Sompo Insurance Singapore Pte. Ltd.
50 Raffles Place, #05-01/06, Singapore Land Tower, Singapore 048623
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Co. Reg. No.: 198905490E | GST Reg. No.: M200903196

MediLite Pre-Application

Please complete this section before proceeding to the Application
(Not applicable for Direct Marketing and Corporate Applicants)

Important Notice
1. If you are a citizen or permanent resident of Singapore, you are covered by MediShield Life for life, for treatment in Singapore, regardless of pre-existing medical conditions or other circumstances that you face. For more details on your coverage, please visit www.medishieldlife.sg.
2. This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.
3. This is a short-term accident and health policy and the insurer is not required to renew this policy. The Insurer may terminate this policy by giving you 30 days' notice in writing.

Insurance Advisor

Your Insurance Advisor is a representative of Sompo Insurance Singapore Pte. Ltd. and can advise you on MediLite.

Name of Insurance Advisor:	Code:

Pre-Application

I am interested to find out more from my insurance advisor to review if MediLite is suitable for me and/or my family. I understand that my insurance advisor must have sufficient information before making a suitable recommendation and the "Know Your Client Form" is a Fact Find Form that allows me to provide information on my financial situation and particular needs, which will be the basis on which advice will be given.

My choice is ☑

❑ 1. To disclose all information requested for in the "Know Your Client Form" (KYCF) to help the insurance advisor access my insurance needs and requirements.

❑ 2. To receive product advice only. (Please see Advisor's Recommendation)

❑ 3. To make the purchase decision without receiving any advice from my Advisor.

Advisor Analysis and Recommendations – Where Client Requires Product Advice Only

Advisor's Recommendations	Reasons for Recommendations	Remarks
❑ Hospital Cash Income and/or Other Protection eg. MediLite		

I agree / do not agree* with the proposed recommendation(s).

Signature of Client : _____ Signature of Spouse* : _____

Date : _____ Date : _____

* Where spouse is one of the proposed lives to be insured.

Signature of Advisor : _____ Date: _____

FOR OFFICIAL USE ONLY – INTERNAL

MediLite Application Form

Important Notice

1. **Statement Pursuant to Section 25(5) of the Insurance Act** you are to 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.
4. This form is valid for three months from date of application, after which has to be re-completed and signed by applicant.

* To be completed as applicable

The Applicant

Name:	
Address :	
NRIC/Passport/ROC No. (whichever applicable):	Nationality *:
Occupation/Profession *:	Business/Trade:
Marital Status *:	E-mail:
Tel: (HP)	(O) (H)

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. / Nationality	Birth Date	Occupation & Biz/Trade	Sex	Wt (kg)	Ht (m)
Self							
Spouse							
Child 1							
Child 2							
Child 3							

Coverage Required

Period of insurance: From to

MediLite

	Self	Spouse	Child 1	Child 2	Child 3
Plan – Circle selected Plan code (Plans 1 to 3)	**1 / 2 / 3**	**1 / 2 / 3**	**1 / 2 / 3**	**1 / 2 / 3**	**1 / 2 / 3**
PREMIUM CALCULATION					
GRAND TOTAL PREMIUM (Inclusive GST) S$					

Lifestyle & Habits of Person(s) to be Insured

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 cigarettes per day _____	Yes / No
Do you and the person(s) to be insured consume beer, wine or other alcohol? If yes, please specify. Name of person(s) _____ Beer _____ cans (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) per week Others (please specify type and amount of consumption): _____	Yes / No
Have you and the person(s) to be insured ever taken any habit forming drugs or been treated for drug addiction?	Yes / No
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:	Yes / No

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.

1. Have you had any health screening with abnormal results during the last 2 years?	Yes / No
2. Have you ever	
(a) Had a surgical procedure?	Yes / No
(b) Been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed?	Yes / No
(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?	Yes / No
3. Are you 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?	Yes / No
(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?	Yes / No
(c) Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis?	Yes / No
(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?	Yes / No
(e) Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system?	Yes / No
(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?	Yes / No
(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?	Yes / No
(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?	Yes / No
(i) Cancer, tumour, cyst or growth of any kind?	Yes / No
(j) Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood?	Yes / No
(k) Physical defects/deformities, congenital anomalies, premature birth?	Yes / No
(l) Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above?	Yes / No
(m) Any other illnesses not listed above, please give details on separate sheets.	Yes / No
4. During the past five years, have you consulted a physician for a general examination or for any reasons not previously noted on this application?	Yes / No
5. Have any of your natural parents or any siblings died or suffered from cancer, heart disease, kidney disease, stroke, diabetes, high blood pressure, mental disorder, tuberculosis or any contagious disease or any hereditary disease or disorder?	Yes / No

Relationship	Age at Onset	Current Age / Age at Death	Diagnosis

For Female Only (Questions 6 & 7)

6. Have you 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?	Yes / No
7a. Are you now pregnant? Name: _____ Expected delivery date: _____	Yes / No
7b. Any complication(s) relating to this / previous pregnancies? If yes, please specify: *Gestational Diabetes / Eclampsia / Hypertension / Others (please state): _____	Yes / No

If you answer "Yes" to questions 1 to 4, 6 to 7, please provide full details.

Qn No	Name of Person	Diagnosis/Description of Illness/Injury	Date of No Diagnosis/ Disability	Type of Treatment	Date & Result of last Treatment / visit to Doctor	Name & Address of Doctor consulted

Remarks:

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, cancelled or renewal refused? If "Yes", please give details/reasons:	Yes / No

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", please give details: Yes / No

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

Declaration

I hereby declare to the best of my knowledge and belief that the statements and answers given in this health declaration are true and complete and that I have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I understand that any misstatement of fact, whether by commission or omission may be grounds for Sompo Insurance Singapore Pte. Ltd. in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable and agree that this proposal and declaration shall be the basis of the contract between me and Sompo Insurance Singapore Pte. Ltd. and shall be deemed to be incorporated in such contract.

I understand that all Pre-Existing Conditions before the effective date of this Policy are not covered.

I am aware that I can seek advice from a qualified insurance advisor before completing this proposal form, and will take responsibility to check that this product is appropriate to my financial needs and insurance objectives. *(Applicable to Direct Marketing)*

I have received the booklet 'Your Guide to Health Insurance' as well as the MediLite brochure, which provides the Product Summary on key product information and provisions, the contents of which have been explained to my satisfaction. *(Not Applicable to Direct Marketing)*

I / We acknowledge and agree (in case of corporate policy, I represent that I 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

I / We am / are aware of and agree to abide by the Policy terms, conditions and exclusions and confirm that the information given in this application/form is true, accurate and complete.

I confirm I have been given the Product Summary Version : ❑ MediLite May 2016* / _____

Note: * delete and state new version code (if different)

❑ Please charge S$_____ to my Visa / Mastercard* (*delete as appropriate)

Where a third party credit card is used, I/We declare that the cardholder has authorized and consented to such use.

Card No. ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ – ☐☐☐☐ Expiry Date: ☐☐ – ☐☐

❑ I/We enclose a cheque for S$ _____ payable to Sompo Insurance Singapore Pte. Ltd.

Bank / Cheque No.: _____

_____ _____

Signature of Applicant
on behalf of person(s) to be insured
(Affix company stamp where applicant is a corporate entity)

Signature of Employee's/Applicant's Spouse
(Where spouse is a person to be insured) on behalf of person(s) to be insured

_____ _____

Signature of Employee
(Where applicant is a corporate entity) on behalf of person(s) to be insured

Date

_____ _____

Signature of Advisor

Date