april international

Individual Medical Questionnaire

Effective 1 January 2016

Important note about filling in this form: The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardize coverage or invalidate a claim.

Statement pursuant to Section 25 (5) Cap. 142 of the Insurance Act or any subsequent amendments thereof – You are to disclose in this proposal form fully and faithfully all the facts which you know or ought to know about the risk that is being proposed, otherwise the policy issued hereunder may be void.

One Medical Questionnaire must be submitted for each person to be covered by an APRIL policy.

Name of Proposer (person who will own the policy)

First Name(s): ______

Family Name: ______

Applicant Details

This is the Medical Questionnaire of:

First Name(s): ______

Family Name: ______

Gender (M/F): ______ Relationship to Proposer: ______

Nationality: ID/Passport Number: ______ Smoker: Yes ☐ No ☐

Date of Birth (ddmmyy): ______ Occupation: ______

Height (cm): ______ Weight (kg): ______ OR Height (feet): ____ ft ____ in Weight (pounds): ______

Residential Address: ______

______

Postal Code: ______ City: ______

Country: ______

Telephone: ______ Mobile: ______

Email: ______

Important:

Please advise us if any persons to be insured do not live at the Proposer's residential Address.

Insurance Details

Have you ever applied for, been covered under, or held an APRIL policy? Yes ☐ No ☐ If Yes, please give details:

______

Do you currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date): ☐ Yes ☐ No

______

Have you ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or had any special terms imposed? ☐ Yes ☐ No If Yes, please give details:

______

Medical Details/History

Please indicate if you have or have ever had any of the signs, symptoms, illnesses or disorders below by ticking the appropriate box.

1)	Cancer, leukaemia, tumour or neoplasm (including benign growths), cysts including fibrocystic breast disorder or any blood disorder	Yes ☐	No ☐
2)	Asthma, chronic bronchitis, allergies, chronic rhinitis or sinusitis, tuberculosis, any disease or disorder of the lungs	Yes ☐	No ☐
3)	Chest pain, raised blood pressure, heart condition, circulatory disorder	Yes ☐	No ☐
4)	Indigestion, gastric reflux, gastric ulcer, haemorrhoids	Yes ☐	No ☐
5)	Spinal condition, bone fracture, joint injury, back, neck or muscle pain	Yes ☐	No ☐
6)	Malaria, dengue fever, other tropical illness	Yes ☐	No ☐
7)	HIV/AIDS	Yes ☐	No ☐
8)	Kidney Stones, kidney disorder, disorder of the urinary bladder or tract	Yes ☐	No ☐
9)	Diabetes, liver disorder, hepatitis	Yes ☐	No ☐
10)	Disorder of the brain or nervous system, stroke, aneurysm	Yes ☐	No ☐
11)	Mental health problem, anxiety, addiction	Yes ☐	No ☐
12)	Gynaecological disorders including pregnancy, irregular periods or bleeding, menstrual pain, complicated pregnancy, HPV infection, or an abnormal smear test result	Yes ☐	No ☐
13)	Eczema, dermatitis, disorder of eyes, ears	Yes ☐	No ☐
14)	Any other disorder/injury	Yes ☐	No ☐

If you answer "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity of the condition declared.

Question No.	Date of first consultaion	Details of Medical condition, including nature of treatment, results, date of last consultation, and whether you have fully recovered	Name and address of doctor, Hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?
	dd/mm/yyyy			Yes ☐ No ☐ dd/mm/yyyy
	dd/mm/yyyy			Yes ☐ No ☐ dd/mm/yyyy
	dd/mm/yyyy			Yes ☐ No ☐ dd/mm/yyyy

Please provide more details on a separate sheet if required.

15) Except as disclosed elsewhere in this form, have you ever been admitted to hospital as an inpatient, or (within the last five years) undergone any procedures, scans, or diagnostic tests whether as an inpatient or outpatient? ☐ Yes ☐ No

16) Are you currently taking any medication? ☐ Yes ☐ No

If Yes, please state your dosage, the approximate cost of medication and the name of the drug

17) Please enter the following details about your usual/family doctor. If you do not have a usual/family doctor, please provide the names, addresses and contact information of all medical providers you have seen in the last 3 years. Use a separate sheet if necessary.

