APPLICATION FORM
FULL MEDICAL UNDERWRITING

MyHEALTH INDIVIDUAL MEDICAL PLANS

www.april-international.com

Liberty Insurance

april international

Please print only if necessary

YOUR APPLICATION, STEP BY STEP.

THIS IS YOUR APPLICATION FORM. COMPLETE IT, SIGN IT, SEND IT.

WANT TO SAVE TIME?
THE SUBMIT BUTTON AT THE END OF THIS FORM ALLOWS YOU TO SEND A SOFT COPY FOR US TO START THE PROCESS.
WE WILL ARRANGE FOR THE SIGNING OF THE FORM AT A LATER STAGE

AN UNDERWRITING OFFER WILL BE PROVIDED IN 2 WORKING DAYS OR LESS.

ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- ☑ your member pack
- ☑ your insurance documents
- ☑ the policy terms and conditions detailing how your policy operates
- ☑ your member card containing emergency contact numbers for requesting assistance services or before admission to hospital
- ☑ a claim form, claim instructions and useful contact information

I YOUR DETAILS

IMPORTANT NOTICE:

Statement pursuant to Section 25 (5) Cap. 142 of the Insurance Act or any subsequent amendments thereof – You are to disclose in this proposal form fully and faithfully all the facts which you know or ought to know about the risk that is being proposed, otherwise the policy issued hereunder may be void.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Liberty Insurance or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

DECLARATION FOR PRODUCT SUMMARY

Name of Applicant: _____

I/We, the Applicant, acknowledge that the Insurance Advisor has given me/us a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my/our satisfaction.

Signature of Applicant
(for and on behalf of all insured persons)
Date: DD/MM/YYYY

Signature of Insurance Advisor
Name of Insurance Advisor:
Date: DD/MM/YYYY

APPLICANT'S DETAILS

Family Name: _____

First Name(s): _____

Date of Birth: D D / M M / Y Y Y Y **Gender:** ◯ Male ◯ Female **Height (cm):** **Weight (kg):**

Occupation: _____
(specify nature of duties) _____

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Smoker: ◯ Yes ◯ No **Marital Status:** _____

Nationality: _____ **NRIC/Passport No.:** _____

Address: _____

_____

Tel.: _____ **Mobile:** _____

Email: _____

Important: this email will be used for sending claims-related communication which may include sensitive medical information.

FAMILY MEMBERS TO BE INSURED

	Spouse/Partner	Child 1	Child 2	Child 3
		Unmarried children proposed for insurance must be aged 18 or under. Unmarried children over 18 in full-time education can be covered up to 23 years old.		
Family Name				
First Name(s)				
Date of Birth	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y	D D / M M / Y Y Y Y
Gender	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male	◯ Female ◯ Male
Marital Status				
Nationality				
Smoker	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
ID/Passport No.				
Occupation (specify nature of duties)				
Height and Weight	cm kg	cm kg	cm kg	cm kg

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I YOUR DETAILS

CHOOSE YOUR COVER

Step 1: Select your Core Cover

The following core modules form the base of your policy. Each member has the flexibility to select the cover they want.

If dependants will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

CORE MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Hospital and Surgery	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Annual Deductible	☐ Nil ☐ SGD 2,000 ☐ SGD 5,000 ☐ SGD 10,000	☐ Nil ☐ SGD 2,000 ☐ SGD 5,000 ☐ SGD 10,000	☐ Nil ☐ SGD 2,000 ☐ SGD 5,000 ☐ SGD 10,000	☐ Nil ☐ SGD 2,000 ☐ SGD 5,000 ☐ SGD 10,000	☐ Nil ☐ SGD 2,000 ☐ SGD 5,000 ☐ SGD 10,000
	• Your selected deductible applies to the Hospital and Surgery module only.				
Area of Cover	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide	☐ Worldwide excluding USA ☐ Worldwide
	• The area of cover chosen will apply to all modules selected. • Services rendered outside of the area of cover are covered up to SGD 65,000 per period of insurance, only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip in the USA. • Please refer to clause 4 of the Policy Terms and Conditions.				

Step 2: Select any Optional Modules that you wish

The following modules are optional. Each member has the flexibility to select the cover they want.

If dependants will have the same cover as the Applicant, please tick here ☐ and complete cover options for the Applicant only.

