ABOUT US

China Taiping Insurance (Singapore) Pte. Ltd. has been operating in Singapore since 1938. We are a member of China Taiping Insurance Group Co., a state-owned financial and insurance group of The People's Republic of China with diversified businesses in more than 20 subsidiaries worldwide.

With more than 70 years of establishment, we have grown to become one of the leading general insurers in Singapore. We offer a wide range of insurance products including motor, home, travel, personal accident, fire, public liability, marine, work injury compensation, contractor's all risks, performance bond, foreign worker bond, foreign workers' medical insurance etc.

We provide quality insurance service to our clients through a high standard of professionalism and we aim to build a distinctive "China Taiping" brand in the world of financial field.

APPLICATION FOR HOSPITAL SAFE POLICY

IMPORTANT NOTES

1. Statement Pursuant to Section 25(5) of the Insurance Act. You are to disclose on this Proposal Form fully and faithfully all the facts which you know or ought to know, otherwise the policy issued hereunder may be void.
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.

Agent Code

THE APPLICANT

Name

Nric/Fin/Passport No.

Mailing Address

Tel

Marital Status

Sex: Male

Female

Email

Occupation

PARTICULARS OF PERSON(S) TO BE INSURED

Relation	Name	NRIC/ Passport No	Birth Date	Occupation	Sex	WT (kg)	HT (m)
Self					F / M		
Spouse					F / M		
Child 1					F / M		
Child 2					F / M		
Child 3					F / M		

LIFESTYLE & HEALTH QUESTIONNAIRE OF PERSON(S) TO BE INSURED

1	Have you and/or the insured person(s) been smoking in the past 12 months? If yes, please provide details. No of years smoking: _____ No of cigarattes per day: _____	Yes	No
2	Do you and the person(s) to be Insured consumed beer, wine or other alcohol? If yes, please provide details. Beer _____ can (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) per week	Yes	No
3	Have you and/or the insured person(s) ever taken any form of drugs regularly or been treated for drug addiction? If yes, please provide details: _____	Yes	No
4	Do you and/or insured person(s) engage in any sports and/or work of hazardous nature? If yes, please provide details: _____	Yes	No
5	Have you had any health screening in the past 2 years?	Yes	No
6	Have you ever had any operation/surgical procedures previously or currently waiting to be performed?	Yes	No
7	Have you received any medical advice or treatment for sexually transmitted disease (eg. Gonorrhea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDs?	Yes	No
8	Have you ever made any claim against any insurer in relation to H&S in the past 2 years? If yes, please provide details: _____	Yes	No
9	Has your application for life insurance and/or H&S insurance been declined, or has any policy been cancelled or refused renewal by the insurer? If yes, please provide details: _____	Yes	No
10	Are you currently undergoing any medical treatment/been treated/been diagnosed/of any of the following:-		
a)	ears, throat, eyes or other physical disability or condition affecting hearing, speech, sight, otitis media, ear discharge, tonsils, cataracts, glaucoma, detached retina, ear infection?	Yes	No
b)	Digestive system, liver, gallbladder, stomach, pancreas, intestines, hapatitis, 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, persistant 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, pititary 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 disoder 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, congential 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 illness not listed above, please give details on separate sheets.	Yes	No
11)	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
12)	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? If yes, please provide detail below:-	Yes	No

Relationship	Age at onset	Current Age / Age at Death	Diagnosis

FOR FEMALE ONLY

13)	Have you ever suffered from or been treated for any disease or disorder of the breast or female organs (uterus, ovary, fallopian tube, cervix, etc) including abnormal pap smear and irregular menses?	Yes	No
14)	Are you now pregnant? Estimated delivery date: _____ /_____ /_____	Yes	No
15)	Any complication(s) relating to this/previous pregnacies? If yes, please specify: *Gestational Diabetes / Eclampia / Hypertension / Others (please state): _____ If you answer “YES” to questions 5 to 11, 13 to 15, please provide details:-	Yes	No

No	Name of Person	Date of Diagnosis	Type of Treatment	Date & result of last treatment	Name & Address of Doctor

PERIOD OF INSURANCE

From To

CHOICE OF PLAN

Enhanced Plus Basic

DECLARATION / MODE OF PAYMENT

I declare that I/person(s) to be insured is/are in good health and free from any physical impairment and residing in Singapore. I will give notice to China Taiping Insurance (Singapore) Pte. Ltd. of any change in health, occupation, activities or country of residence of such person(s). I further declare that I am not an undischarged bankrupt.

