

8 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, cancelled or renewal refused? If 'Yes', please give details/reasons: Yes / No

9. Have you ever made a claim against any Insurance Company in respect of bodily injury or sickness during the past 3 years? Yes / No
If 'Yes', please give details:

Name of Person	Diagnosis/Description of Illness/Injury	Date of Diagnosis/Disability	Type of Treatment	Paid Claims	Outstanding Claims

Declaration

I hereby declare to the best of my knowledge and belief that the statements and answers given in this health declaration are true and complete and that I have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I understand that any misstatement of fact, whether by commission or omission may be grounds for Tenet Insurance Company Ltd in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable and agree that this proposal and declaration shall be the basis of the contract between me and Tenet Insurance Company Ltd and shall be deemed to be incorporated in such contract.

I understand that all Pre-Existing Conditions before the effective date of this Policy are not covered.

I am aware that I can seek advice from a qualified insurance advisor before completing this proposal form, and will take responsibility to check that this product is appropriate to my financial needs and insurance objectives. *(Applicable to Direct Marketing)*

I have received the booklet 'Your Guide to Health Insurance' as well as the MediWell Plus / MediLite brochure, which provides the Product Summary on key product information and provisions, the contents of which have been explained to my satisfaction. *(Not Applicable to Direct Marketing)*

I confirm I have been given the Product Summary Version : **MediWell Plus Oct 2005.2*** / _____

MediLite Nov 2006* / _____

Note: * delete and state new version code (if different)

Please charge S\$ _____ (including GST) to my Visa/Mastercard* (*delete as appropriate)
Card No. - - - Expiry Date: -

I/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
(Affix company stamp where applicant is a corporate entity)

Signature of Employee's / Applicant's Spouse
(Where spouse is a person to be insured) on behalf of person(s) to be insured

Signature of Employee
(Where applicant is a corporate entity) on behalf of person(s) to be insured

Date

Signature of Advisor

Date

July 2008

MediWell Plus/MediLite Pre-Application

Please complete this section before proceeding to the Application
(Not applicable for Direct Marketing and Corporate Applicants)

Insurance Advisor

Your Insurance Advisor is a representative of Tenet Insurance Company Ltd and can advise you on MediWell Plus/MediLite.

Name of Insurance Advisor:	Code:

Pre-Application

I am Interested to find out more from my insurance advisor to review if MediWell Plus/MediLite is suitable for me and/or my family. I understand that my insurance advisor must have sufficient information before making a suitable recommendation and the "Know Your Client Form" is a Fact Find Form that allows me to provide information on my financial situation and particular needs, which will be the basis on which advice will be given.

My choice is

- 1. To disclose all information requested for in the "Know Your Client Form" (KYCF) to help the insurance advisor access my insurance needs and requirements.
- 2. To receive product advice only. (Please see Advisor's Recommendation)
- 3. To make the purchase decision without receiving any advice from my Advisor.

Advisor Analysis and Recommendations – Where Client Requires Product Advice Only

Advisor's Recommendations	Reasons for Recommendations	Remarks
<input type="checkbox"/> Medical expenses protection eg. MediWell Plus		
<input type="checkbox"/> Hospital Cash Income and/or Other Protection eg. MediLite		

I agree / do not agree* with the proposed recommendation(s).

Signature of Client: _____

Signature of Spouse* : _____

Date: _____

Date : _____

*Where spouse is one of the proposed lives to be insured.

Signature of Advisor: _____

Date: _____

FOR OFFICIAL USE ONLY – INTERNAL

Tenet Insurance Company Ltd

A wholly owned company of Hwa Hong Corporation Limited a diversified business group listed on the main board of the Stock Exchange of Singapore

11 Collyer Quay #09-00 The Arcade Singapore 049317 Tel : 6221 2211 Fax : 6221 3302

www.tenetinsurance.com

Company Registration No: 195700067Z

MediWell Plus/MediLite

Personal Insurance

Application Form

IMPORTANT NOTICE

- 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.
- Please note that this insurance is subject to the premium being paid and received in full by the Company (a) before the inception date where 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.
- The liability of the Company does not commence until this Application is accepted and the premium is paid in accordance with clause 2 above.
- This form is valid for three months from date of application, after which has to be re-completed and signed by applicant.
*To be completed as applicable

The Applicant

Name:	
Address:	
NRIC/Passport No./ROC No. (whichever applicable):	Nationality*:
Occupation/Profession*:	Business/Trade*:
Marital Status*:	Email:
Tel: _____ (HP)	_____ (O) _____ (H)

Particulars of Person(s) to be Insured

Details of Spouse and child(ren) are required only if they are included in this cover

Relation	Name	NRIC/Passport No. /Nationality	Birth Date	Occupation & Biz/Trade	Sex	Wt (kg)	Ht (m)
Self							
Spouse							
Child 1							
Child 2							
Child 3							

