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Co. Reg. No. 200412212G GST Reg. No. 20-0412212G
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A Member of MS&AD INSURANCE GROUP

Group Healthcare International
Fact Finding Form

Please complete fully and in 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)

(A) Company Details

Business/Company Name _____

Nature of Company Business/Activity _____ Company/Business Registration No. _____

Address _____

Telephone (O) _____ Fax _____

Contact Person _____ Email _____

(B) Current Medical and Health Related Costs

1. Is your company presently insured for healthcare/medical insurance? ☐ Yes ☐ No

   If "**Yes**", name of current insurer: _____

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

   If "**No**", has your Company provided or funded staff medical benefits? ☐ Yes ☐ No

2. Please provide the following information on the total cost of medical and health related or insurance claim costs, both paid and outstanding during the last 3 years.
   (NB: If no previous insurance was covered, please provide the same information with regards to Company funded staff medical benefits.)

Period of Insurance (dd/mm/yy)		Number of Insured Persons	Paid Claims		Outstanding Claims	
From	To		Number	Amount in SGD	Number	Amount in SGD

3. Please describe briefly the type and level of benefits then provided and attach the Schedule of your previous policy.

   _____

   _____

   _____

4. What annual premium is currently being paid or what is your approximate annual budget for providing the benefits proposed?

   _____

(C) Eligibility Definition

1. How many employees does your Company/Organisation employ? _____

2. Number of employees to be Insured: _____

3. Is cover to apply to all employees? ☐ Yes ☐ No
   If "**No**", please define the class of employees for whom cover is required.
   (For example *"All employees earning over S$x per month"* or *"All directors, managers, supervisors, technicians and administrative staff"* etc)

   _____

   _____

   _____

4. Participation:
   We will assume that participation is on compulsory basis unless otherwise stated.
   Please indicate with a tick ☑ here below to the choice of the insurance product that you like to have a quote from us.

Benefits	**Insurance Coverage**	**Participation**	
		Compulsory	**Voluntary**
Medical	**Group Healthcare**		
	- for employees only		
	- for dependants only		
Others	**Maternity**		
	- for employees only		
	- for dependant (Spouse)		

Please note:
***Voluntary**: Participation is voluntary if employees or dependants are given the choice to opt for the cover, subject to a minimum participation level.*

(D) General Information

1. Is there any person to be insured 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 Persons to be Insured / Age**	**Reason of Hospitalisation / Nature of Illness**	**Sum Insured / Plan**
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

2. Has any person to be insured suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis, blood disorder, kidney failure, systemic lupus erythematosus 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 Persons to be Insured / Age	Reason of Hospitalisation / Nature of Illness	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

3. Is there any person to be insured based outside Singapore? ☐ Yes ☐ No

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

S/N	Number of Persons to be Insured / Age	Country Based In	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

4. Are there any limitations or exclusions imposed on the coverage on any person to be insured? ☐ Yes ☐ No

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

S/N	Number of Persons to be Insured / Age	Limitations / Exclusions	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

5. Is there any member engaged in hazardous occupation or engaged in any regular offshore, underwater, underground, manual or field work exposures? ☐ Yes ☐ No
(Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

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

S/N	Number of Persons to be Insured / Age	Nature of Work	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

6. Is there any person to be insured frequently in remote areas more than 150km distance from adequate medical facilities? ☐ Yes ☐ No

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

S/N	Number of Persons to be Insured / Age	Nature of Work and Exact Geographical Location	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

7. To the best of your knowledge, is there any person to be insured engaged in hazardous sports? ☐ Yes ☐ No
(Hazardous sports e.g. scuba diving, motor racing, bungee jumping, parachuting, skydiving, handgliding etc.)

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

S/N	Number of Persons to be Insured / Age	Type of Sports	Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any person to be insured in hospital at the time of application.			

(E) Geographical Location

a) Persons to be Insured			b) All Dependants (Spouses and Children)		
Usual Country of Residence[1]	Total Number	Nationality	Usual Country of Residence[1]	Total Number	Nationality

[1]**Usual Country of Residence** shall mean:
the country in which the person to be insured is usually living at the Effective Date under the Policy and which is declared on the Application Form, and which is stated in the Schedule or Endorsement thereof.

(F) Basis of Healthcare International Insurance Coverage

Category of Employees / Occupation	Option

An example of above basis could be: [a] Management staff – Option 4
[b] Executives – Option 2

(G) Age / Gender Breakdown of Persons to be Insured

Notes:
- If there is more than 1 option, please provide the number of Persons to be insured under each age band.

