GROUP INSURANCE FACT-FINDING FORM

KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK
Kindly tick boxes [✓] where appropriate

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

REQUEST FOR QUOTATION was submitted on ______________________ (dd/mm/yyyy)

REQUEST FROM **QBE INSURANCE (INTERNATIONAL) LIMITED**
(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 ______________________ (dd/mm/yyyy) to ______________________ (dd/mm/yyyy)

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

f) Average Age of the No. of Employees to be insured: ______________________

g) Participation:

The Insurer 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		
Group Critical Illness		
Group Disability Income		

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
Plan 1				
Plan 2				
Plan 3				
Plan 4				

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/yyy)	Number of Insured as at	Paid Claims		Outstanding Claims	
	(dd/mm/yyyy)	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 seriously ill (e.g. cancer, kidney failure, etc) or in hospital? Yes / No

If **Yes**, kindly provide the following details

Number of members: ______________________

Reason for hospitalisation: ______________________

Nature of illness: ______________________

____

____

____

____

Kindly note that insurer would not reimburse the claim for any member in the 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. **GROUP CRITICAL ILLNESS INSURANCE (if Applicable)**

a) **Basis of Coverage**

	Category of Employees / Occupation	Basis of Coverage Sum Insured (S$)
i)		
ii)		
iii)		
iv)		

Example 1:

Category of Employees / Occupation	Basis of Coverage
i) Senior Management (Director, General Manager, Senior Manager)	100,000
ii) Manager & Executive	50,000
iii) All Others	25,000

Example 2:

Category of Employees / Occupation	Basis of Coverage
i) All Employees	24 x Basic Monthly Salary

b) Is this benefit an advance of or an additional amount to the term life? Yes / No

If it is an advance, what is the percentage on the term life sum insured? ________%

c) **Details of Employees**

Age Band (Age Next Birthday)	No. of Employees		Sum Insured	
	Male	Female	Male	Female
16 – 30				
31 – 35				
36 – 40				
41 – 45				
46 – 50				
51 – 55				
56 – 60				
61 – 65				
Total				

d) **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.

e) Is there any member seriously ill (e.g. cancer, kidney failure, etc) or in hospital? Yes / No

If **Yes**, kindly provide the following details

Number of members: ________________________________

Reason for hospitalisation: ________________________________

Nature of illness: ________________________________

Kindly note that insurer would not cover members with pre-existing medical conditions.

f) Is there any member based outside Singapore? Yes / No

If **Yes**, kindly provide the following details

Number of members: ________________________________

Sum Insured: ________________________________

Country based in: ________________________________

g) Please provide a list of critical illnesses covered (if currently insured).

4. GROUP DISABILITY INCOME INSURANCE (If Applicable)

a) If currently insured, please attach a copy of the definition of Disability.

b) What is the waiting period required? ____________________

c) What is the benefit duration required? ____________________
(i.e. 2 years, 5 years, to age 60 Or 65?)

d) Any requirement for partial disability benefits? Yes / No

e) **Basis of Coverage**

Category of Employees / Occupation		Monthly Salary (S$)	Basis of Coverage Sum Insured (S$) (% of Monthly Salary S$)
i)			
ii)			
iii)			
iv)			

f) **Details of Employees**

Age Band (Age Next Birthday)	No. of Employees		Sum Insured	
	Male	Female	Male	Female
16 – 30				
31 – 35				
36 – 40				
41 – 45				
46 – 50				
51 – 55				
56 – 60				
61 – 65				
Total				

g) **Claims Experience for the past 3 years**

Date of Disability (dd/mm/yyyy)	Cause of Disability / Nature of illness	Claims Amount S$	
		Paid	Outstanding

The Insurer reserves the right to request for more information.

h) Is there any member seriously ill (e.g. cancer, kidney failure, etc) or in hospital? Yes / No

If **Yes**, kindly provide the following details

Number of members: ______________________

Reason for hospitalisation: ______________________

Nature of illness: ______________________

____

____

i) Is there any member based outside Singapore? Yes / No

If **Yes**, kindly provide the following details

Number of members: ______________________

Sum Insured: ______________________

Country based in: ______________________

____

____

j) 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? ______________________

____

____

____

k) 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? ______________________

____

____

____

5. 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
i) Cover for outpatient medical expenses	☐	☐	☐	
ii) Cover for hospitals & surgical expenses	☐	☐	☐	
iii) Cover for dental expenses	☐	☐	☐	
iv) Cover for major illnesses (e.g. cancer, kidney failure, etc.)	☐	☐	☐	
v) Cover for loss of income due to sickness or accident	☐	☐	☐	
vi) Cover for long term medical treatment	☐	☐	☐	

vii) Others : ______________________________

6. DECLARATION

[This section must be printed at the end of each form for all the types of applicable business]

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**

Name:
Designation:
Company Stamp (if applicable):
Date:

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 **Insurance Representative**

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