Coverage Required

Period of insurance: From _____ to _____

MediWell Plus

PART I – BASIC PLAN	Self	Spouse	Child 1	Child 2	Child 3
Design and Plan – Circle selected Design (Essential – E or Surplus – S) and indicate Plan code (Plans A to D)	E/S _____	E/S _____	E/S _____	E/S _____	E/S _____
Deductible to be Assumed (S\$)					
Co-Insurance (%)					
PART II – OPTIONAL RIDERS <input checked="" type="checkbox"/> Please tick					
– Dread Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
– Hospital Cash Allowance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PREMIUM CALCULATION					
Basic Plan Premium (for Part I)					
Less Discounts (Deductible + Co-Insurance + Family Discounts)					
Add Premium for Optional Riders (for Part II)					
	Gross Total Premium S\$				
	GRAND TOTAL PREMIUM INCL GST S\$				

MediLite

	Self	Spouse	Child 1	Child 2	Child 3
Plan – Circle selected Plan code (Plans 1 to 3)	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3	1 / 2 / 3
PREMIUM CALCULATION					
	Gross Total Premium S\$				
	GRAND TOTAL PREMIUM INCL GST S\$				

Lifestyle & Habits of Person(s) to be Insured

Have you and the person(s) to be insured been smoking in the past 12 months? If yes, please specify Name of person(s) _____ No. of years smoking _____ No. of cigarettes per day _____	Yes / No
Do you and the person(s) to be insured consume beer, wine or other alcohol? If yes, please specify Name of person(s) _____ Beer _____ cans (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) per week Others (please specify type and amount of consumption): _____	Yes / No
Have you and the person(s) to be insured ever taken any habit forming drugs or been treated for drug addiction?	Yes / No
Do you and the person(s) to be insured engage in or intend to engage in any sports of hazardous nature (e.g. diving, flying, motor-racing etc)? If yes, please give details: _____	Yes / No

Health Declarations for Applicant and Person(s) to be insured

You may be required to complete a separate questionnaire for any health conditions declared below.

1. Have you had any health screening with abnormal results during the last 2 years?	Yes / No																
2. Have you ever (a) Had a surgical procedure? (b) Been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed? (c) Received any medical advice, counselling or treatment in connection with sexually transmitted disease (E.g. gonorrhoea, syphilis, genital warts/herpes, non-specific urethritis), HIV infection or AIDS?	Yes / No Yes / No Yes / No																
3. Are you currently undergoing any medical treatment for, ever been treated for, under observation for, or have been told of, any disorder or disease of the following: (a) Ears, throat, eyes or other physical disability or condition affecting hearing, speech or sight, otitis media, ear discharge, tonsils, cataracts, glaucoma, detached retina, ear infection? (b) Digestive system, liver, gallbladder, stomach, pancreas, intestines, hepatitis, cirrhosis, stones, hernia, gastritis, ulcer, gastric/intestinal polyp, piles/haemorrhoids, fistula, chronic, diarrhoea, irritable bowel disease, rectal bleeding? (c) Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis? (d) Heart attack, angina, chest pain, rheumatic fever, murmur, heart valve disorder, irregular or fast heart rate, coronary artery disease, high blood pressure, high cholesterol or any disease or disorder of the heart or the blood vessels? (e) Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system? (f) Brain, mental or nervous system disorder, fits, epilepsy, paralysis, stroke, weakness of limb, numbness, poliomyelitis, migraine, prolonged headache, loss of balance, dizziness, fainting spells, anxiety or depression? (g) Albumin, protein, blood, sugar or pus in urine, kidney stones, urinary tract infection, prostate problem, incontinence or any disease or disorder of the kidney, bladder or genitourinary system? (h) Gout, arthritis, slipped-disc, persistent back/neck pain, osteoporosis, Systemic Lupus Erythematosus (SLE) or any disease or disorder of the spine, bones, limbs, joints, muscles or connective tissues? (i) Cancer, tumour, cyst or growth of any kind? (j) Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood? (k) Physical defects/deformities, congenital anomalies, premature birth? (l) Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above? (m) Any other illnesses not listed above, please give details on separate sheets.	Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No Yes / No																
4. During the past five years, have you consulted a physician for a general examination or for any reasons not previously noted on this application?	Yes / No																
5. Have any of your natural parents or any siblings died or suffered from cancer, heart disease, kidney disease, stroke, diabetes, high blood pressure, mental disorder, tuberculosis or any contagious disease or any hereditary disease or disorder?	Yes / No																
	<table border="1"> <thead> <tr> <th>Relationship</th> <th>Age at Onset</th> <th>Current Age / Age at Death</th> <th>Diagnosis</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Relationship	Age at Onset	Current Age / Age at Death	Diagnosis												
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For Female Only (Questions 6 & 7)

6. Have you ever suffered from or been treated for any disease or disorder of the breasts or female organs (uterus, ovary, fallopian tube, cervix, etc) including abnormal Pap smear and irregular menses?	Yes / No
7a. Are you now pregnant? Name: _____ Expected delivery date: _____	Yes / No
7b. Any complication(s) relating to this/previous pregnancies? If yes, please specify: *Gestational Diabetes / Eclampsia / Hypertension / Others (please state): _____	Yes / No

If you answer "Yes" to questions 1 to 4, 6 to 7, please provide full details.

Qn No	Name of Person	Diagnosis/Description of Illness/Injury	Date of Diagnosis/Disability	Type of Treatment	Date and result of last treatment/ to visit doctor	Name & Address of Doctor consulted

Remarks:
