

MSIG Insurance (Singapore) Pte. Ltd.

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Co. Reg. No. 200412212G GST Reg. No. 20-0412212G msig.com.sg

A Member of MS&AD INSURANCE GROUP

## Group Healthcare International – Individual Health Declaration for Employee & Family

The Insurance Act: You are required to disclose fully and faithfully all the facts you know or ought to know in respect to the risk that is being proposed, otherwise, you may not receive any benefit from the Policy.

Please ✓ tick where appropriate (A) Particulars of Policy Policy Number \_ \_\_\_\_ Nature of Insurance Intermediary \_ Name of Employer \_\_\_ (B) Particulars of Person(s) to be Insured NRIC/FIN No. **Nationality** Occupation Name Date of Birth Usual Weight Height (Male/ (dd/mm/yy) Country of (kg) Female) Residence Employee's Name Spouse's Name 1st Child's Name 2<sup>nd</sup> Child's Name 3rd Child's Name 4th Child's Name (C) General Information (All questions must be answered in reference to all Persons to be Insured) Does any person to be insured live or intend to live in any other country? Yes No If Yes, please state: who: \_ which country: \_  $\_$  and when:  $\_$ Has any person to be insured ever smoked in the last 12 months? If Yes, please state the name of the person to beinsured Yes No 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 ☐ Still Smokingr Smoked per day: Stopped Smoking, when?\_ Has any person to be insured had any application for life or disability or health insurance been declined, or had Yes No specialterms imposed, or postponed, or had insurer refused to renew any insurance? If Yes, please provide details. Name of the person to be Insurance Company: Type of Insurance: Reasons: insured: Does any of the person to be insured is now receiving or considering to receive medical treatment from a doctoror Yes No intending to consult a doctor for any reason? If Yes, please state the nature and treatment and provide name &address of doctor.

