## INDIVIDUAL AND FAMILY APPLICATION FORM

# PALLASHEALTH

www.april-international.com

Please print only if necessary

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.

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.

## Declaration for Product Summary

Name of Applicant:

I/We, the Applicant, acknowledge that the Insurance Advisor has given me/us a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my/our satisfaction.

| Signature of Applicant:<br>Date: | Signature of Insurance Advisor:<br>Date: |
|---|---|

## Applicant's Details

| | | | |
|---|---|---|---|
| Family Name: | | | |
| First Name(s): | | | |
| Date of Birth (dd/mm/yyyy): | Gender: ☐ Male ☐ Female | Height (cm): | Weight (kg): |
| Occupation (specify nature of duties): | | | |
| Smoker: ☐ Yes ☐ No | | Marital Status: | |
| Nationality: | | NRIC/Passport Number: | |
| Residential Address: | | | |
| Usual Country of Residence: | | | |
| Tel: | | Mobile: | |
| Email:<br><br>**Important**: this email will be used for sending claims-related communication which may include sensitive medical information. | | | |

## Family Members to be insured

| | Spouse/Partner | Child 1 | Child 2 | Child 3 |
|---|---|---|---|---|
| | | **Important:** Unmarried children proposed for insurance must be aged 18 or under. Unmarried children over 18 in full-time education can be covered up to 23 years | | |
| Family Name: | | | | |
| First Name(s): | | | | |
| Date of Birth: | **dd/mm/yyyy** | **dd/mm/yyyy** | **dd/mm/yyyy** | **dd/mm/yyyy** |
| Gender: | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female |
| Marital Status: | | | | |
| Nationality: | | | | |
| Smoker: | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| ID/Passport Number: | | | | |
| Occupation (specify nature of duties): | | | | |
| Height & Weight: | cm kg | cm kg | cm kg | cm kg |

Please use separate sheet if necessary.
**Important:** Please advise us if any Family Members to be insured do not live at the Applicant's Residential Address.

## Choose Your Cover

| | |
|---|---|
| **Area of Cover** | ☐ Worldwide excluding *North America and the Caribbean* ☐Worldwide<br>The area of cover chosen will apply to all modules selected. Services rendered outside of the area of cover are covered up to US$50,000 per period of insurance. Please refer to section 4 of the Policy Terms and Conditions. |
| **Annual Deductible** | ☐ Nil ☐ US$500 ☐ US$1,500 ☐ US$5,000<br>The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits |
| **Select any Combination of Modules** | ☑ Module I – Core Module, Hospital and Surgery, including evacuation and repatriation<br>☐ Module II – Outpatient Benefits<br>☐ Module III – Maternity Benefits<br>☐ Module IV – Dental and Optical Benefits |

## Insurance Details

| | |
|---|---|
| Have you ever applied for, been covered under, or held a policy administered by APRIL International?<br>If Yes, please give details. | ☐Yes ☐No |
| 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 cancelled, or had any special terms imposed? If Yes, please give details. | ☐Yes ☐No |

## Medical Details/History

Please indicate if you or any person to be insured 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) | Congenital conditions | ☐Yes ☐No |
| 15) | 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.

| Applicant's Name | Quest-ion No. | Date of first consultation | Details of Medical condition, including nature of treatment, results, date of last consultation,and whether you have fully recovered | Name & 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.*

| |
|---|
| 16) Except as disclosed elsewhere in this form, have you or any person to be insured 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 (please provide details) ☐ No |
| 17) Are you or any person to be insured currently taking any medication? If Yes, please state the medicine name, dosage and the approximate cost. ☐ Yes (please provide details) ☐ No |

| 18) Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/ family doctor, please provide the names, addresses and contact information of all medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary. | |
|---|---|
| Name: | |
| Address: | |
| Telephone: | Fax: |
| Email: | |
| 19) Have you or any person to be insured ever made a claim against any insurer in respect of bodily injury or sickness during the last 3 years? If yes, please give details.<br><br>Name of Claimant:<br>Name of Insurer:<br>Nature of Claim:<br>Date of Claim (ddmmyy):<br><br>*Please use separate sheet if necessary.* | ☐Yes ☐No |

## 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.

| |
|---|
| |

| **Commencement Date** | ☐On Acceptance |
|---|---|
| | ☐ Another date (dd/mm/yyyy):<br>(We cannot backdate cover to a date earlier than the Offer Acceptance Date) |

**Important**: This Individual and Family Application Form is valid for 14 calendar days from date of application signature to date of receipt by APRIL Singapore Pte Ltd.

| **Intermediary Access** | |
|---|---|
| Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account? ☐ Yes ☐ No | |
| Do you authorize us to discuss and/or share claims and medical information with your insurance intermediary? ☐Yes ☐No | |
| Producer Name: | Producer Code: |
| Company Name: | |
| Tel: | Email: |

## Payment Method

☐ **Cheque – Annual Payment Only**

Cheques should be drawn on a Singapore clearing bank and made payable to "Liberty Insurance Pte Ltd". Kindly indicate (1) Name of Proposer or policyholder; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your cheque

☐ **Bank Transfer – Annual Payment Only**

Relating to payment for SGD Singapore-related risks policies:

Beneficiary Bank

| | |
|---|---|
| Beneficiary Name: | Liberty Insurance Pte Ltd. |
| Beneficiary Address: | 51 Club Street, Liberty House, #03-00, Singapore 069428 |
| Bank Name: | UOB |
| Bank Account No: | 451-304-455-5 |
| Bank Address: | 80 Raffles Place, #29-03 UOB Plaza 1, Singapore 048624 |
| Bank Code: | 7375 |
| Branch Code: | 001 |
| Swift Code: | UOVBSGSG |
| Currency: | SGD |

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number as a payment detail to your bank.
3. Please fax (+65) 6222 4473 or email contact.sg@april.com the bank remittance advice or instruction slip with your Policy Number to us for our

☐ **Credit Card – Annual or Instalment Payment**

❑ MasterCard ❑ VISA

❑ Full Payment

❑ 0% Interest Instalment Plan[1]

Premium S$500 and above: ❑ 6 months ❑ 12 months

❑ Citibank ❑ DBS/POSB ❑ Standard Chartered

❑ UOB

Name of Cardholder:
(as shown on card) ______________________________

Credit Card No.: [ | | | ] - [ | | | ] - [ | | | ] - [ | | | ]

Expiry Date: [ | ] / [ | ]

Card Verification Value (CVV): [ | | ]

I hereby authorize Liberty Insurance Pte Ltd to debit my Credit Card account specified above.

Signature:______________________________ Date: ______________________

[1]Only applicable for instalment payment through participating banks in Singapore and is subject to their Credit Card Agreement Terms & Conditions.

## 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 by Applicant

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.

| **Name and Title:** | **Signature:** | **Date:** |
| --- | --- | --- |
| | | |

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) | Fax: (+65) 6223 6434

Arranged by:

**APRIL Singapore Pte Ltd**
Co. Reg. No. 200613924G
60 Paya Lebar Road, #06-45 Paya Lebar Square
Singapore 409051
Tel: (+65) 6736 0057 | Fax: (+65) 6557 0796
Email: contact.sg@april.com

Liberty Insurance

april international

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