MSIG Insurance (Singapore) Pte. Ltd.
4 Shenton Way, #21-01 SGX Centre 2
Singapore 068807
Tel +65 6827 7888
Co. Reg. No. 200412212G GST Reg. No. 20-0412212G
msig.com.sg
A Member of MS&AD INSURANCE GROUP

Prestige Healthcare Insurance – Group Application Form

The Insurance Act: In this Application Form, you are required to disclose fully and faithfully all the facts you know or ought to know in respect of the risk that is being proposed; otherwise, the Policy issued hereunder may be void.

Please tick ☑ in the appropriate box

(A) Particulars of Applicant

Name of Employer _____ Company/Business Registration No _____

Employer's Address _____

Nature of Company/Business Activity _____

Contact Person _____ Telephone (O) _____

Email _____ Fax _____

(B) Basis of Prestige Healthcare Insurance Coverage

Please provide basis of Prestige Healthcare Insurance Coverage:

Category Of Employees / Occupation	Option

An example of above basis could be: *(a) Management staff – Platinum Plan*
(b) Executives – Deluxe Plan

(C) Plan to be Insured

Choice of Plan

☐ Platinum Plan with Maternity#
☐ Deluxe Plan with Maternity#
☐ Elite Plan
☐ Platinum Plan without Maternity
☐ Deluxe Plan without Maternity

#Please complete the Maternity Health Declaration Form if the Maternity option is chosen. The optional benefit is available provided that the Insured and his/her spouse are covered under the same plan.

Annual Aggregate Deductible Per Person Per Period of Insurance
(applicable for all Plans without Maternity and is for Inpatient (including Day Care Surgery) Expenses, with all other benefits remain)
We will advise you the premium discount if You opt for Deductible. The following range of Deductible is available for your selection:

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $30,000

(D) Declaration

1. I/We hereby apply for Prestige Healthcare Insurance Policy underwritten by MSIG Insurance (Singapore) Pte. Ltd. ('MSIG').

2. I/We hereby declare that to the best of my/our knowledge and belief the statements and answers given in this Application Form are true and complete and that I/we have not withheld any material facts, that is, facts likely to influence the assessment and acceptance of this Application by MSIG. Except as declared herein, all persons to be insured ("Insured Persons") are currently in good health. I/We agree that if the health status of an Insured Person changes after this application is signed before MSIG issues the policy, I/we shall immediately notify MSIG of the change.

3. I/We hereby agree on behalf of myself/ourselves and any Insured Person, firm or corporate, that in the event of claims, I/we authorise any Doctor who has attended to the Insured Person to release any information to MSIG which it may require, and I/we will cooperate fully with MSIG and furnish such additional medical evidence as required in support of my/our claim. I/We agree to accept the insurance as specified in the Policy.

4. I/We agree to accept the terms, conditions and exceptions of the insurance as specified in the policy. I/We also agree that MSIG reserves the right to alter the Policy as it reasonably considers appropriate with 30 days advance notice to me/us.

5. I/We understand this Application will be subject to the approval and acceptance by MSIG and the premium fully paid and additional premium may be charged or special terms and conditions imposed depending on MSIG underwriting assessment of my/our Application.

6. I/We am/are aware that I/we can seek advice from a qualified advisor before I/we sign this Application Form. Should I/we choose not to, I/we take the sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.

7. I/We understand that certain personal accident benefit of the insurance will only be payable upon an accident occurring.

_____ _____

Signature of Authorised Officer
(for and on behalf of all persons to be insured)

Date (dd/mm/yy)

Name _____

Company Stamp (if applicable):

Designation _____

IMPORTANT NOTE

This document is not a contract of insurance. Full details of the terms, conditions and exceptions of this insurance are provided in the Policy and will be sent to You upon acceptance of Your application by MSIG Insurance (Singapore) Pte. Ltd.

Insurance Intermediary Information (Not applicable to Direct Marketing)

Name of Advisor: _____ Account Number (if applicable) _____

Email Address: _____

Contact Number: _____ (HP) _____ (O) _____ (Fax)

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Prestige Healthcare Insurance – Individual Health Declaration for Employee & Family

The Insurance Act: In this Application Form, you are required to disclose fully and faithfully all the facts you know or ought to know in respect of the risk that is being proposed; otherwise, the Policy issued hereunder may be void.

Important Note: This form is to be completed only if you are applying for insurance coverage under the Prestige Healthcare Insurance Policy issued by MSIG Insurance (Singapore) Pte. Ltd. to your Employer.

