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

Pre-contract disclosure for medical insurance plans for Work Permit and S Pass Holders

PRODUCT NAME: GROUP MEDIWELL CLASSIC INSURANCE

This product provides coverage for the following features that comply with the Ministry of Manpower's (MOM) enhanced Medical Insurance requirements[1]:

	Yes/No
Annual claim limit of at least $60,000, inclusive of a first-dollar cover of $15,000	Yes
For portion of the bill above $15,000, the employer must co-pay up to 25% (to the hospital)	Yes
Exclusions are in line with MOM's list of allowable exclusions[2]	Yes
Age-differentiated premiums are in 2 age bands: (1) ≤50 years old and (2) >50 years old	Yes
Insurers will reimburse our portion of the hospital bill to hospitals directly upon admissibility of the medical claim	No

[1] Scan the QR code for MOM's press release on the enhanced medical insurance.

[2] Refer to link below for the list of allowable exclusions.

https://www.mom.gov.sg/-/media/mom/documents/press-releases/2023/annex_implementation-ofenhanced-medical-insurance-for-foreign-employees-to-better-support-employers.pdf

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Group Mediwell Classic Proposal 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: _____ **Intermediary's Code:** _____

1. General Information

Name of Company: _____

Address of Company: _____

Nature of Business: _____

ROC: _____ Tel :_____ E-mail:_____

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

Total Number of Employees: _____ Number of Employees to be Insured: _____

2. Insurance History

a) Are you currently insured under any other medical, hospitalization, accident or life insurance (excluding schemes provided by CPF)? If "**Yes**", please give details:

Name of Insurance Company _____

Type of Coverage or Product Name _____

b) Has any Accident or Health policy covering you ever been cancelled or its renewal refused? If "**Yes**", give details:

_____

c) 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? If "**Yes**", give details:

_____

3. Claims Experience for Past 3 Years

Name of Person	Nature of Illness/ Injury	Date of Claim	Result of treatment	Paid Claims	Outstanding Claims

4. Coverage Required

☐ Plan 1 (Co-Payment)

☐ Plan 2 (No Co-Payment)

S/N	Name of Employee to Be Insured	Work Permit / S Pass No.	Gender	Date of Birth	Occupation
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that all the employees listed are in good health and free from physical defects or infirmity and that the statements and answers given in this enrolment form and health declarations are true, accurate 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 Sompo Insurance Singapore Pte. Ltd. ("Sompo") 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 if such contract between me/us and Sompo 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 Sompo.

I/We acknowledge and agree (in case of corporate policy, I/we represent that I/we have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my/our personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg

I/We consent to receive marketing and promotional information from Sompo (e.g. via email, mail, SMS, etc.). I/We understand that I/we can withdraw or manage my/our consent to receive marketing and promotional information at www.sompo.com.sg

_____ _____

Signature of Authorized Personnel
Name of Authorized Signatory:
Designation:
Company Stamp (if applicable):

Date

I/We declare and acknowledge that I/We have reviewed this Group Hospital & Surgical Insurance application with the authorized officer of the Company, and that I/We have explained all requirements of this application form to him/her.

_____ _____

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

Date