OPTIONAL MODULES	APPLICANT	SPOUSE/PARTNER	CHILD 1	CHILD 2	CHILD 3
Outpatient	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Dental and/or Optical included with Elite plan only	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite	☐ Essential ☐ Extensive ☐ Elite
Maternity	☐ SGD 7,000 ☐ SGD 13,500 ☐ SGD 20,000	☐ SGD 7,000 ☐ SGD 13,500 ☐ SGD 20,000	☐ SGD 7,000 ☐ SGD 13,500 ☐ SGD 20,000	☐ SGD 7,000 ☐ SGD 13,500 ☐ SGD 20,000	☐ SGD 7,000 ☐ SGD 13,500 ☐ SGD 20,000
	• **Important:** Available to women between 19 to 45 years of age who have selected at minimum an Extensive or Elite Hospital and Surgery on a NIL deductible basis, plus an optional Outpatient module.				

UNDERWRITING QUESTIONNAIRE II

INSURANCE DETAILS

Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.	◯ Yes ◯ No
Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).	◯ Yes ◯ No
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.	◯ Yes ◯ No

MEDICAL DETAILS AND HISTORY

Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.

1	Cancer, leukaemia, tumour or neoplasm (including benign growths), cysts including fibrocystic breast disorder, or any blood disorder	◯ Yes ◯ No
2	Asthma, chronic bronchitis, allergies, chronic rhinitis or sinusitis, tuberculosis, any disease or disorder of the lungs	◯ Yes ◯ No
3	Chest pain, raised blood pressure, heart condition, circulatory disorder	◯ Yes ◯ No
4	Indigestion, gastric reflux, gastric ulcer, haemorrhoids	◯ Yes ◯ No
5	Spinal condition, bone fracture, joint injury, back, neck or muscle pain	◯ Yes ◯ No
6	Malaria, dengue fever, other tropical illness	◯ Yes ◯ No
7	HIV/AIDS	◯ Yes ◯ No
8	Kidney Stones, kidney disorder, disorder of the urinary bladder or tract	◯ Yes ◯ No
9	Diabetes, liver disorder, hepatitis	◯ Yes ◯ No
10	Disorder of the brain or nervous system, stroke, aneurysm	◯ Yes ◯ No
11	Mental health problem, anxiety, addiction	◯ Yes ◯ No
12	Gynaecological disorders including pregnancy, irregular periods or bleeding, menstrual pain, complicated pregnancy, HPV infection, or an abnormal smear test result	◯ Yes ◯ No
13	Eczema, dermatitis, disorder of eyes, ears	◯ Yes ◯ No
14	Congenital conditions	◯ Yes ◯ No
15	Any other disorder/injury	◯ Yes ◯ No

II UNDERWRITING QUESTIONNAIRE

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured	Question no.	Date of first consultation	Details of Medical condition, including nature of treatment, results, date of last consultation,and whether you have fully recovered	Name & Address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY
		DD/MM/YYYY			◯ Yes ◯ No DD/MM/YYYY

Please provide more details on a separate sheet if required.

16	Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or (within the last five years) undergone any procedures, scans, or diagnostic tests whether as an inpatient or outpatient? If Yes, please give details. _____	◯ Yes ◯ No
17	Are you or any person to be insured currently taking any medication? If Yes, please state the medicine name, dosage and the approximate cost. _____	◯ Yes ◯ No
18	Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. If you have never seen a doctor in the past 3 years, please indicate that below. Name: _____ Address: _____ _____ Telephone: _____ Fax: _____ Email: _____	
19	Have you or any person to be insured ever made a claim with any insurer in respect of bodily injury or sickness during the last 3 years? If yes, please give details. Name of Claimant: _____ Name of Insurer: _____ Nature of Claim: _____ Date of Claim: _____	◯ Yes ◯ No

Please provide more details on a separate sheet if required.

ADDITIONAL SPACE FOR FURTHER REMARKS

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

COMMENCEMENT DATE

◯ **On Acceptance**

◯ **Another Date:**
(We cannot backdate cover to a date earlier than the date you accept our final offer.)

INTERMEDIARY ACCESS

Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account?

◯ Yes ◯ No

Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?

◯ Yes ◯ No

Producer Name: _____ Producer Code: _____

Company Name: _____

Telephone: _____ Email: _____

III PAYMENT METHODS

◯ **Cash**

◯ **Cheque – Annual Payment Only**
Cheques should be drawn on a Singapore clearing bank and made payable to "Liberty Insurance Pte Ltd". Kindly indicate (1) Name of Applicant or policyholder; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your cheque

◯ **Bank Transfer – Annual Payment Only**

Beneficiary Name:	Liberty Insurance Pte Ltd.
Beneficiary Address:	51 Club Street, Liberty House, #03-00, Singapore 069428
Bank Name:	UOB
Bank Account No:	451-304-455-5
Bank Address:	80 Raffles Place, #29-03 UOB Plaza 1, Singapore 048624
Bank Code:	7375
Branch Code:	001
Swift Code:	UOVBSGSG
Currency:	SGD

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number as a payment detail to your bank.
3. Please fax (+65) 6222 4473 or email contact.sg@april.com the bank remittance advice or instruction slip with your Policy Number to us for our accounting records and to issue an Official Receipt.