Please tick ☑ in the appropriate box

(A) Particulars of Policy

Policy Number: _____ Name of Insurance Intermediary (where applicable): _____

Name of Employer: _____

(B) Particulars of Person(s) to be Insured

	Full Name	Gender (Male/ Female)	Date of Birth (dd/mm/yy)	NRIC/FIN No.	Nationality	Usual Country of Residence	Height (cm)	Weight (kg)	Occupation
Employee									
Spouse									
1st Child									
2nd Child									
3rd Child									
4th Child									

(C) Plan to be Insured as selected by the Employer

Choice of Plan

☐ Platinum Plan with Maternity#
☐ Deluxe Plan with Maternity#
☐ Elite Plan
☐ Platinum Plan without Maternity
☐ Deluxe Plan without Maternity

#Please complete the Maternity Health Declaration Form if the Maternity option is chosen. The optional benefit is available provided that the Insured and his/her spouse are covered under the same plan.

Annual Aggregate Deductible Per Person Per Period of Insurance
(applicable only for all Plans without Maternity and is for Inpatient (including Day Care Surgery) Expenses, with all other benefits remain)
We will advise the Employer the premium discount if You opt for Deductible. The following range of Deductible is available for your selection:

☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $30,000

(D) Declaration of Health (All questions must be answered in reference to all Persons to be Insured)

1.	Does any person to be insured have, ever had, been told to have or been treated for any health condition relating to:	
a)	High Blood Pressure, Stroke, Chest Pain or Breathlessness, Raised Cholesterol, Irregular or Fast Heart rate or any disorder of the Heart or Heart Valvular or Blood Vessels?	☐ No ☐ Yes
b)	Asthma, Bronchitis, Persistent Cough, or any disorder of the Respiratory system?	☐ No ☐ Yes
c)	Gastritis, Liver, Hepatitis, Jaundice, Stomach, Gall Bladder, Pancreas, Gastric or Duodenal Ulcers, Hernia, Intestinal or Bowel disorder?	☐ No ☐ Yes
d)	Diabetes, Thyroid disorders?	☐ No ☐ Yes
e)	Genito-Urinary system, Kidney Stones, Urinary Tract Infection, Blood/Protein/Sugar in urine, Prostate disorders?	☐ No ☐ Yes
f)	Epilepsy, Fits, Paralysis, Weakness of Limb, Prolonged Headache, Depression, Nervous Breakdown, any Mental or Nervous disorder or disability?	☐ No ☐ Yes
g)	Ear, Nose, Throat, Otitis Media, Ear Discharge, Tonsils, Cataract, Glaucoma, Detached Retina, Sinusitis, Rhinitis, Hearing problems, Tinnitus or any disorder of the Ear, Eye, Nose or Throat?	☐ No ☐ Yes
h)	Psoriasis, Eczema, Dermatitis, or any disorder of the Skin?	☐ No ☐ Yes
i)	Blood disorders, Anaemia, Thalassemia, Varicose Veins, Deep Vein Thrombosis or any disorder of the Immune system?	☐ No ☐ Yes
j)	Bone, Cartilage, Limbs, Joints, Gout, Arthritis, Rheumatoid Arthritis, Rheumatism, Osteomyelitis, Osteoporosis, Spinal Column, Back or Neck Pain?	☐ No ☐ Yes
k)	Cancer, Leukaemia, Tumours, Cysts or Growth of any kind?	☐ No ☐ Yes
l)	Congenital abnormalities, either anatomical or functional, Premature birth?	☐ No ☐ Yes
m)	Any other ailment/illness/injury/accident, condition, medical investigation, hospital treatment not mentioned above?	☐ No ☐ Yes
2.	Does any person to be insured have or ever had i) been advised to abstain from donating blood or receive transfusion, or	☐ No ☐ Yes
	ii) in the last 3 months had any of the following symptoms for more than one week continuously; fatigue, weight loss, diarrhoea, enlarged nodes or unusual lesions?	☐ No ☐ Yes
3.	Is any person to be insured now receiving or considering to receive medical treatment from a doctor or intending to consult a doctor for any reason? If Yes, please state the nature and treatment and provide name and address of doctor.	☐ No ☐ Yes
4.	Do you have a regular doctor?	☐ No ☐ Yes
5.	Has any person to be insured consulted a doctor (other than for flu and/or cough which did not last for more than 7 days) or had any medical/diagnostic tests in the past 5 years? If Yes, please give details and provide all copies of such reports and results.	☐ No ☐ Yes
6.	Has any person to be insured been hospitalised or had any surgical operation or consulted a specialist in the past 5 years? If Yes, please provide details.	☐ No ☐ Yes
7.	Does any person to be insured engage in any risk, special dangers or conditions which may be considered hazardous connected to his/her job, hobbies or past-time activities? If Yes, please provide details.	☐ No ☐ Yes
8.	Has any person to be insured ever smoked in the last 12 months? If Yes, please state the name of the person to be insured who smoked and the average number of sticks smoked per day and whether he/she is still smoking. Name of the person to be insured _____ Average Number of Sticks Smoked per day _____ ☐ Still Smoking ☐ Stopped Smoking, when? _____ Number of Years Smoked _____	☐ No ☐ Yes
9.	Does any person to be insured live or intend to live in any other country? If Yes, please state who _____ which country _____ when _____ and length of stay _____	☐ No ☐ Yes
10.	Has any person to be insured ever made a claim against any insurer in respect of bodily injuries or sickness? If Yes, please provide details.	☐ No ☐ Yes
11.	Has any person to be insured had any application for life or disability or health insurance been declined, or had any special terms imposed, or postponed, or had insurer refused to renew any insurance? If Yes, please provide details. Name of the person to be insured _____ Insurance Company _____ Type of Insurance _____ Reasons /Terms _____	☐ No ☐ Yes
12.	**To be completed for Female Persons to be Insured only** i) Does any person to be insured suffer from or is aware of any breast lumps or any other disorder of the breast(s)?	☐ No ☐ Yes
	ii) Does any person to be insured suffer from irregular or painful or unusually heavy menstruation, endometriosis, fibroid(s), cysts or any other disorder of the female organs?	☐ No ☐ Yes
	iii) Does any person to be insured have or ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the next six months?	☐ No ☐ Yes
	iv) Does any person to be insured have or ever had been advised to have a mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations? If Yes, please state type, reason, date of test done and results of test (copy to be submitted if available).	☐ No ☐ Yes

