GROUP INSURANCE FACT-FINDING 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 note that this insurance is subject to the premium being paid and received in full by the Company (a) before the inception date here 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 the clause 2 above.

KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK

Kindly tick boxes [√] where appropriate

PERIOD OF INSURANCE from _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

REQUEST FOR QUOTATION was submitted on _____
(dd/mm/yyyy)

REQUEST FROM _____

AGENT NAME/CODE:

_____

1. GENERAL INFORMATION

a) Name of Applicant/Company: _____

b) Company Address: _____

c) Tel: _____ Email: _____ Nature of Business: _____

d) Presently insured under other medical, hospitalisation, accident or life insurance: **Yes / No**

If **Yes**, Name of Current Insurer: _____

e) Type of Policy/Name of Plan: _____

Period of Insurance: From _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

f) Total Number of Employees: _____No. of Employees to be insured _____

Eligibility: Date of Employment/Confirmation* (*delete where appropriate)

Participation: The insurer will assume that participation of the group insurance program is on compulsory basis unless otherwise stated. Please tick [√] accordingly to the choice of the insurance product that you like to have a quote from us.

Benefits	Insurance Coverage			Participation	
				Compulsory	Voluntary
Personal Accident	**1**	Group Personal Accident (GPA)			
Medical	**2**	Group Hospital & Surgical (GHS)	Employee only		
			Dependant (Spouse and/or Children)		
		Group Major Medical (GMM)	Employee only		
			Dependant (Spouse and/or Children)		
Others	**3**	Group Outpatient	Employee only		
			Dependant (Spouse and/or Children)		
		Dental	Employee only		
			Dependant (Spouse and/or Children)		

Note: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s), subject to a minimum participation level.

1 Are there any members currently in hospital or requires frequent admission (e.g. hospital admission more than 2 times per year) to hospital? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

2 Has any member suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that causes progressive irreversible functional or physical disability? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

3 Is there any member based outside Singapore? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Country based in	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

4 Are there any limitations or exclusions imposed on the coverage on any members? **Yes / No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Limitations / Exclusions	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

5 Is there any member engaged in hazardous occupation? **Yes / No**
(Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

If **Yes,** kindly provide the following details:

S/N	# of members / Age	Nature of Work	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

6 To the best of your knowledge, is there any member engaged in hazardous sports? **Yes / No**
(Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.)

If **Yes,** kindly provide the following details:

S/N	# of members / Age	Type of Sports	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

1. BENEFIT: GROUP PERSONAL ACCIDENT INSURANCE

Occupational Classifications

Class 1	Clerical, administrative or other similar non-hazardous occupations.
Class 2	Occupations where some degree of risk is involved, e.g. supervision of manual workers, totally administrative job in an industrial environment.
Class 3	Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident.
Class 4	High risk occupations involving heavy manual work including hot works.

a) Basis of Coverage

		Category of Employees/Occupation (refer to the examples)	Basis of Coverage - Sum Insured (refer to the examples)	# of Employees
GPA	(i)			
	(ii)			
	(iii)			
	(iv)			

Example 1

Category of Employees / Occupation	Basis of Coverage
(i) Senior Management (Director, General Manager, Senior Manager)	100,000
(ii) Manager & Executive	50,000
(iii) All Others	25,000

Example 2

Category of Employees / Occupation	Basis of Coverage
(i) All Employees	24 X Basic Monthly Salary*

* Please provide salary information if the basis of coverage is in terms of basic monthly salary.

b) Claims Experience for the past 3 years

Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	Paid Claims	Outstanding Claims
		# of Claims	Amount (S$)
Note: The insurer reserves the right to request for more information.			

2. BENEFIT: GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

a) **Basis of Coverage**

Important Note:

(1) Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.

Category of Employees / Occupation		Room & Board Benefit Plan (S$)	Currently with TMIS Yes / No	Proposal with TMIS Yes / No
(i)				
(ii)				
(iii)				
(iv)				

(2) Please provide the Deductible /Co-insurance for respective employee category or occupation, if applicable.

