

FOREIGN WORKERS' MEDICAL INSURANCE APPLICATION FORM (Foreign Worker, excluding Foreign Domestic Worker)

IMPORTANT

- Statement Pursuant to Section 25(5) of the Insurance Act, Singapore: You are to disclose in this Proposal Form fully and faithfully all the facts which you know or ought to know, otherwise the policy issued hereunder (the "Policy") may be void.
- Your Personal Data Is Important To Us.** This is an application for an insurance product provided by China Taiping Insurance (Singapore) Pte. Ltd. ("CTPIS" or "Company"). We will use all information provided in this form to assess your application for our insurance product and services. Before you provide any information in this form, please read our Privacy Policy which is made available on our website at www.sg.cntaiping.com/en/privacypolicy
- 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).

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Benefits

1. Daily Room & Board	4/6 Bedded	4/6 Bedded	4/6 Bedded	4/6 Bedded	4/6 Bedded	4/6 Bedded
2. Intensive Care Unit (ICU)						
3. Other Hospital Services						
4. Surgical Benefits						
5. In-Hospital Consultation	As charged up to	As charged up to	As charged up to	As charged up to	As charged up to	As charged up to
6a. Pre-Hospitalisation Specialist Consultation (within 90 days prior to admission)	S\$15,000 Per Policy Year	S\$15,000 Per Policy Year	S\$15,000 Per Policy Year	S\$15,000 Per Disability	S\$15,000 Per Disability	S\$15,000 Per Disability
6b. Pre-Hospitalisation Diagnostic X-ray & Lab Test (within 90 days prior to admission)						
7. Post Hospitalisation Treatment (within 90 days of discharge)						
Death Benefit	S\$3,000	S\$3,000	S\$3,000	S\$3,000	S\$3,000	S\$3,000
Personal Accident (Death & Permanent Disability)	NIL	S\$10,000	NIL	NIL	S\$10,000	NIL
Personal Accident (Death & Permanent Disability)	NIL	NIL	S\$15,000	NIL	NIL	S\$15,000
Per Foreign Worker (before GST)	S\$105	S\$110	S\$115	S\$110	S\$115	S\$120
Please Indicate Choice of Plan						

Eligibility

All foreign workers, employed by the Proposer, age between 16 and 65 and must be in Active Service (as defined in the Policy).

Territorial Limit / Operative Time

Within Singapore only / 24 Hours

Main Exclusions (refer to policy wordings for a complete listing of policy exclusions)

- Congenital conditions or birth defects or conditions arising therefrom.
- Ambulance Fee.

Limitation

Each hospital confinement must be for a minimum of Six (6) consecutive hours before any benefits are payable. However no minimum period of hospital confinement is required if the confinement is due to a surgical operation or if the Hospital makes a charge for Daily Room and Board.

Non-Application of the (Rights of Third Parties) Act

The contract of insurance is between the Policyholder/Proposer and the Company only. A person who is not a party to this Policy shall have no rights whatsoever to enforce any of its terms. An insured worker may exercise any demand for rights under this Policy only through the Policyholder. The Company reserves the right not to respond to any communication from an insured worker except through the Policyholder. If the insured worker wishes to direct the benefit payment to a particular person, the insured worker should instruct the Policyholder and the Policyholder must instruct the Company and discharge the Company from any liability upon payment of the claim.

2 Details of Proposer

Name of Company (Policyholder)

Address

Country:

Postal Code:

Contact Numbers (For overseas line, please indicate Country Code and Area Code)

Tel No.:

Fax No.:

Person-in-charge E-mail

Nature of Business

3 Period of Insurance

From

To

/ /

/ /

(or until the cessation of the employment whichever is earlier)

The Policyholder / Proposer hereby agrees:

1. To furnish all information regarding insured required by the Company for the purpose of calculating premiums or benefits.
2. That the statements in this proposal and all the information received by the Company shall form part of this application, and shall be the basis for the underwriting.
3. All individuals, for whom application for insurance is submitted, or may be submitted during the continuance of the Policy, shall be full-time salaried employees of the Proposer.
4. That the Proposer shall notify the Company in writing of any addition or termination of employees and the insurance cover or cancellation of cover for such employees shall take effect immediately, unless otherwise advised. Changes of plan or insurance amount shall be effective only on policy anniversary and may be subject to satisfactory evidence of insurability as required by the Company.
5. That the Policy is subject to the premium being paid and received in full by the Company within the period specified in the Premium Payment Warranty applied to the Policy, failing which there will be no liability under this cover.

Important Notice

1. Work Permit Holders and S-Pass Holders must complete a medical examination required by MOM as a condition for grant of work pass.
2. Coverage excludes work-related accidents for Foreign Workers, unless otherwise agreed.
3. 90 days pre & 90 days post hospitalisation outpatient services must be related to the hospitalisation for the claim to be admitted.
4. Policy will be issued on Named-Basis and premiums payable for this coverage are not guaranteed and may be revised at each Policy renewal at the full discretion of the Company.
5. There is no Free Look provision in this Policy.
6. Cancellation Refund: 50% of annual premium if cancellation is effected within 6 months of commencement, no refund thereafter. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. No premium will be refunded if claims have already been made by the Insured.

I confirm that the terms as stated in this Proposal Form have been accepted by me for and on behalf of the Policyholder / Proposer in my capacity as the authorised representative of the Policyholder / Proposer. I hereby acknowledge that by signing this Proposal Form, I warrant that the declarations and disclosures herein are true and complete and they are to be the basis of contract of insurance between the Policyholder and the Company.

Authorised Signatory & Company Stamp

Agent/Broker's Name

Name:

Code:

Date:

* Please provide the following:

- Names of Employee, Passport/WP No., Gender and Date of Birth in Microsoft "Excel" or "Word" format AND,
- Employees Renewal Notice or IPA forms (if available)

Version accurate as of 15 September 2022.

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