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A Member of MS&AD INSURANCE GROUP

Group Insurance Fact-Finding Form

Kindly complete fully in block letter and ink. (Tick boxes ☑ where appropriate)

Period of Insurance from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

Request for Quotation was submitted on _____ (dd/mm/yyyy)

Request from _____ (Name of Insurance Company)

(A) General Information

Name of Company _____

Nature of Business _____ Presently insured? ☐ Yes ☐ No

If Yes, name of current insurer _____ Type of Policy _____

Period of Insurance from _____ (dd/mm/yyyy) to _____ (dd/mm/yyyy)

Total No. of Employees _____ No. of Employees to be insured _____

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
Medical	1	Group Hospital & Surgical (GHS)	Employee only		
			Dependant (Spouse and/or Children)		
		Group Major Medical (GMM)	Employee only		
			Dependant (Spouse and/or Children)		
Others	2	Group Outpatient	Employee only		
			Dependant (Spouse and/or Children)		
		Dental	Employee only		
			Dependant (Spouse and/or Children)		
	3	Maternity	Employee only		
			Dependant (Spouse)		

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

S/N	Number 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.			

(B) Benefit: Group Hospital & Surgical Insurance / Major Medical Insurance

a) Basic coverage

Category of Employees / Occupation		Room & Board Benefit Plan (S$)	Currently with TMIS Yes / No	Proposal with TMIS Yes / No	Medical Insurance for S Pass and Work Permit holders Yes / No
(i)					
(ii)					
(iii)					
(iv)					

Important Note:

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

(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)	Number of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
71-75		
Above 75		
Total		

C) Details of insured members

For GHS and GMM:

	Number 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*				

	Number of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
**refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore*				

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

	Number 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*				

	Number of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
**refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore*				

d) Claims experience for the past 3 years

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

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

(C) Benefit: Group Outpatient Insurance

a) Category of employees to be insured (Tick boxes ☑ where appropriate)

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

b) Age profile of employees

Age Band (Age Next Birthday)	Number of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
71-75		
Above 75		
Total		

c) Claims experience for the past 3 years

Paid Claims

Period of Coverage From / To (dd/mm/yyyy)	Number of Insured as at (dd/mm/yyyy)	Clinical*		Specialist*		Diagnostic X- Ray / Lab Tests*		Dental*	
		Number of visits	Amount (S$)	Number of visits	Amount (S$)	Number of visits	Amount (S$)	Number of visits	Amount (S$)

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

Outstanding Claims

Period of Coverage From / To (dd/mm/yyyy)	Number of Insured as at (dd/mm/yyyy)	Clinical*		Specialist*		Diagnostic X- Ray / Lab Tests*		Dental*	
		Number of visits	Amount (S$)	Number of visits	Amount (S$)	Number of visits	Amount (S$)	Number of visits	Amount (S$)

**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						

(D) Benefit: Maternity Insurance

a) Basis of coverage

Category of Employees (refer to the example)		Number of headcount
(i)		
(ii)		
(iii)		

Example 1

Category of Employees/Occupation

(i) Senior Management (Director, General Manager, Senior Manager)
(ii) Manager & Executive
(iii) All Others

Example 2

(i) All Employees

b) Claims experience for the past 3 years

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

c) 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 Policy Year (S$)		Deductible / Co-insurance (S$)	
Normal Delivery				
Caesarian Delivery				
Others:				

(E) Needs Analysis & Product Recommendation

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

Company's Priorities	Low	Medium	High	Advisor's Recommendation
Cover for Outpatient Medical Expenses	☐	☐	☐	
Cover for Hospital and Surgical Expenses	☐	☐	☐	
Cover for Dental Expenses	☐	☐	☐	
Cover for Major or Illnesses (e.g. cancer, kidney failure, etc)	☐	☐	☐	
Cover for Loss of Income due to sickness or accident	☐	☐	☐	
Cover for Long Term Medical Treatment	☐	☐	☐	

Others: _____

(F) Declaration

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

Company Stamp (if applicable):

Name

NRIC/FIN No.

Designation

Date

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

Company Stamp (if applicable):

Name

NRIC/FIN No.

Designation

Date