◯ **GIRO - Quarterly Payment**
Please complete the Interbank GIRO form and submit together with the Application Form

◯ **Credit Card – Annual or Instalment Payment** ◯ MasterCard ◯ VISA

☐ Full Payment

☐ 0% Interest Instalment Plan[1]

☐ Citibank - 6 months	☐ Standard Chartered - 6 months
☐ Citibank - 12 months	☐ Standard Chartered - 12 months
☐ DBS/POSB - 6 months	☐ United Overseas Bank - 6 months
☐ DBS/POSB - 12 months	☐ United Overseas Bank - 12 months

Name of Cardholder:
(as shown on card) _____

Credit Card No.: | | | | | – | | | | | – | | | | | – | | | |

Expiry Date: | | / | | | **Card Verification Value (CVV):** | | | |

[1] Only applicable for instalment payment through participating banks in Singapore and is subject to their Credit Card Agreement Terms & Conditions.

PERSONAL DATA PROTECTION

I/We give consent to Liberty Insurance Pte Ltd ("Liberty") and its employees, related companies, agents and service providers to collect, use and disclose all personal and credit card data for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to premium payment, collection, accounting, audit, compliance, regulatory, research, analysis, verification, and dispute resolution. I/We have read and agreed to the terms of the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If any personal data furnished is not about me/us, I/we warrant that I/we have obtained consent from the data subject (or if lacking in legal capacity, his/her legal representatives, guardians or parents as the case may be) for Liberty to collect, use and disclose his/her personal data for the above purposes and on the terms in this document, and as if the said data are about me/us. I/We warrant that all personal data I/we have provided are accurate and complete, and I/we will inform Liberty of any changes to the data as soon as practicable.

_____

Signature of Cardholder

Notes: The liability of the Company (Liberty Insurance Pte Ltd) commences only when the proposal/renewal has been accepted by the Company and premium successfully deducted. Acceptance of premium does not constitute acceptance of liability.

ACKNOWLEDGEMENT & PERSONAL DATA PROTECTION ACT (PDPA) IV

PERSONAL DATA PROTECTION STATEMENT

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION BY APPLICANT

I/We do hereby declare and warrant that:

a) All information provided by me/us in connection with this application is true, accurate and complete. I/We have not withheld any material fact and except as declared herein all persons to be insured are currently in good health to the best of my/our knowledge and belief.

b) I/We understand that any inaccurate, incomplete or false information given or any omission of information required, may at Liberty Insurance Pte Ltd's (**"Liberty"**, the **"Company"**) discretion, render this application invalid.

c) I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.

d) I/We agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

e) I/We agree to inform if there is any change in any of the details I have provided to Liberty in this application. I understand and agree that it is my sole responsibility to inform and update Liberty of any changes to the health or personal information of any person to be insured. I hereby agree to indemnify and absolve Liberty of any liability arising out of any use and/or disclosure by Liberty of any inaccurate or incomplete information due to my failure to update Liberty promptly of any changes to the health or personal information of any person to be insured.

Name & Title	Signature	DD/MM/YYYY Date

Important: *The application form must be sent to us within 14 days from this date for your application to be valid.*

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
51 Club Street #03-00 Liberty House
Singapore 069428
Tel: 1800-LIBERTY(5423 789) | Fax: (+65) 6223 6434

Arranged by:

GlobalHealth Asia Pte. Ltd.
A fully owned subsidiary of APRIL International SA
Co. Reg. No. 200613924G
60 Paya Lebar Road, #06-45 Paya Lebar Square
Singapore 089315
Tel: (+65) 6736 0057 | Fax: (+65) 6222 4473
Email: contact.sg@april.com

Liberty Insurance

april international

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Click SUBMIT if want your default email program to send this document to us.

Alternatively, save this file and send it to contact.sg@april.com

OR

PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to contact.sg@april.com

Mail to APRIL
60 Paya Lebar Road,
#06-45 Paya Lebar Square
Singapore 409051