

Supplementary to GROUP MEDIWELL CLASSIC application where the application cover Singapore Citizen and/or Singapore Permanent Resident

KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK

NAME OF APPLICANT/COMPANY: _____

I. 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".

	<u>Participation</u>	
	Compulsory	Voluntary
▪ Group Hospital & Surgical insurance for employees only	<input type="checkbox"/>	<input type="checkbox"/>

Note

Voluntary: Participation is voluntary if employees are given the choice to opt for the cover(s).

II. GROUP HOSPITAL & SURGICAL INSURANCE

a) **Basis of Coverage**

Category of Employees / Occupation	No. of Employees	Room & Board Benefit Plan Please tick [✓]			Currently with TMIS? Yes / No	Proposal with TMIS? Yes / No
		C1	C2	C3		
i)						
ii)						
iii)						
iv)						

b) **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.

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

III. NEEDS ANALYSIS & PRODUCT RECOMMENDATION

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

<u>Company's Priorities</u>	<u>Low</u>	<u>Med</u>	<u>High</u>	<u>Advisor's Recommendation</u>
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 : _____				

IV. 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

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