Name:

Address:

Telephone: Fax:

Email:

Additional space for further remarks

You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application

Personal Data Protection Statement

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/ . If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

Declaration

We will cover you on Standard Terms if you are of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, illness, Injury, bodily infirmity or physical or mental disability, and you must not have attained 61 (sixty-one) years of age at the time of acceptance. If these conditions are not met and you have not attained 80 (eighty) years of age at the time of acceptance, we may offer you on special terms. If we decide to offer the cover on special terms, you will receive an endorsement in which these terms are stated.

Declaration: I acknowledge that presentation of this form does not entitle me or anyone else to cover under this, or any other insurance product or service provided by Liberty Insurance Pte Ltd and or its representative APRIL Singapore Pte Ltd I also acknowledge that the decision as to whether I will be offered cover under this, or any other insurance product or service provided by Liberty Insurance Pte Ltd and or its representative APRIL Singapore Pte Ltd, remains entirely at Liberty Insurance Pte Ltd and or its representative APRIL Singapore Pte Ltd absolute discretion at all times.

Cashless Out-patient Facility: (Applicable only to nil deductible policies with Out-patient Benefits selected) I/We authorise APRIL Singapore Pte Ltd to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and any records APRIL Singapore Pte Ltd may have regarding the insured person(s) shown on the namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the insured person(s). By signing this declaration, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event of authorisation of payment and/or payment is made by Liberty Insurance Pte Ltd for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, Liberty Insurance Pte Ltd reserves the right to recover the said sum or excess from you.

This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then APRIL Singapore Pte Ltd reserves the right to suspend the direct billing service to you without further notice.

PREMIUM PAYMENT WARRANTY (INDIVIDUAL): Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and no benefits whatsoever shall be payable by the Company.

Declaration: I do hereby and warrant the answers given above in every respect are true and correct and I have not withheld any information likely to affect acceptance of this Proposal, and agree that this Proposal Declaration shall be the basis of the Contract between the Company and myself, and I further agree to accept the Company's Policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto.

Consent Clause

I/We do hereby declare and warrant that:

1. All information provided by me/us in connection with this application is true, accurate and complete. I/We have not withheld any material fact and except as declared herein all persons to be insured are currently in good health to the best of my/our knowledge and belief.
2. I/We understand that any inaccurate, incomplete or false information given or any omission of information required, may at Liberty Insurance Pte Ltd's ("**Liberty**", the "**Company**") discretion, render this application invalid.
3. I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.
4. I/We agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.
5. I/We agree to inform if there is any change in any of the details I have provided to Liberty in this application. I understand and agree that it is my sole responsibility to inform and update Liberty of any changes to the health or personal information of any person to be insured. I hereby agree to indemnify and absolve Liberty of any liability arising out of any use and/or disclosure by Liberty of any inaccurate or incomplete information due to my failure to update Liberty promptly of any changes to the health or personal information of any person to be insured.

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact Liberty Insurance or visit the GIA or SDIC websites (www.gia.org.sg or www.sdic.org.sg).

This policy is not a Medisave-approved policy and you may not use Medisave to pay the premium for this policy.

This is a short-term accident and health policy and the insurer is not required to renew this policy. The insurer may terminate this policy by giving you 30 days' notice in writing.

Signature of Policyholder or Applicant

Date

The liability of the Company does not commence until this Proposal has been accepted by the Company.

For Official Use Only

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
51 Club Street #03-00 Liberty House
Singapore 069428
Tel: 1800-LIBERTY (5423 789)

Arranged and administered by:

APRIL Singapore Pte Ltd
60 Paya Lebar Road, #06-45 Paya Lebar Square
Singapore 409051
Tel: (+65) 6736 0057 | Fax: (+65) 6557 0796
Email: contact.sg@april.com