a NIL deductible basis.

Annual Premium

Annual Premium for Basic Hospital & Surgical Coverage:	S$
Premium Saving Options (Discount):	S$
Family Discount (if applicable):	S$
Optional Outpatient Services Rider:	S$
Optional Dental Care Rider:	S$
Optional Maternity Care Rider:	S$
Total Annual Premium excluding prevailing GST:	S$
plus prevailing GST:	S$
Total Annual Premium including prevailing GST:	S$

Health Statement

1. Have you or any of your Additional Insured Person(s) ever had, been told to have or been treated for any health condition relating to any Congenital abnormalities, either anatomical or functional, hereditary conditions, Premature birth? If 'yes', please provide details: _____	Please select

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Name of Proposer: _____

Health Statement (cont'd)

2. Have you or any of the Additional Insured Person(s) ever:	
a. had surgical operation?	Please select
b. been advised to have any test done such as x-ray, ultrasound, CT Scan, biopsy, electrocardiogram (ECG), endoscopy, blood or urine test? If "yes", please provide the type of test, reason, date of the test done and the result of the test (copy to be submitted if available). _____	Please select
3. Are you or any of the Additional Insured Person(s) currently undergoing any medical treatment, ever been treated, under observation for, or told that you or they had, any disorder or disease of the following:	
a. Skin, ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problems?	Please select
b. Stomach, intestines, liver, kidney, gall-bladder, pancreas, bladder, genitourinary system, cirrhosis, hernia, piles or used drugs for any other reason?	Please select
c. Diabetes (Type 1 or Type 2), protein in urine, or hormonal problem?	Please select
d. Lungs, bones, joints, ligament, asthma, bronchitis, pneumonia, tuberculosis, slipped disc, back trouble, fractures, arthritis, rheumatism, polio, muscular dystrophy?	Please select
e. Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine?	Please select
f. Lymphatic system, goiter, thyroid?	Please select
g. Any enlarge glands or any form of Cancer, tumors, AIDS or disorders of the blood?	Please select
h. For female only: • Do you or any person to be insured have or have ever had any of the signs, symptoms, illnesses related to gynaecological disorders including endometriosis, fibroids, cysts, polycystic ovaries, uterine polyps, menopause problems, pregnancy, irregular periods or bleeding, menstrual pain, complicated pregnancy, HPV infection, or an abnormal smear test result?	Please select
• Have you had or been advised to have mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or breasts or any other gynaecological investigations? If "yes", please state type, reason, date of test done and results of test (copy to be submitted if available). _____	Please select
i. For male only: Diseases or disorders of the male reproductive system, genitals or prostate? e.g., balanitis, benign prostatic hyperplasia (BPH) or enlarged prostate, cryptorchidism or undescended testicles, erectile dysfunction, fertility or infertility, phimosis and prostatitis.	Please select

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Name of Proposer	_____

Health Statement (cont'd)

j. Any other ailment, impairment, Bodily Injury, Accident, condition(s) or medical investigations not mentioned above? _____ If your answer to any of the above is "yes", please provide particulars in Question 5.	Please select
4. Have you or any of your Additional Insured Person(s) during the past 5 years, had any treatments, examinations or advices for a complaint by a Physician or other Medical Practitioners, at a clinic, hospital, dispensary, or sanitorium? If your answer to any of the above is "yes", please provide particulars in Question 5.	Please select
5. State full particulars of any affirmative answers to Questions 2, 3 and 4.	