I understand and agree that benefits under this policy will only be payable upon an accident occuring. I am aware that I can seek advice from a qualified advisor to ensure that this product is appropriate for my financial needs and insurance objectives before I sign this application. I hereby declare that the statements made in this application are true and complete which shall be the basis of contract between me and China Taiping Insurance (Singapore) Pte. Ltd.

Please charge S$ (Including GST) to my VISA/MASTERCARD

CARD No. – – –

BANK

Expiry Date –

I enclose a cheque for S$ (Inclusive GST) payable to “China Taiping Insurance (Singapore) Pte. Ltd.”

I enclose S$ Cash Payment

Proposer’s Signature Date

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 us or visit the GIA / LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

"KNOW YOUR CLIENT"

Confidential Fact Find Form

For

(Name of Client)

By

(Name & Code of Advisor)

IMPORTANT NOTICE TO CLIENTS

Your insurance advisor is :

☐ a representative of CHINA TAIPING INSURANCE (SINGAPORE) PTE LTD

☐ a broker with _____

Your advisor is able to source for and objectively recommend the products of various general insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he/she sources the products.

Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given.

A policy purchased without the completion of a "Know Your Client" form may not be appropriate to your needs.

APPLICATION TYPE

Client's Choice (please tick the appropriate box) :

1. ☐ I/We wish to disclose all information requested for in this Form (Please complete and sign "Know Your Client" and "Our Advice and Reasons Why" forms).
2. ☐ I/We wish to receive product advice only (Please sign below and upon completion of Section 2 – "Our Advice and Reasons Why", sign Section 3 – Acknowledgement).
3. ☐ I/We do not wish to receive any advice from my/our advisor (Please sign below).

I/We acknowledge that the insurance advisor has provided me/us with a copy of the completed "Know Your Client" Form.

Signature of Client : _____
(On behalf of all applicants)

Date :

Signature of Advisor : _____

Date :

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

Personal Information

Name of Client ☐Dr ☐Mr ☐Mrs ☐Miss	NRIC / Passport No.	Date of Birth (ddmmyyyy)

Gender	Marital Status	Nationality	Singapore PR?	Age
☐ Female ☐ Male	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated		☐ Yes ☐ No	

Email Address	Contact No. (Hm / / Mobile)
Current Occupation / Nature of Work	Monthly Income Range ☐ Below $2,500 ☐ $2,501 to $5,000 ☐ $5,001 & Above

Details of Spouse & Dependants (if family coverage is required)

Name	Relationship	Date of Birth (ddmmyyyy)	Gender (M/F)	Occupation	Monthly Income Range		
					Below $2500	$2501 to $5000	$5000 & Above

Existing Health Insurance Policies

This covers all Health Insurance Policies you currently have (eg. CPF-approved Medical Scheme, Personal Medical, Hospital Income, Long Term Care, Employer Sponsored Scheme, etc)

Policy Type*	Insured**	Sum Insured	Annual Limit	Lifetime Limit	Annual Premium++	Expiry Date++
	☐ Y ☐ S ☐ J					
	☐ Y ☐ S ☐ J					
	☐ Y ☐ S ☐ J					

* If the policy is provided by your current employer, please indicate "E" next to the policy plan.

** Y = You, S = Spouse, J = Joint

++ Please provide benefit schedule and disability definition for disability benefit, if available

Personal Priorities

Your Health Insurance Needs	Level of Priority in Your Personal Needs		
	Low	Medium	High
Cover for hospital and surgical expenses	☐	☐	☐
Cover for outpatient medical expenses	☐	☐	☐
Cover for major illnesses (eg. cancer, kidney dialysis, etc)	☐	☐	☐
Cover for dental expenses	☐	☐	☐
Cover for old age disabilities	☐	☐	☐
Cover for loss of income due to illness or sickness	☐	☐	☐
Cover for health screening	☐	☐	☐

Health Condition

Do you or any of your dependents above have any medical condition(s) which require you or any of them to receive regular attention from a doctor in a clinic or hospital? ☐ Yes ☐ No

If "Yes", what are these medical condition(s)?

_____

Replacement of Policy

Is this product intended to replace any existing health insurance policy(ies)? ☐ Yes ☐ No

If "Yes", Advisor should state the reasons for replacement in the "Advisor's Analysis & Recommendation" section on page 3.

Advisor's Declaration

I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact finding in the process of recommending suitable insurance products and shall not be used for any other purposes.

