

Tenet Insurance Company Ltd
(A wholly owned company of Hwa Hong Corporation Limited)
11 Collyer Quay #09-00 The Arcade Singapore 049317
Tel: (65) 6221 2211 Fax: (65) 6221 3302
Company Registration No. 195700067Z
Website: <http://www.tenetinsurance.com>



GROUP I INSURANCE FACT-FINDING AND APPLICATION FORM

Important Notice

1. Statement Pursuant to Section 25(5) of the Insurance Act you are to disclose to us fully and faithfully the facts you know or ought to know otherwise you may not receive any benefits from your Policy.
2. Please note that this insurance is subject to the premium being paid and received in full by the Company (a) before the inception date here the Policy is issued to an Individual; or (b) within the period specified in the Premium Payment Warranty applied to the Policy in all other instances, failing which there will be no liability under this cover.
3. The liability of the Company does not commence until this Application is accepted and the premium is paid in accordance with the clause 2 above.

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 _____

AGENT NAME/ CODE: _____

1. GENERAL INFORMATION

- a) Name of Applicant/ Company: _____
- b) Address of Company: _____
- c) Tel: _____ Email: _____ Nature of Business: _____
- d) Presently insured under other medical, hospitalisation, accident or life insurance: **Yes / No**
If **Yes**, Name of Current Insurer: _____
- e) Type of Policy/Name of Plan: _____
Period of Insurance: From _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)
- f) Total Number of Employees: _____ No. of Employees to be insured: _____
Eligibility: Date of Employment/Confirmation* (**delete where appropriate*)

- 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		

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 – Employees

* Age Band	No. of Employees									
	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
< 19										
19 – 40										
41 – 50										
51 – 60										

* Based on Age Next Birthday

c) **Details of Insured Members – Dependants**

* Age Band	No. of Dependants									
	Plan 1		Plan 2		Plan 3		Plan 4		Plan 5	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
< 19										
19 – 40										
41 – 50										
51 – 60										

* Based on Age Next Birthday

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

Name of Person as at (dd/ mm/ yyyy)	Nature of Illness/ Injury	Date of Illness/ Disability	Result of treatment	Paid Claims		Outstanding Claims	
				Number	Amount	Number	Amount

*If more space is required, please write on a separate sheet of paper and attach herewith.
The Insurer reserves the right to request for more information.*

e) Kindly attach a copy of the Schedule of Benefits (if currently insured).

f) 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.

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

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

Number of members: _____

Country based in: _____

h) 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?

i) 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 Hospitals & 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 Illnesses (e.g. 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 : _____				

4. COVERAGE REQUIRED FOR MEDI WELL PLUS APPLICATION

Employees		Plan Indicate Plan Type/ No. of Unit plan required		Optional Riders (please ✓ below)			Choice of Deductible/ Co- insurance	
Category	No.	Aggregate Plan	Unit Plan (max 4 units)	Dread Disease Rider	Hospital Cash Allowance	Parent's Accommodation as Companion	Deductible (\$)	Co-insurance (%)

5. INSURANCE HISTORY

a) Has any Accident or Health policy covering you ever been cancelled or renewal refused? **Yes / No**

If **Yes**, give details:

b) Has any proposal or application made by you for a Life, Accident or Health policy insurance ever been declined, postponed or accepted at other than normal terms? **Yes / No**

If **Yes**, give details:

6. DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that the statements and answers given in this enrolment form and health declarations are true and complete and that I/we have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I/We understand that any misstatement of fact, whether by commission or omission may be grounds for the Insurance Company in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I/We agree that if a contract of insurance is effected, all information submitted in connection with this application, including the proposal and health declaration forms completed by the respective insured persons, shall form the basis of such contract between me/us and the Insurance Company and shall be deemed to be incorporated in such contract. I/We understand that this insurance if accepted will be an annual contract renewable at the discretion of the Insurance Company.

Please charge S\$ _____ to our Visa / MasterCard* (delete as appropriate)
Card No _____ - _____ - _____ - _____ Expiry Date ____ / ____

We enclose a cheque for S\$ _____ (including GST) payable to **Tenet Insurance Company Ltd.**
Bank/Cheque No. _____

Signature of Applicant
on behalf of person(s) to be insured

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

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: