MSIG Insurance (Singapore) Pte. Ltd.
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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 – 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

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

1.	Does any person to be insured live or intend to live in any other country? If Yes, please state: who: _____ , which country: _____ and when: _____			☐ Yes ☐ No
2.	Has any person to be insured ever smoked in the last 12 months? If Yes, please state the name of the person to beinsured who smoked and the average number of sticks smoked per day and whether he/she is still smoking.			☐ Yes ☐ No
	Name of the person to be insured:	Average Number of Sticks Smoked per day:	☐ Still Smokingr ☐ Stopped Smoking, when? _____	
3.	Has any person to be insured had any application for life or disability or health insurance been declined, or had specialterms imposed, or postponed, or had insurer refused to renew any insurance? If Yes, please provide details.			☐ Yes ☐ No
	Name of the person to be insured:	Insurance Company:	Type of Insurance:	Reasons:
4.	Does any of the person to be insured is now receiving or considering to receive medical treatment from a doctoror intending to consult a doctor for any reason? If Yes, please state the nature and treatment and provide name &address of doctor.			☐ Yes ☐ No

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 12 months? If Yes, please give details and provide all copies of suchreports and results.	☐ Yes ☐ No
6.	Has any person to be insured been hospitalised or had any surgical operation or consulted a specialist in the past 5years? If Yes, please provide details.	☐ Yes ☐ No
7.	Does any person to be insured has or has had or been told to have or been treated for any health condition relating to: 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 illness or disorder or operation or accident or injury or physical disability or defects? If Yes, please provide details.	☐ Yes ☐ No
8.	Does any person to be insured engage in any risk, special dangers or conditions which may be considered hazardous connected with his/her job, hobbies or past-time activities? If Yes, please provide details:	☐ Yes ☐ No

If 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.

Qn No.	Name of Person to be Insured	Details of Diagnostic Test with Reason & Result, Doctor's Diagnosis / Injury / Treatment	Duration of Illness		Name of Doctor Consulted & Address of Clinic
			From	To	

(D) Particulars of Policy

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.

(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) _____

Email Address _____

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

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