

HOSPITAL SAFE PROPOSAL FORM

Agent / Broker:	Agent / Broker Code:

IMPORTANT

- 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 (the "Policy") may be void.
- 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.
- The liability of the Company does not commence until this application is accepted and the premium is paid in accordance with clause 2 above.
- 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/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 CTPIS or visit the GIA / LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

1 Personal Particulars of the Proposer

Name		<input type="radio"/> Mr <input type="radio"/> Ms <input type="radio"/> Mdm	
Address			
Country:		Postal Code:	
Contact Numbers			
Home No.:		Office No.:	
Mobile No. (Mandatory):		Email Address (Mandatory):	
Nationality		NRIC / FIN (Please attach a copy of your Identity Document)	
<input type="radio"/> Singaporean <input type="radio"/> Singapore PR <input type="radio"/> Others, please specify:			
Marital Status		Gender	
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced		<input type="radio"/> Male <input type="radio"/> Female	

2 Personal Particulars of Person(s) To Be Insured

Relationship	Name	NRIC / FIN	Date of Birth	Occupation	Gender	Weight (kg)	Height (m)
Self							
Spouse							
Child 1							
Child 2							
Child 3							

3 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: Yes No
 No. of years smoking: No. of cigarettes per day:
2. Do you and the person(s) to be Insured consumed beer, wine or other alcohol? If yes, please provide details: Yes No
 Beer can (330ml) Wine glasses (100ml)
 Spirits tots (30ml) per week
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. Gonorrhoea, 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, hepatitis, 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, persistent 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, pituitary 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 disorder 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, congenital 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

3 Lifestyle & Health Questionnaire of Person(s) to be Insured (continued)

Applicable for Females 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? Yes No
 Estimated delivery date: / /
15. Any complication(s) relating to this/previous pregnancies? If yes, please specify: Yes No
 *Gestational Diabetes Eclampsia Hypertension Others (please state):

.....
 If you answer "YES" to questions 5 to 11, 13 to 15, please provide details:-

Name of Person	Date of Diagnosis	Type of Treatment	Date & result of last treatment	Name & Address of Doctor

4 Details of Cover

From

 / /

To

 / /

5 Choice of Plan/Coverage (please tick)

- Enhanced Plus Basic

6 Declaration

I declare that I / person(s) to be insured am / 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 / person(s) to be insured am / are not an undischarged bankrupt.

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..

7 MODE OF PAYMENT (Please tick)

- I enclosed a cheque of S\$ payable to "CHINA TAIPING INSURANCE (SINGAPORE) PTE. LTD."

Bank / Cheque No.:

- Please charged S\$



NAME OF CARD HOLDER _____

 - - -

EXPIRY DATE: /
 Month Year

- I enclosed cash payment of S\$

1. Consent to Privacy Policy

I / We further confirm that I / we have read and understood and hereby consent to the collection, use, disclosure and processing of my / our personal data in accordance with and agree to be bound by CTPIS Privacy Policy which is made available on our website at www.sg.cntaiping.com/privacypolicy, as may be amended from time to time.

I / We agree on my / our behalf and on behalf of every insured person that in addition to the release of information to any medical source, or other entity mentioned in this Proposal Form, CTPIS is authorised to collect, retain, use and / or disclose as it reasonably deems fit, any information in respect of me / us / any insured person, that is received by CTPIS to its Representatives and relevant third parties, companies within China Taiping Insurance Group, reinsurers, medical organisations, my / our Representatives, financial institutions, credit agencies, investigators, service providers (who may have to disclose my / our data to their service providers such as medical providers, reinsurers, medical evacuation agencies), judicial, regulatory, government, statutory authorities, dispute resolution parties and industry entities) whether within or outside Singapore. As far as reasonably possible, CTPIS will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with relevant law.

2. Marketing Consent (please tick the relevant boxes to indicate consent)

I / We hereby consent to CTPIS (including Representatives of China Taiping), China Taiping group of companies and their service providers to contact me / us (even though my / our telephone number(s) are already registered or may be registered on the National Do Not Call Registry), by way of:

Voice Mail

Mail / Email / Any other avenues of marketing activities

SMS

I / We am / are aware that the consent provided by me / us in this Proposal Form is an addition to and does not supersede, vary or qualify any consent which I / we may have provided previously in respect of the above purposes, unless my / our consent is withdrawn through the withdrawal form.

Signature of Insured Person or his/her Authorised Representative

Date