Liberty Insurance

www.libertyinsurance.com.sg

Proposal Form

proMedico Plus

Please complete all sections to facilitate the processing of your application.

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

Name of Producer & Producer Code: _____

Particulars of Proposer

☐ Corporate

Name of Proposer:	**Contact No.:**
_____	_____
Mailing Address: _____ Postal Code ( )	
Email:	**Nature of Business:**
_____	_____

☐ Individual

Name of Proposer:	**Occupation:**
_____	_____
Name of Employer:	**Nature of Employer's Business:**
_____	_____

Particulars of Insured Person

Name of Insured Person:		**NRIC/FIN No.:**	
_____		_____	
Mailing Address: _____ Postal Code ( )			
Email:		**Contact No.:**	
_____		_____	
Nationality:	**Country of Residence:**	**Gender:** ☐ Female ☐ Male	
_____	_____		
Date of Birth:	**Marital Status:**	**Height (m):**	**Weight (kg):**
_____	_____	_____m	_____kg
Occupation: _____			

Name of Proposer: _____

Particulars of Additional Insured Person(s) (Spouse/Children/Employee)

Name	Relationship	Date of Birth	NRIC/ FIN No.	Country of Residence	Gender	Occupation	Weight / Height

Selection of Plan

☐ **Essential Plus** ☐ **Economy Plus** ☐ **Executive Plus** ☐ **International Plus**

☐ **Rider-Outpatient Services (Optional)** **Premium Saving Options**

Annual Premium:

Annual Premium: S$_____

Family (Discount): S$_____

Premium Saving Options (Discount): S$_____

Rider-Outpatient Services (Optional): S$_____

Total Annual Premium excluding prevailing GST (7%): S$_____

plus prevailing GST (7%): S$_____

Total Annual Premium including prevailing GST (7%): S$_____

Period of Insurance: From _____ To _____

Health Statement

1. **Have you or any of your Additional Insured Person(s) ever had any physical defects or infirmity?** ☐ Yes ☐ No
   If 'Yes', please provide details:
   _____

2. **Have you or any of the Additional Insured Person(s) ever:**
   a. **had surgical operation?** ☐ Yes ☐ No
   b. **been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed?** ☐ Yes ☐ No
   If Yes, please provide particulars in Question 5 below.

3. **Are you or any of the Additional Insured Person(s) currently undergoing any medical treatment, ever been treated, under observation for, or told that you or they had, any disorder or disease of the following:**
   a. **Skin, ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problems?** ☐ Yes ☐ No
   b. **Stomach, intestines, liver, kidney, gall-bladder, pancreas, bladder, prostrate, genio urinary system, cirrhosis, hernia, piles, diabetes, protein in urine or used drugs for any other reason?** ☐ Yes ☐ No

Name of Proposer: _____

Health Statement

c. Lungs, bones, joints, ligament, asthma, bronchitis, pneumonia, tuberculosis, slipped disc, back trouble, fractures, arthritis, rheumatism, polio, muscular dystrophy?	☐ Yes	☐ No
d. Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine?	☐ Yes	☐ No
e. Lymphatic system, goiter, thyroid?	☐ Yes	☐ No
f. Any enlarge glands or any form of Cancer, tumors, AIDS or disorders of the blood?	☐ Yes	☐ No
g. Female reproductive system (for female insured), breast lumps, fibroids, cysts, menorrhagia?	☐ Yes	☐ No
h. Any other ailment, impairment, Bodily Injury, Accident, condition(s) or medical investigations not mentioned above?	☐ Yes	☐ No

If your answer to any of the above is Yes, please provide particulars in Question 5.

4. Have you or any of your Additional Insured Person(s) during the past 5 years, had any treatments, examinations or advices for a complaint by a Physician or other Medical Practitioners, at a clinic, hospital, dispensary, or sanitorium?	☐ Yes	☐ No

If your answer to any of the above is Yes, please provide particulars in Question 5.