Age (Years)	Option 1						Option 2						Option 3						Option 4						Option 5					
	No. of Insured		No. of Spouses		No. of Children		No. of Insured		No. of Spouses		No. of Children		No. of Insured		No. of Spouses		No. of Children		No. of Insured		No. of Spouses		No. of Children		No. of Insured		No. of Spouses		No. of Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
15 days - 17																														
18 - 39																														
40 - 49																														
50 - 59																														
60 - 69																														
Total																														

Please use a separate paper if there is not enough space.

(H) Your Choice of Healthcare International Benefits

(Please tick the required boxes and indicate the required Limits)

A. Hospital & Related Services (HRS)

	Option 1 ☐	Option 2 ☐	Option 3 ☐	Option 4 ☐	Option 5 ☐	Option 6 ☐
Maximum Limit per Insured Person per Period of Insurance	$15,000	☐ $20,000 or ☐ $25,000	☐ $30,000 or ☐ $35,000	☐ $40,000 or ☐ $45,000 or ☐ $50,000	☐ $55,000 or ☐ $60,000 or ☐ $65,000 or ☐ $70,000 or ☐ $75,000 or ☐ $80,000 or ☐ $85,000 or ☐ $100,000 or ☐ $200,000	$250,000
Maximum Limit on Room and Board	$100	$150	$200	$250	Standard Single Bedded	Standard Single Bedded
Pre-hospital diagnostic services (within 30/60 days of admission)	30	30	30	30	30	60
Post-hospital follow-up treatment (within 60/90 days of discharge)	60	60	60	60	60	90
B. Outpatient Cancer Treatment - Available when HRS Limit is $30,000 or more per Insured Person, or more - Limit is included within HRS Limit			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
C. Outpatient Kidney Dialysis - Available when HRS Limit is $30,000 or more per Insured Person , or more - Limit is included within HRS Limit			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
D. Organ Transplantation - Available when HRS Limit is $30,000 or more per Insured Person, or more - Limit is included within HRS Limit			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
E. Increased International Cover - Available when HRS Limit is $75,000 per person, or more - Quadruples (4 X) the HRS Limit when outside the Usual Country of Residence and Home Country up to a limit of $1,000,000					☐ Yes ☐ No	☐ Yes ☐ No
F. Outpatient Services - Available when HRS Limit is $75,000 per person, or more - Limit = 10% of HRS Limit - Deductible = $100 per claim or course of treatment					☐ Yes ☐ No	☐ Yes ☐ No
G. Emergency Medical Assistance and Evacuation Services - Available when HRS Limit is $75,000 per person, or more - Limit = same as HRS Limit					☐ Yes ☐ No	☐ Yes ☐ No
H. Repatriation or Local Burial of Mortal Remains - Available when HRS Limit is $75,000 per person, or more - Limit = 10% of HRS Limit					☐ Yes ☐ No	☐ Yes ☐ No

I. Maternity Benefi t (Available for person insured under option 5 or 6)
Cover up to $12,000 (complicated delivery) and $4,750 (normal delivery)
■ **Required** ☐ **Not Required [Can Skip i) to iii) and proceed to Section 9]**

If Maternity benefit is required, **please provide**:

i) Basis of Cover:

☐ All married female employees and spouses of male employees below age 46
☐ All married female employees, below age 46
☐ Others, please specify the category _____

ii) Number of eligible persons: _____

iii) Please tick the option(s) that has this Maternity Benefit

	Option 1	Option 2	Option 3	Option 4	Option 5 ☐	Option 6 ☐
					☐ Yes ☐ No	☐ Yes ☐ No

(I) Needs Analysis & Product Recommendation

Company's Priorities	Low	Medium	High	Advisor's Recommendation
Cover for Outpatient Medical Expenses	☐	☐	☐	
Cover for Hospitals 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: _____

(J) 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 MSIG Insurance (Singapore) Pte. Ltd.

_____
Signature of Authorised Officer (on behalf of Applicants)

_____
Date (dd/mm/yyyy)

_____
Name of Authorised Officer

Company Stamp (if applicable):

_____
Designation

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 Intermediary

_____
Name of Insurance Representative

_____
Date (dd/mm/yyyy)

_____
Designation

Company Stamp (if applicable):

_____

Insurance Intermediary Information (where applicable)

Name of Insurance Intermediary _____

Name of Insurance Intermediary Company _____

Contact Number _____ (Office) _____ (Home) _____ (Hp)

Email _____

Account Number (if applicable) _____

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