Example 1

Category of Employees / Occupation	**R&B Benefit Plan (S$)**
(i) Senior Management (Director, General Manager, Senior Manager)	360
(ii) Manager & Executive	200
(iii) All Others	100

b) **Age Profile of Employees**

Age Band (Age Next Birthday)	# of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) Details of Insured Members

For GHS and GMM:

	# of Employees (Singaporeans & SPRs*)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

	# of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

For GMM (if the basis of coverage differs from GHS):

	# of Employees (Singaporeans & SPRs*)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

	# of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

d) Claims Experience for the past 3 years

Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	Paid Claims	Outstanding Claims
		# of Claims	Amount (S$)
Note: The insurer reserves the right to request for more information.			

e) Kindly attach a copy of the Schedule of Benefits at the end of this form, if the benefits are on insured basis (i.e. currently Insured).

3. BENEFIT: GROUP OUTPATIENT / DENTAL INSURANCE

a) Category of Employees to be insured (please tick as appropriate)

Category of Employees		Clinical GP	Specialist	Diag X-Ray/Lab Tests	Dental
(i)					
(ii)					
(iii)					
Dependant (where applicable)					
# of Headcount					

b) **Age Profile of Employees**

Age Band (Age Next Birthday)	# of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) **Claims Experience for the past 3 years**

Paid Claims

		Clinical*		Specialist *		Diagnostic X-Ray / Lab Tests*		Dental*	
Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	# of Visits	Amt (S$)	# of Claims	Amt (S$)	# of Claims	Amt (S$)	# of Claims	Amt (S$)

** inclusive of visits to non-panel clinics*
Note: The insurer reserves the right to request for more information.

Outstanding Claims

		Clinical*		Specialist *		Diagnostic X-Ray / Lab Tests*		Dental*	
Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	# of Visits	Amt (S$)	# of Claims	Amt (S$)	# of Claims	Amt (S$)	# of Claims	Amt (S$)

** inclusive of visits to non-panel clinics*
Note: The insurer reserves the right to request for more information.

d) Kindly attach a copy of the Schedule of Benefits if the benefits are on insured basis.
If currently self-insured, kindly provide the following details:
Please indicate “Unlimited” if there is no cap and “NA” if it is not applicable.

Benefits	Maximum Limit per Visit (S$)		Maximum Limit per Policy Year (S$)		Co-Payment (S$) / Co-Insurance (%)	
	Clinic on Company’s panel	Non-panel Clinic	Clinic on Company’s panel	Non-panel Clinic	Clinic on Company’s panel	Non-panel Clinic
Clinical GP						
Specialist						
Diagnostic-X-Ray/ Lab Tests						
Dental						
Others						

4. NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box to indicate the priority of your company's needs:

Company's Priorities	Low	Med	High	Advisor's Recommendation
Cover for Outpatient medical expenses	☐	☐	☐	
Cover for Hospital & Surgical expenses	☐	☐	☐	
Cover for Dental expenses	☐	☐	☐	
Cover for Major illnesses (e.g. cancer, kidney failure, etc.)	☐	☐	☐	
Cover for long term medical treatment	☐	☐	☐	

Others : _____

5. PERSONAL DATA COLLECTION STATEMENT

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 Application Form, CTPIS is authorized 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 organizations, 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 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.

I / We hereby declare that, to the best of my / our knowledge and belief, the information given here are true and complete, and agree that if a contract of insurance is effected, all information submitted in connection with this application shall form the basis of such contract between the Company and the Insurer.

_____
Signature of Authorised Officer

Name:
NRIC/Fin No., Designation:
Date: Company Stamp (if applicable):

6. DECLARATION BY INSURANCE REPRESENTATIVE

I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the requirements of this Fact-Finding form to him / her.

_____
Signature of Insurance Representative

Name:
NRIC/Fin No.
Designation:
Date: Company Stamp (if applicable):