

# QBE Group Medical Prestige Application Form

QBE Insurance (Singapore) Pte Ltd



## Important Notes

- Under Section 25(5) of the Insurance Act Cap 142 or any subsequent amendment thereof, you are to disclose in this Application form, fully and faithfully, all facts which you know or ought to know; otherwise, the policy issued may be void.
- Please complete this form by carefully answering all questions. It is important a complete answer be given to every question, including dates where applicable to avoid unnecessary delays in the processing of this application. You are advised to keep a record (including copies of letters) of all information you supplied.
- No liability is undertaken until our Company has accepted this application.

## Section A : Particulars Of Group Policyholder

Company Name	<input type="text"/>		
Company Address	<input type="text"/>		
UEN No.	<input type="text"/>		
Current Insurer	<input type="text"/>	Nature of Business	<input type="text"/>
Email	<input type="text"/>		
Contact Person	<input type="text"/>		
Contact No.	(O) <input type="text"/>	(H) <input type="text"/>	
	(HP) <input type="text"/>	(Fax) <input type="text"/>	
Period of insurance:	From: <input type="text"/>	To: <input type="text"/>	

ELIGIBILITY  Employee only  Employees plus Dependants

1. Each full-time employee will be eligible for insurance:

- upon the Effective Date of the Policy.
- upon completion of \_\_\_\_\_ months of continuous service.

2. Each future full-time employee shall be eligible for insurance:

- upon the Effective Date of the Policy.
- upon completion of \_\_\_\_\_ months of continuous service.

ADMINISTRATION  Headcount\*  Named Basis

CLAIM PAYEE DETAILS  Payable to Policyholder  Payable to Insured Members

INSURED NAME	EMAIL	BANK CODE / NAME	BANK BRANCH CODE	BANK ACCOUNT NO
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Important Notes:**

1. In Section B, please indicate the category of employees to be insured, e.g. Management, Executive, Other Staff.
2. Eligible dependants include spouse, unemployed child aged 15 days to 25 years of age.
3. A dependant's cover will be the same as the employee's coverage. Once inception, it will apply to all eligible employees in the same category.
4. \*Headcount basis only applies to a company insuring all their employees into the plan with headcount above 15 pax; otherwise, please provide the names of employees you are insuring. Please be advised any under-declaration of headcount will result in a forfeiture of coverage.
5. Completion of Health Declaration Form is required for group size of 15 and below for new business inception and for member who is 70 years old and above.

**Section B : Basis Of Coverage**

Category of Employee	Number of Applicants			Basic Medical Cover		General Practitioner panel	Specialist	Dental rider
	EE	SP	CH	Plan	Deductible	Plan	Plan	Plan

**Important:**

QBE will require additional and separate details of of hospitalization for applicants who have been hospitalized in the last 3 years. Please take note any non-disclosures will result in a forfeiture of coverage.

**Policy Owners' Protection Scheme**

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact your insurer or visit the GIA/LIA or SDIC websites ([www.gia.org.sg](http://www.gia.org.sg) or [www.lia.org.sg](http://www.lia.org.sg) or [www.sdic.org.sg](http://www.sdic.org.sg)).

# Medical Insurance Application/Health Declaration Form

## Important Notes:

- Under Section 25(5) of the Insurance Act Cap 142 or any subsequent amendment thereof, you are to disclose in this application form, fully and faithfully, all the facts, which you know or ought to know, otherwise the policy issued may be void.
- Please complete this form by answering carefully all questions. It is important that a complete answer be given to every question including dates where applicable in order to avoid unnecessary delay in the processing of this application. You are advised to keep a record (including copies of letters) of all information you supplied herein.
- No liability is undertaken until our Company has accepted this Application.
- The plan chosen for each Insured must not be higher than that chosen by The Applicant/Proposer.
- All Eligible Members of the Insured's Family must be insured under the Policy, except those members who are covered for medical insurance as part of their employment contract.
- The Policy & its endorsements are subject to premium payment warranty (corporate) and premium before cover warranty (individual).
- In respect of asterisked items, please elaborate further (if necessary) on a separate sheet and provide copies of results.
- Pre-existing conditions are NOT covered under the policy unless declared and accepted by QBE Insurance (Singapore) Pte Ltd.
- Please ensure that the height and weight of the applicants are completed.

## Declaration & Consent

We declare that all the information supplied above is true and correct and I hereby agree that this Application and the Declaration shall be held as promissory and shall be the basis of the Contract between me / Policyholder and QBE Insurance (Singapore) Pte Ltd and I understand that any false, incorrect or misleading statements may render this application null and void.

We hereby agree that all the Applicants for insurance are in good health and free from any physical defects or infirmity (except as stated above). I further authorise any medical source, insurance office, organisation or person to release any relevant information acquired in the course of my examination or treatment to QBE Insurance (Singapore) Pte Ltd. A photocopy of this authorisation shall be valid as the original.

