

Tenet Insurance Company Ltd

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



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.



Group Insurance Individual Health Declaration Form (for group compulsory/voluntary scheme)

Agent Name/Code: _____

The Applicant

Name of Employee _____

Name of Employer _____

Eligibility: Date of Employment/Confirmation* _____
 (*delete where appropriate)

Period of Insurance: From _____ to _____

Marital Status _____ Tel _____ (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.	Birth Date	Occupation & Biz/Trade	Sex	Wt (kg)	Ht (m)
Employee							
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

Habits of Person(s) to be Insured

	Self		Answer only if Insured			
	Yes	No	Spouse		Child(ren)	
			Yes	No	Yes	No
1. 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 sticks _____ daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you and the person(s) to be insured consume beer, wine or other alcohol? If yes, please specify consumption per week. Name of person(s) _____ Beer _____ cans (330ml) Wine _____ glasses (100ml) Spirits _____ tots (30ml) Others (please specify type and amount of consumption): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you and the person(s) to be insured ever taken any habit forming drugs or been treated for drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.	Self		Answer only if Insured			
			Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Have you or the person(s) to be insured had any health screening with abnormal results during the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or the person(s) to be insured ever						
a) Had a surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been advised to have any diagnostic test, hospital confinement or surgical procedure which has not yet been performed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Received any medical advice, counselling or treatment in connection with sexually transmitted disease (e.g. gonorrhoea, syphilis, genital arts/herpes, non-specific urethritis), HIV infection or AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you or the person(s) to be insured 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Respiratory system, chest or breathing discomfort, lung conditions, asthma, bronchitis, pneumonia, persistent cough, tuberculosis, pneumothorax, nasal bleeding, nasal polyps, sinusitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Diabetes, thyroid gland, pituitary gland or any disease or disorder of the endocrine system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Cancer, tumour, cyst or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Anaemia, thalassaemia, haemophilia or any disease or disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Physical defects/deformities, congenital anomalies, premature birth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Skin problem, drug allergy or any other illness, disorder, physical disability or injury not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Any other illnesses not listed above, please give details on separate sheets.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past five years have you or the person(s) to be insured consulted a physician for a general examination or for any reasons not previously noted on this application?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For Female Only (Question 5 and 6)	Self		Answer only if Insured			
			Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
5. Have you or the person(s) to be insured 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6a. Are you or the person(s) to be insured now pregnant? Expected delivery date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6b. Any complication(s) relating to this / previous pregnancies? If yes, please specify: *Gestational Diabetes / Eclampsia / Hypertension / Others(please state): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Qn No.	Name of Person	Nature of Illness/Injury	Date of Diagnosis/ Disability	Date of operation	In-patient or Out-patient	Date of last treatment/ symptoms/ visit to doctor	Result of Treatment	Name & Address of Physician/ Hospital

	Self		Answer only if Insured			
			Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
7. Has any Accident or Health policy covering you or the person(s) to be insured ever been cancelled or its renewal refused? If "Yes", give details/reasons:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? If "Yes", give details/reasons:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you ever made a claim against any Insurance Company in respect of bodily injury or sickness during the past 3 years? If "Yes", give details:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Name of Person	Nature / Diagnosis of Illness/Injury	Date of Diagnosis / Disability	Result of Treatment	Paid Claims	Outstanding Claims

Declaration

I/We hereby declare to the best of my/our knowledge and belief that the statements and answers given in this health declaration 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 Tenet Insurance Company Ltd in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I/We agree that this proposal and declaration shall be the basis of the contract between me/us and Tenet Insurance Company Ltd 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 Tenet Insurance Company Ltd.

For group VOLUNTARY scheme only:

I/We have been given a copy of 'Your Guide to Health Insurance' and 'Product Summary' and their contents have been explained to my/our satisfaction.

Signature of Employee
for and On behalf of all persons to be insured

Date