SOMPO INSURANCE

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

Group Mediwell Plus Individual Health Declaration 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: ____

Group Insurance (for group compulsory/voluntary scheme)

A. The Applicant

Name of Employee ____

Name of Employer ____

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

Period of Insurance: From ______________________ to ________________

Marital Status ____________ Tel ______________ (O) ______________ (H)

B. Particulars of Person(s) to be Insured
Details of Spouse and child(ren) are required only if they are included in this cover

Relation	Name	NRIC/ Passport No.	Birth Date	Occupation & Biz/Trade	Sex	Wt (kg)	Ht (m)
Employee							
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

C. Habits of Person(s) to be Insured			Answer only if Insured			
	Self		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Have you and the person(s) to be insured been smoking in the past 12 months? If "**Yes**", please specify Name of person(s) ______________ No. of years smoking ________ No. of sticks ________ daily	☐	☐	☐	☐	☐	☐
2. Do you and the person(s) to be insured consume beer, wine or other alcohol? If "**Yes**", please specify consumption per week. Name of person(s) ______________ Beer ________ cans (330ml) Wine ________ glasses (100ml) Spirits ______ tots (30ml) Others (please specify type and amount of consumption): ______	☐	☐	☐	☐	☐	☐

	Yes	No	Yes	No	Yes	No
3. Have you and the person(s) to be insured ever taken any habit forming drugs or been treated for drug addiction?	☐	☐	☐	☐	☐	☐
4. Do you and the person(s) to be insured engage in or intend to engage in any sports of hazardous nature (e.g. diving, flying, motor-racing etc.)? If "**Yes**", please give details ______	☐	☐	☐	☐	☐	☐

D. Health Declarations **For Applicant and Person(s) to be insured. You may be required to complete a separate questionnaire for any health conditions declared below.**			**Answer only if Insured**			
	Self		**Spouse**		**Child(ren)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
1. Have you or the person(s) to be insured had any health screening with abnormal results during the last 2 years?	☐	☐	☐	☐	☐	☐
2. Have you or the person(s) to be insured ever						
a) Had a surgical procedure?	☐	☐	☐	☐	☐	☐
b) Been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed?	☐	☐	☐	☐	☐	☐
c) Received any medical advice, counselling or treatment in connection with sexually transmitted disease (e.g. gonorrhoea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDS?	☐	☐	☐	☐	☐	☐
3. Are you or the person(s) to be insured currently undergoing any medical treatment for, ever been treated for, under observation for, or have been told of, any disorder or disease of the following:-						
a) Ears, throat, eyes or other physical disability or condition affecting hearing, speech or sight, otitis media, ear discharge, tonsils, cataracts, glaucoma, detached retina, ear infection?	☐	☐	☐	☐	☐	☐
b) Digestive system, liver, gallbladder, stomach, pancreas, intestines, hepatitis, cirrhosis, stones, hernia, gastritis, ulcer, gastric/intestinal polyp, piles/haemorrhoids, fistula, chronic diarrhoea, irritable bowel disease, rectal bleeding?	☐	☐	☐	☐	☐	☐
c) Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis?	☐	☐	☐	☐	☐	☐
d) Heart attack, angina, chest pain, rheumatic fever, murmur, heart valve disorder, irregular or fast heart rate, coronary artery disease, high blood pressure, high cholesterol or any disease or disorder of the heart or the blood vessels?	☐	☐	☐	☐	☐	☐
e) Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system?	☐	☐	☐	☐	☐	☐
f) Brain, mental or nervous system disorder, fits, epilepsy, paralysis, stroke, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, loss of balance, dizziness, fainting spells, anxiety or depression?	☐	☐	☐	☐	☐	☐
g) Albumin, protein, blood, sugar or pus in urine, kidney stones, urinary tract infection, prostate problem, incontinence or any disease or disorder of the kidney, bladder or genitourinary system?	☐	☐	☐	☐	☐	☐
h) Gout, arthritis, slipped-disc, persistent back / neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE) or any disease or disorder of the spine, bones, limbs, joints, muscles or connective tissues?	☐	☐	☐	☐	☐	☐
i) Cancer, tumour, cyst or growth of any kind?	☐	☐	☐	☐	☐	☐
j) Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood?	☐	☐	☐	☐	☐	☐
k) Physical defects/deformities, congenital anomalies, premature birth?	☐	☐	☐	☐	☐	☐
l) Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above?	☐	☐	☐	☐	☐	☐
m) Any other illnesses not listed above, please give details on separate sheets.	☐	☐	☐	☐	☐	☐

	Yes	No	Yes	No	Yes	No
4. During the past five years have you or the person(s) to be insured consulted a physician for a general examination or for any reasons not previously noted on this application?	☐	☐	☐	☐	☐	☐
For Female Only (Question 5 and 6)			**Answer only if Insured**			
	Self		**Spouse**		**Child(ren)**	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
5. Have you or the person(s) to be insured ever suffered from or been treated for any disease or disorder of the breasts or female organs (uterus, ovary, fallopian tube, cervix, etc.) including abnormal Pap smear and irregular menses?	☐	☐	☐	☐	☐	☐
6a. Are you or the person(s) to be insured now pregnant? Expected delivery date: _______________________________	☐	☐	☐	☐	☐	☐
6b. Any complication(s) relating to this / previous pregnancies? If yes, please specify: *Gestational Diabetes / Eclampsia / Hypertension/ Others(please state): ____	☐	☐	☐	☐	☐	☐

If you answer "**Yes**" to questions D1 to D6, please provide full details.

Qn No.	Name of Person	Nature of Illness/ Injury	Date of Diagnosis/ Disability	Date of operation	In-patient or Out-patient	Date of last treatment/ symptoms/ visit to doctor	Result of Treatment	Name & Address of Physician/ Hospital

	Self		**Answer only if Insured**			
			Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
7. Has any Accident or Health policy covering you or the person(s) to be insured ever been cancelled or its renewal refused? If "**Yes**", give details/reasons:	☐	☐	☐	☐	☐	☐
8. 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/reasons:	☐	☐	☐	☐	☐	☐
9. Have you ever made a claim against any Insurance Company in respect of bodily injury or sickness during the past 3 years? If "**Yes**", give details:	☐	☐	☐	☐	☐	☐

Name of Person	Nature / Diagnosis of Illness/Injury	Date of Diagnosis / Disability	Result of Treatment	Paid Claims	Outstanding Claims

DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that the statements and answers given in this health declaration 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 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 this proposal and declaration shall be the basis of the 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

For group VOLUNTARY scheme only:
I/We have been given a copy of 'Your Guide to Health Insurance' and 'Product Summary' and their contents have been explained to my/our satisfaction.

____	____
Signature of Employee	Company Stamp and/or Signature of Employer
Designation:	Name of Authorised Signatory:
Date:	Designation:
	Date :