5. State full particulars of any affirmative answers to Questions 2, 3 and 4.

Question No.	Name of Person(s)	Nature of Illness/ Disability	Date of Illness/ Disability	Duration of Illness/ Disability	Results of Treatment	Name & Address of Doctors and/or Hospital

6. Do you have any other medical insurance? ☐ Yes ☐ No

If Yes, please provide details:

Name of Insurer(s)	Period of Insurance	
	From	To
	From	To
	From	To

7. Has any Accident or Health policy covering you or any of the Additional Insured Person(s) ever been declined or its renewal refused? ☐ Yes ☐ No

If Yes, please provide details:

Name of Insurer(s)	Period of Insurance		Renewal Declined	Refused due to
	From	To		
	From	To		
	From	To		

Name of Proposer: _____

Health Statement

8. Has any application made by you or any of the Additional Insured Person(s) for Life, Accident and Health insurance been declined, postponed, withdrawn or subject to special terms and conditions? ☐ Yes ☐ No
If 'Yes', please provide details.

Name of Insurer(s)	Period of Insurance		Application declined/ postponed/ withdrawn due to	Application subject to following special terms/condition
	From	To		
	From	To		
	From	To		

9. Have you ever made a claim against any insurer in respect of Bodily Injury or sickness during the last 3 years? ☐ Yes ☐ No
If 'Yes', please provide details.

Name of Insurer(s)	Date of Claim	Nature of Claim	Claim Amount (S$)

Name of Doctor(s)

Family Doctor	Last Doctor Consulted	Company's Doctor
Name of Clinic: _____	**Name of Clinic:** _____	**Name of Clinic:** _____
Name of Doctor: _____	**Name of Doctor:** _____	**Name of Doctor:** _____

Mode of Payment

Annual Premium excluding prevailing GST (7%):	**plus prevailing GST (7%):**	**Total Annual Premium including prevailing GST (7%):**
S$ _____	S$ _____	**S$** _____

☐ **Cash**
☐ **Check**[1] Bank: _____ Check No.: _____
☐ **Credit Card**

- ☐ Full Payment
- ☐ 0% Interest Instalment Plan[2]
  - I. Premium S$500 and above: Participating Bank - Instalment Period
  - II. Premium below S$500: (subject to minimum premium S$100) Participating Bank - Instalment Period

Name of Cardholder: (as shown on card) _____

Name of Proposer: _____

Credit Card No.: ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiry Date: ____ / ____ Card Verification Value (CVV): ____

I hereby authorize Liberty Insurance Pte Ltd to debit my Credit Card account specified above.

[1]Please cross your check & make payable to "LIBERTY INSURANCE PTE LTD". Kindly indicate (1) Name of Proposer; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your check.
[2]Only applicable for instalment payment through participating banks in Singapore and is subject to their Credit Card Agreement Terms & Conditions.

PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and no benefits whatsoever shall be payable by the Company.

PREMIUM PAYMENT WARRANTY (CORPORATE)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within 60 days of the inception date of the coverage, failing which the Policy shall be deemed to be automatically canceled and a pro-rata premium is to be charged for the period that the Company is on risk.

PERSONAL DATA PROTECTION

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, other insurers, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished 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 my policies, communicating with me, 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 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

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
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

_____ Date

_____ Signature of Proposer
Company Stamp (if any)

Liberty Insurance

www.libertyinsurance.com.sg

Declaration for Product Summary

proMedico Plus

Name of Proposer: _____

Please complete all sections to facilitate the processing of your application.

A duly signed copy must be filed with Liberty Insurance Pte Ltd for record purpose.

Presented to: Name of Proposer	**Expiry Date of Cover:**
_____	_____

I/We, the Proposer, acknowledge that the Insurance Adviser 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.

Name of Insured Person(s)	Gender	Age Next Birthday

_____ Date

_____ Signature of Proposer

_____ Date

_____ Name and Signature of Insurance Adviser