We agree that collective consent have been obtained allowing QBE to collect, use, process and disclose personal data in accordance with the PDPA and QBE's Privacy Policy which we have read, understood and agreed to its contents. (Please refer to the Privacy Policy at <http://www.qbe.com.sg>)

We confirm that I have received a copy of "YOUR GUIDE TO HEALTH INSURANCE" and "PRODUCT SUMMARY" and have read and understood the contents of these two documents (Applicable to Individual and Voluntary Plans).

Name of Insurance Advisor

Account Code:

Signature of Applicant

Date

## Questionnaire (Applicable to all APPLICANT(S) for insurance)

**Note: Any Questions Not Answered on this Form will be taken as an Answer in the Negative.**

QUESTION	MAIN INSURED	SPOUSE	CHILD 1	CHILD 2
1. Do you or any of the Applicants intend to or engage in any hazardous avocations, activities, sports, or pastime?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you or any of Applicants reside or intend to reside in or travel to any other country outside Singapore for a period of 90 days and above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you or any of the Applicants currently have Workmen Compensation plan, Medical Accident, or Life Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you or any of the Applicants have had your Life, Accident and Health insurance being declined, deferred, cancelled or subject to special terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or any of the Applicants EVER had or been told to have, been treated, or are currently undergoing observation, medical treatment, or surgical operation which has not yet been performed for any diseases or disorders:				
i) Any respiratory disorders? E.g. asthma, bronchitis, pneumonia, persistent cough, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) Any ear, nose, throat or eye(s) disorder? E.g. otitis, sinusitis, tonsillitis, retinal detachments, cataracts, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii) Any brain (neurological) disorder, heart disorder, hypertension, raised cholesterol, stroke or circulatory disease? E.g. epilepsy, prolonged headache, migraine, heart murmur, palpitation, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iv) Any liver, pancreas, gallbladder disorders? E.g. hepatitis, cirrhosis, stones, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
v) Any stomach, intestines, or rectal disorders? E.g. gastritis, ulcers, piles, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
vi) Any kidney, urinary, or genital disorders? E.g. stones, urinary infection, blood/protein urine, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
vii) Female Applicants: Any female or gynaecological disorder? E.g. endometriosis, cyst(s), fibroid(s), irregular menstruation, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
viii) Any pain, deformity, or disorders of muscles, back, limbs, or joints? E.g. gout, arthritis, slipped disc, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ix) Any endocrine or blood disorders? E.g. thyroid, diabetes, anaemia, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
x) Any cancer, tumour, cyst, or growth of any kind?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
xi) Any other illness, physical defects, congenital anomalies, injury, disability, symptoms, or recurrent complaints that may indicate a disorder not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No



## Declaration of Product Summary

I/We confirm the terms as stated in this quotation and its attachments have been explained and accepted by us.

I/We also confirm the Plan applied for had not been in whole or in part terminated by another insurer due to non-payment of the premium in the last 12 months.

I/We warrant the information supplied in this application is true and correct and I/We hereby agree this Proposal and the Declaration will be held as promissory and shall be the basis of the contract between the Policyholder and the Insurer and we understand any false, incorrect or misleading statement may render this insurance null and void.

Name & Signature of Authorised Officer

Company Stamp

Designation

Date

## Declaration

I/We have read and understood the Personal Information Collection Statement attached to this Application Form.

I/We would like to receive information about goods and services of QBE SG or their affiliates via email and/or phone.

Yes

No

Signature & Company stamp:

Date:

## Personal Information Collection Statement

In relation to the personal data collected by QBE Insurance (Singapore) Pte. Ltd. ("QBE SG"), I/We agree and acknowledge that:

- a) the personal data requested is necessary for QBE SG to process your application for insurance or claim and any such data not provided may mean this application or claim cannot be processed;
- b) the personal data collected in this form may be used by QBE SG for the purposes stated in its Privacy Policy found at <https://www.qbe.com/sg/privacy-policy>. These include underwriting and administering the insurance policy being applied for (including obtaining reinsurance, underwriting renewals, claim processing, investigation, payment and subrogation and any related purposes);
- c) QBE SG may transfer the personal data to the following classes of persons (whether based in Singapore or overseas) for the purposes identified in (b) above:
  - i. third parties providing services related to the administration of my/our policy (including reinsurance);
  - ii. financial institutions for the purpose of processing this application and obtaining policy payments;
  - iii. in the event of a claim, loss adjustors, assessors, third party administrators, emergency providers, legal services providers, retailers, medical providers and travel carriers;
  - iv. another member of the QBE group (for all of the purposes stated in (b)) in any country; or
  - v. other parties referred to in QBE's Privacy Policy for the purposes stated therein;
- d) I/We may gain access to, or request correction of my/our personal data (in both cases, subject to a reasonable fee), via email or post at:

QBE Insurance (Singapore) Pte. Ltd.  
Address: 1 Wallich Street, #35-01, Guoco Tower, Singapore 078881  
Email: [info.sing@qbe.com](mailto:info.sing@qbe.com)
- e) that where I/We are providing personal data on behalf of another person to QBE SG, I/We have obtained consent from the other person who have agreed that their personal data will be released to QBE SG in accordance with paragraphs (a), (b) and (c) above.

## For Intermediary Use

Intermediary's Name

Intermediary's Code

Date (dd/mm/yyyy)