5. Nos any person to be insured consulted a doctor (other than for fiv any) are got details and provide all actigors of such any details and provide all actigors of such and any surgical operation or consulted a logical for such activities.  4. Has any person to be insured been hospitalised or had any surgical operation or consulted a specialist in the past Syears? If Yes   No Yes   please provide details.  5. Hose any person to be insured than or has had or been told to have or been treated for any health condition relating to the forest, furnas, Kidney, Liver, Heaptist, Thrond, Kervous System, Breast, Reproductive System, Heroditizin or congenital conditions, Camer or Tumous, Tibelo, Diabetes, High Bod of Pressure, \$15 (Explenius Liques, Prichematossu), or has gill lines or disorder or operation or accident or injury or physical disability or defects? Yes, pitase provide details.  5. Does any person to be insured debe, Diabetes, High Bod of Pressure, \$15 (Explenius Liques Prichematossu), or has gill lines or disorder or operation or accident or injury or physical disability or defects? Yes, pitase provide details.  5. Does any person to be insured debe, Diabetes, High Bod of Pressure, \$15 (Explenius Liques Prichematossu), or has gill lines or disorder or operation or accident or injury or physical disabilities.  6. Does any person to be insured details.  6. The answer to Questions (4) to (7) in Part C is "Yes", please provide full details here. Please indicate on a separate sheet of paper if there is insufficient space here and this must be duly signed by the Employee.  6. No Name of Person to be insured this must be duly signed by the Employee.  6. No Name of Person to be insured this must be duly signed by the Employee.  7. From To  8. Name of Doctor Consulted & Address of Clinic  8. Result, Doctor's Diagnosis / Injury / Treatment  9. No Name of Person to be insured this must be duly signed by the Employee.  9. No Name of Person to be insured Persons on Coneme during the repulsion of flow which the insured								
Yes, please provide details.    Does any person to be insured has or has had or been told to have or been treated for any health condition, classing to:   Heart, Lung, Kidney, Liver, Hepatilis, Twoid, Nervous System, Bread, Reproduct to System, Hereditary or Congenital Conditions, Cancer or Tunous, Stroke, Diablets, High Bood Pressure, SEL Systemic Lusure, Strhematosus, Johnson   Research   Program   Program   Program   Program	0	or had any medical/diagnostic tests in the past 12 months? If Yes, please give details and provide all copies of suchreports						
Heart, Lings, Kidney, Liver, Hepatitis, Thyroid, Nervous System, Great, Reproductive System, Hereditary or Congenital Conditions, Cancer or Tumour, Stroke, Diabetes, High Blood Pressure, SE Gystemic Luoys Erythematosus), or has any illness or disorder or operation or accident or injury or physical disability or defects? If Yes, please provide details.  B. Does any person to be insured managed in any risk, special dangers or conditions which may be considered hazardous [Yes ] No encept of the consequence of the consequenc								
connected with his/her job, hobbies or past-time activities? If Yes, please provide details:  If the answer to Questions (8) to (7) in Part C is 'Yes', please provide full details here. Please indicate on a separate sheet of paper if there is insurfficient space here and this must be duly signed by the Employee.  On Name of Person to be insured  Result, Doctor's Diagnosis / Injury/ Treatment  Duration of Itllness From To  No.   Duration of Itllness Address of Clinic  Name of Doctor Consulted & Address of Clinic	F	Heart, Lungs, Kidney, Liver, Hepatitis, Thyroid, Nervous System, Breast, Reproductive System, Hereditary or Congenital Conditions, Cancer or Tumour, Stroke, Diabetes, High Blood Pressure, SLE (Systemic Lupus Erythematosus), or has any						
Sinsufficient space here and this must be duly signed by the Employee.     Duration of Illness   Name of Person to be Insured   Details of Diagnosis / Injury / Treatment   From   To   Address of Clinic   Promised   Address of Clinic   Promised   Promised   Address of Clinic   Promised   Promise	c	connected with his/her job, hobb		iich may be co	onsidered ha	azardous	Yes No	
No.   Name of Person to be Insured   Details of Diagnostic Test with Reason & Result, Doctor's Diagnosis / Injury / Treatment   From   To   Name of Doctor Consulted & Address of Clinic				e. Please ind	icate on a s	eparate sheet o	f paper if there	
(D) Particulars of Policy  [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/an 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 medication, or medication, or which treatment, or medication, or which the results 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 medication, or medication, or which the temperature or which the existence of any medical practice, or disposis has been sught or received or was foreseeable prior to the commencement of cover for the insured Persons concerned under the Policy regardless whether I/We have declared or undeclared.  Whe declare that information given above is true and complete and I/We have not whitheld any material facts. I/We agree that this declaration shall form the basks 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 examine 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. A photocopy of this authorisation shall be considered as effective and valid as the roriginal.  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		Name of Doc	octor Consulted &					
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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 suclainformation provided.  (For Voluntary Group Application)  I/We confirm that I/we have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these documents.  Signature of Employee (for and on behalf of all persons to be insured)  Date (dd/mm/yy)  Insurance Intermediary Information (Not Applicable to Direct Marketing)  Page 14 Account Number (if applicable)  Email Address	unawar that the sought signs of the con I/We de form the effectiv I/We co any of informa	re of the existence of any medical Policy benefits will not apply to or received or was foreseeable properties of which the Insured number of cover for the Insured number that information given above after it has been accepted and onsent to MSIG seeking information. I/We also consent to MSIG ation. I/We also consent to MSIG	al condition or disease foreseeable requiring hospit any Injury, Illness, condition or symptom (a) for whorior to the commencement of cover for the Insured Persons concerned were aware or should reason sured Persons concerned under the Policy regardle ove is true and complete and I/we have not with ge issued under the Policy. I/We understand that d confirmed in writing by MSIG Insurance (Singapo ion from any hospital, surgeon, medical practition orised to maintain any medical record relating to seeking information from any other insurance con	talisation of a nich treatmen of Persons cor ably have bee ess whether I neld any mate the insurance ore) Pte. Ltd. ( er or clinic or any Insured npany to whic	ny Insured F t, or medical ncerned und en aware or /we have de erial facts. I/ e coverage fa "MSIG"). other perso Persons and h any of the	Person in the futution, or advice, or ler the Policy, or (which originated sclared or undeclude agree that the or the Insured Persons I/we authorise Insured Persons	are, and understandiagnosis has been b) which presente or existed, prior that ared.  Also declaration shatersons shall only be the giving of such as been propose	
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 suci information provided.  (For Voluntary Group Application)  I/We confirm that I/we have received a copy of Your Guide to Health Insurance and Product Summary and have read and understood the contents of these documents.  Signature of Employee (for and on behalf of all persons to be insured)  Date (dd/mm/yy)  Insurance Intermediary Information (Not Applicable to Direct Marketing)  Name of Advisor Account Number (if applicable)								
Name of Advisor Account Number (if applicable)	Insured covera <u>c</u>	d Persons intends to seek any m ge is provided to the Insured Pe	edical consultation, investigation or treatment b	etween the o	date of this	declaration and	the date insuranc	
Insurance Intermediary Information (Not Applicable to Direct Marketing)  Name of Advisor Account Number (if applicable)  Email Address	I/We co	onfirm that I/we have received a	copy of Your Guide to Health Insurance and Prod	uct Summary	and have re	ead and understo	ood the contents o	
Name of Advisor Account Number (if applicable) Email Address	 Signatu	ure of Employee (for and on beh	alf of all persons to be insured)			Date (dd/mm	ı/yy)	
Email Address	Insura	ance Intermediary Information	(Not Applicable to Direct Marketing)					
	Name	ne of Advisor Account Number (if applicable)						
Contact Number (HP) (O) (Fax)	Email	Address						
	Conta	act Number	(HP) _		(O)		(Fax)	