Signature of Advisor : _____ Date : _____

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

Section 2 - "Our Advice and Reasons Why" Form

IMPORTANT NOTICE :
The recommendations in this document are based on the information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing the form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the "Know Your Client" Form.

ANALYSIS AND CALCULATION WORKSHEET

Medical Expenses (also known as Hospital / Surgical Expenses)			
Average annual patient treatment expenses			
Average annual surgical expenses			
Total average annual medical expenses			
Less : Existing H&S policy maximum limit per annum			
Add : Deductible and Co-insurance			
Estimated level of medical expenses protection needed			
2. *Hospital Cash Income*			
Total monthly expenses			
Less : Existing disability benefit per month			
Existing hospital cash benefit per month			
Estimated level of income protection needed			

ADVISOR ANALYSIS AND RECOMMENDATIONS

Total Health Insurance Budget (if applicable) : _____ per month / per annum

Advisor's recommendations	Reasons for recommendations	Remarks
☐ Medical Expenses Protection (also known as Hospital / Surgical Expenses Protection)		Replacement Y/N
☐ Hospital Cash Protection		Replacement Y/N
☐ Others		Replacement Y/N

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

Section 3

ACKNOWLEDGEMENT

I/We understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form and

☐ I/We agree with the proposed recommendation(s).

☐ I/We do not agree with the proposed recommendation(s), based on the reasons cited below and would like to make the changes as highlighted.

_____

_____

If I/we should decide to switch from one health insurance product to another insurance product, I/we understand that :

(a) I/We may not be insurable at standard terms;
(b) I/We may have to pay a different premium;
(c) Terms and conditions may differ.

Signature of Client : _____
(On behalf of all applicants)

Signature of Advisor : _____

Date :

Date :

OPINION OF THE RECOMMENDATION

This section is to be completed by a qualified staff of the insurer or Principal Firm of the advisor

I understand that the above recommendation(s) is/are based on the facts furnished in the "Know Your Client" Form and

☐ I agree with the proposed recommendation(s).

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

Comments (if in disagreement with recommendation)

_____

_____

Remedial Action proposed :

_____

_____

Signature of Authorised Officer : _____

Name & Position : _____

Date : _____

中国太平 CHINA TAIPING

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

HEALTH DECLARATION 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 answer every applicable question and furnish complete details to avoid unnecessary delay in the processing of this application. Any question not answered will be taken as an answer in the negative.

3 This form is valid for **three** months from date of application, after which has to be re-completed and signed.

Agent Name & Code : _____ Policy No: _____

1. INSURED'S PARTICULARS

Name: _____ NRIC/Passport: _____

Gender: Female ☐ Male ☐ Height: (m) Weight: (kg)

Nationality: _____ Date of Birth: _____ (dd/dd/yy) Occupation: _____

2. HEALTH DECLARATION

You may required to complete a separate questionnaire or submit a medical report (expenses to borne by you) for any health conditions declared below.

*	Have you had any health screening in the past 2 years?	Yes/No
*	Have you ever had any operations/surgical procedures or are you currently waiting to be performed?	Yes/No
1	Have you and/or the insured person(s) been smoking in the past 12 months? If yes, Please provide details. No of years smoking: _____ No of cigarettes per day: _____	Yes/No
2	Do you and the person(s) to be Insured consumed beer, wine or other alcohol? If yes. Please provide details. Beer _____ can (330ml Wine _____ glasses (100ml) Spirits _____ tots (30ml) per week	Yes/No
3	Have you and/or the insured person(s) ever taken any form of drugs regularly or been treated for drug addiction?If yes, please provide details: _____	Yes/No
4	Do you and/or insured person(s) engage in any sports AND/OR WORK of hazardous nature? If yes, please provide details: _____	Yes/No
5	Have you had any health screening in the past 2 years?	Yes/No
6	Have you ever had any operations/surgical procedures or are you currently waiting to be performed?	Yes/No
7	Have you received any medical advice or treatment for sexually transmitted disease(eg. Gonorrhea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDs?	Yes/No
8	Have you ever made any claim against any insurer in relation to H&S in the past 2 years? If yes, please provide details: _____	Yes/No
9	Has your application for life insurance and/or H&S insurance been declined, or has any policy been cancelled or refused renewal by the insurer? If yes, please provide details: _____	Yes/No

中国太平保险(新加坡)有限公司
CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD.
3 Anson Road #16-00 Springleaf Tower Singapore 079909
Tel: 6389 6111 Fax: 6222 1033
Website: www.sg.cntaiping.com
Co. Reg. No. 200208384E