Question No.	Name of Person(s)	Nature of Illness/ Disability	Date of Illness/ Disability	Duration of Illness/ Disability	Results of Treatment	Name & Address of Doctors and/or Hospital

6. Do you have any other medical insurance? If 'yes', please provide details:	Please select

Name of Insurer(s)	Period of Insurance
	From To
	From To
	From To

7. Has any Accident or Health policy covering you or any of the Additional Insured Person(s) ever been declined or its renewal refused? If 'yes', please provide details:	Please select

Name of Insurer(s)	Period of Insurance	Renewal Declined	Refused due to
	From To		
	From To		
	From To		

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Name of Proposer:	_____

Health Statement (cont'd)

8. Has any application made by you or any of the Additional Insured Person(s) for Life, Accident and Health insurance been declined, postponed, withdrawn or subject to special terms and conditions? If 'yes', please provide details:				Please select
Name of Insurer(s)	Period of Insurance		Application declined/ postponed/ withdrawn due to	Application subject to following special terms/conditions
	From	To		
	From	To		
	From	To		
9. Have you ever made a claim against any insurer in respect of Bodily Injury or sickness during the last 3 years? If 'yes', please provide details:				Please select
Name of Insurer(s)	Date of Claim	Nature of Claim		Claim Amount (S$)
				S$
				S$
				S$

10. Name of Doctor(s) – Mandatory Information (Do not input 'Nil' or 'N.A. - Not Applicable)

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

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Name of Proposer: _____

Mode of Payment (Mastercard/Visa/Amex/UOB IPP/DBS IPP)

Total annual premium including prevailing GST: S$

☐ Credit Card

1. The Proposer will receive a payment link from the Producer/Liberty via email. Please ensure the Proposer's email address is provided in this Proposal Form.
2. Upon clicking on the link, the Proposer will be directed to our authorized third-party payment gateway, 2C2P, for secure credit card payment.
3. The Policy will be issued upon successful payment of premium.
4. For information regarding other payment methods, please refer to https://www.libertyinsurance.com.sg/finance

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 cancelled and no benefits whatsoever shall be payable by the Company.

PREMIUM PAYMENT WARRANTY (CORPORATE)

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) within 60 days of the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and a pro-rata premium is to be charged for the period that the Company is on risk.

DECLARATION

I, the Proposer, declare and warrant that:

a) All information provided by me/us in connection with this application are true, accurate and complete

b) I agree that this application and declaration shall be the basis of the contract between Liberty and myself

c) I agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto

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

e) I agree to the policy terms, exclusions and conditions as expressed in the brochure, proposal form, policy wordings and endorsements

f) I/We have read & agreed entirely to all terms in Liberty's Data Protection Policy, available on request & also at www.libertyinsurance.com.sg/data-protection-policy, both now & in advance as it may be amended from time to time

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Name of Proposer: _____

IMPORTANT NOTICE TO SUBMITTER

If you, the submitter of this form, are submitting this form for another person who is the actual Proposer; and in consideration for Liberty processing this application upon your request:

a) You agree that you have been validly & legally authorised by the Proposer to do so; and

b) You warrant that you have shown this entire completed document to the intended Proposer and had obtained his/her agreement to everything; and

c) You, in your personal capacity, agree to indemnify and keep Liberty Insurance Pte Ltd indemnified against all proceedings, costs, expenses, claims, liabilities, losses or damages if any part of this Notice turns out to be false, howsoever whatsoever, on a strict liability basis, that is, even if your state of mind was unintentional, intentional, negligent, inadvertent, accidental, unknowing, etc

_____
Date

_____
Signatory of Insured Person
(for and on behalf of all persons to be insured)

_____
Date

_____
Name and Signatory of Proposer or Company's Authorized Person and Company Stamp (for corporate proposer)

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 us (servicecenter@libertyinsurance.com.sg) or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

Name of Proposer: _____

Declaration for Product Summary - proMedico

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

A duly signed copy must be filed with Liberty Insurance Pte Ltd for record purpose.

Presented to: Name of Proposer:	Expiry Date of Cover:
_____	_____

I/We, the Proposer, acknowledge that the Insurance Adviser has given me/us a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my/our satisfaction.

Name of Insured Person(s)	Gender	Age Next Birthday	Selected Plan	Deductible
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select
	Please select		Please select	Please select

_____
Date

_____
Signatory of Insured Person
(for and on behalf of all persons to be insured)

_____
Date

_____
Name and Signatory of Proposer or Company's Authorized Person and Company Stamp (for corporate proposer)

_____
Date

_____
Name and Signatory of Insurance Adviser