If the answer to any of the above questions in Part (D) is 'Yes', please provide with full details here. Please indicate on a separate sheet of paper if there is insufficient space here and this must also be duly signed by the Employee.							
	Question Number	Doctors' Diagnosis/ Nature of Illness/ Disability	Duration of Illness/ Disability		Type & Results of Treatment/ Surgery	Need for any follow-up Treatment/ Consultation	Name & Address of Doctor/ Clinic/ Hospital
			From (mmyyyy)	To (mmyyyy)			
Applicant							
Spouse							
Child 1							
Child 2							
Child 3							

(E) Declaration and Authorisation

I/We declare that all persons to be insured ("Insured Persons") are in good health and free from physical disabilities, defect or infirmity. I/We am/are unaware of the existence of any medical condition or disease foreseeable requiring hospitalisation of any Insured Person in the future, and understand that the Policy benefits will not apply to any Injury, Illness, condition or symptom (a) for which treatment, or medication, or advice, or diagnosis has been sought or received or was foreseeable prior to the commencement of cover for the Insured Persons concerned under the Policy, or (b) which presented signs or symptoms of which the Insured Persons concerned were aware or should reasonably have been aware or which originated or existed, prior to the commencement of cover for the Insured Persons concerned under the Policy regardless whether I/we have declared or undeclared.

I/We declare that information given above is true and complete and I/we have not withheld any material facts. I/We agree that this declaration shall form the basis of the insurance coverage issued under the Policy. I/We understand that the insurance coverage for the Insured Persons shall only be effective after it has been accepted and confirmed in writing by MSIG Insurance (Singapore) Pte. Ltd. ("MSIG").

I/We consent to MSIG seeking information from any hospital, surgeon, medical practitioner or clinic or other person who has attended to or examined any of the Insured Persons or is authorised to maintain any medical record relating to any Insured Persons and I/we authorise the giving of such information. I/We also consent to MSIG seeking information from any other insurance company to which any of the Insured Persons has been proposed for insurance and I/we authorise the giving of such information. A photocopy of this authorisation shall be considered as effective and valid as the original.

I/We agree to inform MSIG as soon as possible if there is any change in the state of health or activities of any of the Insured Persons or if any of the Insured Persons intends to seek any medical consultation, investigation or treatment between the date of this declaration and the date insurance coverage is provided to the Insured Persons by MSIG. I/We understand that MSIG may impose or vary terms of insurance coverage based on such information provided.

I understand and accept that my personal particulars will be collected, used and disclosed by MSIG in accordance with the Personal Data Protection Act 2012 and MSIG's Privacy Policy, for the provision of all services related to, and protection under, this insurance policy, including for proper servicing, underwriting and claims administration. MSIG may disclose my personal particulars to its business partners and third party service providers for these purposes. MSIG may also send me marketing mailers by post or emails. Where there are more than one individual insured persons, I confirm they have consented to MSIG's collection, use and disclosure of their personal particulars. The full MSIG's Privacy Policy can be found at www.msig.com.sg.

_____ _____

Signature of Employee (for and on behalf of all persons to be insured) Date (dd/mm/yy)

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Insurance Intermediary Information (Not applicable to Direct Marketing)

Name of Advisor: _____ Account Number (if applicable) _____

Email Address: _____

Contact Number: _____(HP) _____ (O) _____(Fax)