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

FOREIGN WORKERS' MEDICAL INSURANCE APPLICATION FORM

(Foreign Worker, excluding Foreign Domestic Worker)

Benefits	
1) Daily Room & Board	6 Bedded
2) Intensive Care Unit (ICU)	As charged up to S$15,000 per Policy Year
3) Other Hospital Services	
4) Surgical Benefits	
5) In-Hospital Consultation	
6a) Pre-Hospitalisation Specialist Consultation (within 90 days prior to admission)	
6b) Pre-Hospitalisation Diagnostic X-ray & Lab Test (within 90 days prior to admission)	
7) Post Hospitalisation Treatment (within 90 days of discharge)	
Co-insurance / Deductible	NIL
Death Benefit	S$3,000

Per Foreign Worker (before GST)	**S$70.00**

Eligibility
All foreign workers, employed by the Proposer, age between 16 and 65 (renewable up to age 70) and must be in Active Service.

Territorial Limit / Operative Time
Within Singapore only / 24 Hours

Main Exclusions (refer to policy wordings for a complete listing of policy exclusions)
a) Congenital conditions or birth defects or conditions arising therefrom.
b) 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 is between the Policyholder 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.

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DETAILS OF PROPOSER	
Name of Company (Policyholder):	
Address:	
Tel No.:	**Fax No.:**
Person-in-charge E-mail:	
Nature of Business:	
Period of Insurance: From	To

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 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 applicant.
4. That the applicant 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 hospitalization outpatient services must be related to the hospitalization 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 application form have been accepted by me. 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.

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Authorised Signatory & Company Stamp

Agent/Broker's Name

Name/Date:

Code:

***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)**