SOMPO

Sompo Insurance Singapore Pte. Ltd.
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Co. Reg. No.: 198905490E I GST Reg. No.: M200903196

Group Insurance Fact-Finding Form

Important Notice

1. **STATEMENT Pursuant to Section 25(5) of the Insurance Act** (or any subsequent amendments thereof) - We would remind you that you must disclose to us fully and faithfully the facts you know or ought to know otherwise you may not receive any benefits from your Policy.
2. Please note that this insurance is subject to the premium being paid and received in full by the Company
   a) before the inception date where the Policy is issued to an Individual; or
   b) within the period specified in the Premium Payment Warranty applied to the Policy in all other instances,
   failing which there will be no liability under this cover.
3. The liability of the Company does not commence until this Application is accepted and the premium is paid in accordance with clause 2 above.

Intermediary's Name / Code: ____

1. General Information

a) Proposer's Name: ____

b) Address of Company: ____

____

c) Tel: ______________ Fax: ______________ Email: ______________________

d) Principal Activity of Business: ____

e) Period of Insurance from ______________________ to ______________________
(dd/mm/yyyy) (dd/mm/yyyy)

f) Presently insured under other medical, hospitalization, accident or life insurance? **Yes / No** *

If **Yes**, Name of current insurer: ____

Type of Policy /Name of Plan: ____

Period of Insurance: From ______________________ to ______________________
(dd/mm/yyyy) (dd/mm/yyyy)

g) Total Number of Employees: ______________ Number of Employees to be Insured: ______________

Eligibility: Date of Employment/Confirmation* *(*delete where appropriate)*

h) The Insurer would assume that participation of the group insurance program is on compulsory basis, unless otherwise **indicated <u>with a tick here</u>** below under "Participation - Voluntary".

Insurance Coverage	**Participation**	
	Compulsory	**Voluntary**
Group Hospital & Surgical		
- for employees only		
- for dependents only		

Please note:
***Voluntary**: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s).*

2. Group Hospital & Surgical Insurance

a) **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**: Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.*

Example 1:

Category of Employees / Occupation	**R&B Benefit Plan**
i) Senior Management (Director, General Manager, Senior Manager)	360
ii) Manager & Executive	200
iii) All Others	100

b) **Details of Insured Members – Employees**

***Age Band**	**No. of Employees**									
	Plan 1		**Plan 2**		**Plan 3**		**Plan 4**		**Plan 5**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
< 19										
19 – 40										
41 – 50										
51 – 60										

** Based on Age Next Birthday*

c) **Details of Insured Members – Dependants**

***Age Band**	**No. of Dependants**									
	Plan 1		**Plan 2**		**Plan 3**		**Plan 4**		**Plan 5**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
< 19										
19 – 40										
41 – 50										
51 – 60										

** Based on Age Next Birthday*

c) **Details of Insured Members – Dependents**

***Age Band**	**No. of Dependents**									
	Plan 1		**Plan 2**		**Plan 3**		**Plan 4**		**Plan 5**	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
< 19										
19 – 40										
41 – 50										
51 – 60										

** Based on Age Next Birthday*

d) **Claims Experience for the past 3 years**

Name of Person as at ____________ (dd/mm/yyyy)	**Nature of Illness/ Injury**	**Date of Illness/ Disability**	**Result of treatment**	**Paid Claims**		**Outstanding Claims**	
				Number	**Amount**	**Number**	**Amount**

If more space is required, please write on a separate sheet of paper and attach herewith.
The Insurer reserves the right to request for more information.

e) Kindly attach a copy of the Schedule of Benefits (if currently insured).

f) Is there any member seriously ill (e.g. cancer, kidney failure, etc.) or in hospital? **Yes / No**

If **Yes**, kindly provide the following details:

Number of members: ____________________

Reason for hospitalization: ____________________

Nature of illness: ____________________

Kindly note that insurer would not reimburse the claim for any member in the hospital at the time of application.

g) Is there any member based outside Singapore? **Yes / No**

If **Yes**, kindly provide the following details:

Number of members: ____________________

Country based in: ____________________

h) Is there any member engaged in hazardous occupation? **Yes / No**
(Hazardous occupation e.g. welder, diver, rigger, sandblaster, offshore workers, etc.)

If **Yes**, what is the nature of work? ____________________

i) To the best of your knowledge, is there any member engaged in hazardous sports? **Yes / No**
(Hazardous sports e.g. scuba diving, motor racing, bungee jumping, etc.)

If **Yes**, what kind of sports? ____________________

3. Needs Analysis & Product Recommendation

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

Company's Priorities	Low	Med	High	Advisor's Recommendation
Cover for Outpatient Medical Expenses	☐	☐	☐	________________
Cover for Hospitals & 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 : ____

4. Coverage Required For Mediwell Plus Application

Employees		**Plan** Indicate Plan Type/No. of Unit plan required		**Optional Riders** (please ✓ below)			Choice of Deductible/Co-insurance	
Category	**No.**	**Aggregate Plan**	**Unit Plan (max 4 units)**	**Dread Disease Rider**	**Hospital Cash Allowance**	**Parent's Accommodation as Companion**	**Deductible** (S$)	**Co-insurance (%)**

5. Insurance History

a) Has any Accident or Health policy covering you ever been cancelled or renewal refused? **Yes / No**
If **Yes**, give details: ____

b) Has any proposal or application made by you for a Life, Accident or Health policy insurance ever been declined, postponed or accepted at other than normal terms? **Yes / No**
If **Yes**, give details:

____

DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that the statements and answers given in this enrolment form and health declarations are true and complete and that I/we have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I/We understand that any misstatement of fact, whether by commission or omission may be grounds for the Insurance Company in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I/We agree that if a contract of insurance is effected, all information submitted in connection with this application, including the proposal and health declaration forms completed by the respective insured persons, shall form the basis of such contract between me/us and the Insurance Company and shall be deemed to be incorporated in such contract. I/We understand that this insurance if accepted will be an annual contract renewable at the discretion of the Insurance Company.

☐ Please charge S$ _______________ to our Visa / MasterCard* (delete as appropriate)

Card No__ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expiry Date__ __ / __ __

☐ We enclose a cheque for S$__________(including GST) payable to **Sompo Insurance Singapore Pte. Ltd**.

Bank/Cheque No.______________________________________

____
Signature of Applicant
on behalf of person(s) to be insured

Name:
Designation:
Company Stamp (if applicable):
Date:

____
Signature of Authorised Officer

Name:
Designation:
Company Stamp (if applicable):
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 Insurance Representative

Name / NRIC:
Designation:
Company Stamp (if applicable):
Date: