

Group Mediwell Plus 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 / Code: _____

1. The Applicant

Name of Applicant/Company: _____

Address of Company: _____

Nature of Business: _____

ROC: _____ Tel: _____ E-mail: _____

Period of Insurance: From _____ to _____

Employees: Total No. _____ No. to be insured _____ Eligibility: Date of Employment/Confirmation*
 (*delete where appropriate)

2. Insurance History

- a) Are you currently insured under any other medical, hospitalisation, 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 Disability	Result of Treatment	Paid Claims	Outstanding Claims

4. Coverage Required

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 (%)

DECLARATION

We hereby declare to the best of our knowledge and belief that the statements and answers given in this enrolment form and health declarations are true, accurate and complete and that we have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. 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.

We agree that this proposal and health declaration forms completed by the respective insured persons shall be the basis of the contract between us and Sompo and shall be deemed to be incorporated in such contract. We understand that this insurance if accepted will be an annual contract renewable at the discretion of Sompo.

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 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

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

Company Stamp and/or Signature of Applicant

Date

Name of Authorised Signatory:

Designation: