



GROUP INSURANCE FACT-FINDING FORM

KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK

Kindly tick boxes [✓] where appropriate

PERIOD OF INSURANCE from _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

REQUEST FOR QUOTATION WAS SUBMITTED ON _____
(dd/mm/yyyy)

REQUEST FROM _____
Name of Insurance Company

1. GENERAL INFORMATION

a) Name of Company: _____

b) Nature of Business: _____

c) Presently Insured: _____ Yes / No

If Yes, Name of Current Insurer: _____

d) Type of Policy: _____

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

e) Total Number of Employees: _____ No. of Employees to be insured: _____

f) Participation:
We would assume that participation of the group insurance program is on compulsory basis, unless otherwise indicated with a tick here below under "Participation - Voluntary".

Insurance Coverage	Participation	
	Compulsory	Voluntary
Group Hospital & Surgical		
- for employees only		
- for dependants only		

*Please note:
Voluntary: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s).*



2. GROUP HOSPITAL & SURGICAL INSURANCE

a) Basis of Coverage

Category of Employees / Occupation	Room & Board Benefit Plan	Currently with TMIS Yes / No	Proposal with TMIS Yes / No
i)			
ii)			
iii)			
iv)			

Important Note: Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.

Example 1:

Category of Employees / Occupation	R&B Benefit Plan
i) Senior Management (Director, General Manager, Senior Manager)	360
ii) Manager & Executive	200
iii) All Others	100

b) Details of Insured Members

	No. of Employees				
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5
Employee Only					
Employee & Spouse					
Employee & Child(ren)					
Employee & Family					

c) Claims Experience for the past 3 years

Period of Coverage From / To (dd/mm/yyyy)	Number of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		Number	Amount	Number	Amount

The Insurer reserves the right to request for more information.



d) **KINDLY ATTACH A COPY OF THE SCHEDULE OF BENEFITS
(IF CURRENTLY INSURED).**

e) **Is there any member terminally ill (e.g. cancer, kidney failure, etc) or in hospital?
If Yes, kindly provide the following details** **Yes/No**

Number of members: _____

Reason for hospitalization: _____

Nature of illness: _____

Please note that we would not reimburse the claims for any members in hospital at the time of application.

f) **Is there any member based outside Singapore?** **Yes / No**
If Yes, kindly provide the following details

Number of members: _____

Country based in: _____

g) **Is there any member engaged in hazardous occupation?** **Yes / No**
(Hazardous occupation e.g. welder, diver, rigger, sandblaster, offshore workers, etc)

If Yes, what is the nature of work?

h) **To the best of your knowledge, is there any member engaged in hazardous sports?** **Yes/No**
(Hazardous sports e.g. scuba diving, motor racing, bungee jumping, etc)

If Yes, what kind of sports?



3. NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box to indicate the priority of your company's needs:

Company's Priorities	Low	Med	High	Advisor's Recommendation
Cover for Outpatient Medical Expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Hospital & Surgical Expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Dental Expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Major Expenses (eg. Cancer, Kidney Failure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Loss of Income due to (sickness or accident)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for Long Term Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

DECLARATION

I / We hereby declare that, to the best of my / our knowledge and belief, the information given here is 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 the Insurer.

Signature of Authorised Officer

Date

Name:
Designation:
Company Stamp (if applicable):

TO BE COMPLETED BY AGENT/BROKER

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 Broker/Agent

Date

Name / NRIC:
Designation:
Company Stamp (if applicable):