10	Are you currently undergoing any medical treatment/been treated/been diagnose/of any of the following below?	Yes/No
a)	ears, throat, eyes or other physical disability or condition affecting hearing, speech, sight, otitis media, ear discharge, tonsils, cataracts,glaucoma, detached retina, ear infection?	Yes/No
b)	Digestive system, liver, gallbladder, stomach, pancreas, intestines, hapatitis, cirrhosis, stones,hernia	Yes/No
c)	Respiratory system, chest or breathing discomfort,lung conditions, asthma, bronchitis, pneumonia, persistant 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, pititary 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 disoder 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, congential 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 illness not listed above, please give details on separate sheets.**	
11	During the past five years, have you consulted a physician for a general examination or for any reasons not previously noted on this app?	Yes/No
12	Have any of your natural parentsor any siblings died or suffered from cancer, heart disease, kidney disease, stroke,diabetes, high blood pressure, mental disorder, tuberculosis or any contagious diease or any hereditary disease or disorder?	Yes/No

I declare that I/person(s) to be insured is/are in good health & free from any physical impairment and residing in Singapore. I will give notice to China Taiping Insurance (Singapore) Pte Ltd of any change in health, occupation, activities or country of residence of such person(s). I further declare that I am not an undischarged bankrupt.

Name & Signature of Applicant _____

Date: _____

PERSONAL DATA COLLECTION STATEMENT

China Taiping Insurance (Singapore) Pte Ltd ("CTIS") recognises its obligations under the Personal Data Protection Act 2012 (PDPA) which includes the collection, use and disclosure of personal data for the purpose for which an individual has given consent to.

The personal data collected by CTIS includes all personal data provided in this form, or in any document provided, or to be provided to us by you or your insured persons or from other sources, for the purpose of this insurance application or transaction. It includes all personal data for us to evaluate or administer this application or transaction

You may not alter any of the wordings in this "Personal data collection statement". Any attempt to do so will be of no effect.

1. To process, administer and/or manage your relationship, account and policy with CTIS, CTIS will necessarily need to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes (i) information set out in this Personal Data Collection Statement and any other personal information provided by you or possessed by CTIS and (ii) your claims.

2. Such personal data will be collected, used, disclosed and/or processed by CTIS for the purpose (s) of:

   (a) considering whether to provide you with the insurance you applied for;
   (b) processing your application for underwriting and insurance;
   (c) administering and/or managing your relationship, account and/or policy with CTIS;
   (d) processing and/or dealing with any claims including the settlement of claims and any necessary investigations relating to the claims, under your policy;
   (e) carrying out due diligence or other screening activities (including background checks) in accordance with legal or regulatory obligations or risk management procedures that may be required by law or that may have been put in place by CTIS;
   (f) carrying out your instructions or responding to any enquiries by you;
   (g) dealing in any matters relating to the services and/or products which you are entitled to under this policy which you are applying for or have applied; (including the mailing of correspondence, statements, invoices, reports or notices to you, which could involve disclosure of certain personal data about you to bring about delivery of the same as well as on the external cover of envelopes/mail packages);
   (h) investigating fraud, misconduct, any unlawful action or omission, whether relating to your application, your claims or any other matter relating to your policy, and whether or not there is any suspicion of the aforementioned; and/or
   (i) complying with applicable law in administering and managing your relationship with CTIS.

   (Collectively the "Purpose")

3. We may/will also be collecting from sources other than yourself, personal data about you, for one or more of the above Purposes, and thereafter using, disclosing and/or processing such personal data for one or more of the above Purposes.

4. Your personal data may/will be disclosed by CTIS to its third party service providers or agents (including its lawyers/law firms) which may be sited outside of Singapore, or one or more of the above Purposes, as such third party service providers or agents, if engaged by CTIS would be processing your personal data for CTIS for one or more the above Purposes.

5. by signing below, you:

   (a) consent to CTIS collecting, using, disclosing and/or processing your personal data for the Purposes as described above;

   (b) consent to CTIS collecting personal data about you from sources other than yourself and using, disclosing and/or processing the same, for one or more the Purposes as described above;

   (c) consent to CTIS disclosing your personal data to its third party service providers, or agents (including its lawyers/law firm), for the Purposes as described above;

   (d) consent to CTIS transferring your personal data out of Singapore to its third party service providers, or agents where such third party service providers or agents are sited (whether in Singapore or outside of Singapore), for the Purposes as described above.

I have read and agree to the above.

_____

Name:

NRIC No:

Date: