PROPOSAL FORM – EQ HOSPITAL & SURGICAL PLAN

IMPORTANT NOTES

1. Pursuant to Section 25(5) of the Insurance Act (Chap. 142) and any replacement thereof, you are to disclose in this Proposal Form all the facts, which you know or ought to know, otherwise the Policy issued hereunder may be void.
2. All questions in this Proposal Form must be answered before this proposal can be considered. Any question not answered will be taken as answered in the negative. The liability of the Company does not commence in respect of this proposal until acceptance has been communicated by the Company to the Proposer or his Agent or Broker.
3. If the space provided is insufficient, please write the details on a separate sheet of paper and attach it to this Proposal Form.

PROPOSER / INSURED PARTICULARS (ALL FIELDS ARE MANDATORY)

Full Name:	
Address:	Postal Code ( )
NRIC / FIN No.:	Nationality:
Date of Birth (dd/mm/yyyy):	Occupation:
Gender: ☐ Male ☐ Female	Marital Status:
Height (m): Weight (kg):	Smoker: ☐ Yes ☐ No No. of sticks / day: _____ Years of smoking: _____
Contact No.: (Home) (Office) (Mobile)	Email:

PARTICULARS OF PERSON(S) TO BE INSURED [DETAILS OF SPOUSE AND CHILD(REN) ARE REQUIRED ONLY IF THEY ARE TO BE INCLUDED IN THIS COVER]

Relation	Name	NRIC / FIN No.	Date of Birth (dd/mm/yyyy)	Gender	Height (m)	Weight (kg)	Smoker (Y/N)
Spouse							
Child 1							
Child 2							
Child 3							
Child 4							

Occupation of Spouse: _____

For smokers:

Name: _____ No. of stick / day: _____ Years of smoking: _____

Name: _____ No. of stick / day: _____ Years of smoking: _____

DETAILS OF EMPLOYER (COMPANY) [COMPLETE THIS SECTION ONLY IF PREMIUM IS PAID BY EMPLOYER AND POLICY TO BE ISSUED TO EMPLOYER]

Name of Employer:
Address of Employer:
Nature of Employer's Business:
Is your Employer a GST registered company? ☐ Yes ☐ No If yes, what is the GST Registration No.? _____

PERIOD OF INSURANCE

From	To

CHOICE OF PLAN / COVERAGE (PLEASE TICK)

Plan	Platinum	Gold	Silver	Basic
Individual / Main Insured	☐	☐	☐	☐
Spouse	☐	☐	☐	☐
Child(ren)	☐	☐	☐	☐

Note: Spouse and Child(ren)'s plan must not be higher than that of the Main Insured's.

QUESTIONAIRE (HEALTH DECLARATION)

PART 1 - HABITS OF INSURED PERSON (S) Please complete for all members to be insured	Main Policyholder		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Have you been smoking in the last 12 months? If Yes, please provide details: a. No. of sticks you smoke per day b. No. of years you have been smoking	☐	☐	☐	☐	☐	☐
2. Do you consume beer, wine or other alcoholic beverages? If Yes, please provide details of alcohol consumption: a. Type of alcohol consumed b. Average weekly consumption with units of measurement	☐	☐	☐	☐	☐	☐
3. Do you engage in or intend to engage in any sport(s) of a dangerous / hazardous nature? E.g. scuba / skin diving, motor racing, private flying, parachuting, etc? If Yes, please state details on the type of sports you participate in:	☐	☐	☐	☐	☐	☐

PART 2 - STATEMENT OF HEALTH OF INSURED PERSON (S) Please complete for all members to be insured	Main Policyholder		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
1. Has any one of the applicants ever had any Health or Life Insurance application or renewal declined, postponed, withdrawn or accepted on special terms?	☐	☐	☐	☐	☐	☐
2. Is any one of the applicants currently undergoing or considering to undergo any medical treatment or medication, medical follow up or routine checkup?	☐	☐	☐	☐	☐	☐
3. Has any one of the applicants ever undergone any health screening or had any medical investigations carried out, such as X-ray, ultrasound, electrocardiogram (ECG), barium meal examination, CT scan, biopsy, blood or urine test, etc., in the past 5 years?	☐	☐	☐	☐	☐	☐
4. Have you or any of the applicant (s) been treated for alcoholism?	☐	☐	☐	☐	☐	☐
5. Have you or any of the applicant(s) ever taken drugs, narcotics, glue sniffing or been treated for drug addiction?	☐	☐	☐	☐	☐	☐

If you have answered 'Yes' to any of the above questions from Part 2 (1-5), please provide the full details below.

Question No	Name of Insured Person	Where (Insurer / Clinic)	Reason / Result

PART 2 - STATEMENT OF HEALTH OF INSURED PERSON (S) CONTINUED Please complete for all members to be insured	Main Policyholder		Spouse		Child(ren)	
	Yes	No	Yes	No	Yes	No
6. Have you or any of the applicant (s) ever had or are currently being treated for:	☐	☐	☐	☐	☐	☐
a. Diabetes (Type 1 or 2), or Endocrine disorders e.g. thyroid disorders or hormonal disorders	☐	☐	☐	☐	☐	☐
b. Cancer, tumours, cysts or growths of any kind e.g. polys, nodules (benign or malignant)	☐	☐	☐	☐	☐	☐
c. Congenital anomalies or hereditary conditions	☐	☐	☐	☐	☐	☐
d. Blood disorders e.g. anaemia, hepatitis, HIV or advised to abstain from donating blood, or received blood transfusion or blood products on account of haemophilia or any other reason	☐	☐	☐	☐	☐	☐
e. High or low blood pressure, high cholesterol, chest discomfort or chest pain, breathlessness, irregular or fast heart rate, heart attack or heart failure, coronary artery disease, heart valve prolapse or any disease and/or disorder of the heart	☐	☐	☐	☐	☐	☐
f. Disease and/disorders of the ear, eye, nose or throat e.g. cataracts, glaucoma, macular degeneration, detached retina, sinusitis, deviated septum, otitis media	☐	☐	☐	☐	☐	☐
g. Slipped disc, back troubles, arthritis, rheumatism, polio, muscular dystrophy, joint pain or deformity, and/or disorders of the muscles, spine, limbs or joints or severe injury	☐	☐	☐	☐	☐	☐
h. Stomach, intestines, bowels, liver, kidney, gallbladder, pancreas, piles, hernia, blood in stools or any change in bowel habits	☐	☐	☐	☐	☐	☐
i. Brain, mental or nervous disorders, dementia, Parkinson's disease, epilepsy, fits, migraine, multiple sclerosis, stroke, paralysis or any other disease of the brain	☐	☐	☐	☐	☐	☐
j. Albumin or protein in urine, blood or sugar in urine, kidney stones, recurrent urinary infections, urinary incontinence or retention or any other disorders of the kidney, urinary or bladder	☐	☐	☐	☐	☐	☐
k. Asthma, persistent cough, coughing with blood, pneumonia, tuberculosis, bronchitis, chest or breathing difficulties or discomfort, and/or any other lung disorders	☐	☐	☐	☐	☐	☐
l. Physical disability or any other illness, disorder, operation, hospital admission, accident or injury not mentioned above	☐	☐	☐	☐	☐	☐
7. Have you been told to have, or received any medical advice or counselling or treatment in connection with sexually transmitted disease, AIDS, or AIDS Related Complex or any other AIDS related condition?	☐	☐	☐	☐	☐	☐
8. a. Have you ever had HIV testing done?	☐	☐	☐	☐	☐	☐
b. Have you in the last 3 months had any of the following symptoms for more than one week continuously: fatigue, weight loss, diarrhoea, enlarged nodes or unusual skin lesions?	☐	☐	☐	☐	☐	☐
9. FOR **FEMALE** ONLY (Also to be completed for child(ren) aged 12 years and above)						
a. Have you ever been found to have or are you aware of any breast lumps or any other disease or disorders of the breast?	☐	☐	☐	☐	☐	☐
b. Have you ever suffered from irregular or painful or unusually heavy menstruation, fibroids, cysts or any disorders of the female organs?	☐	☐	☐	☐	☐	☐
c. Have you ever had any abnormal pap smear test or been told by any doctor to have a repeat pap smear within the six months?	☐	☐	☐	☐	☐	☐
d. Have you been advised to have mammogram, biopsy, operation of the breasts, ultrasound of the pelvis or any other gynaecological investigations?	☐	☐	☐	☐	☐	☐
e. Are you pregnant now?	☐	☐	☐	☐	☐	☐
If Yes, please state the weeks / months of pregnancy	____ wk / mth		____ wk / mth		____ wk / mth	
f. Were there any complications during any of your pregnancy such as gestational diabetes, hypertension, etc?	☐	☐	☐	☐	☐	☐
10. FOR **MALE** ONLY (Also to be completed for child(ren) aged 12 years and above)						
a. Have you ever been found to have or are you aware of any urinary issues such weak urine flow or frequent nighttime urination or any disease and/or disorder of the male reproductive system e.g. benign prostatic hyperplasia (BPH) or enlarged prostate, erectile dysfunction or any issues with male fertility?	☐	☐	☐	☐	☐	☐

If you have answered 'Yes' to any of the above questions from Part 2 (6-10), please provide the full details below.

Question No	Name of Insured Person	Diagnosis / Nature of Illness / Medical Condition (Please include the onset date – Date symptoms 1st started)	Type and Results of Treatment (Please include the last follow up date)	Name and Address of Treating Clinic / Doctor / Hospital

DECLARATION / REPLACEMENT OF EXISTING MEDICAL INSURANCE

Is any one of the applicants currently insured under or applying for any medical insurance? ☐ Yes ☐ No
If "Yes", please provide details:

Name of Insured	Name of Insurer	Type of Policy	Limits (Annual / Lifetime, etc)	Expiry Date

Is the insurance now applied for intended to replace any of the policy(ies) listed above? ☐ Yes ☐ No
If "Yes", please provide details: _____

DECLARATION AND AUTHORISATION

I/We declare and warrant that:

1. All statements and answers in this application together with any required questionnaires or document are full, complete, true and correct and that no information or material has been withheld to affect acceptance of this application.
2. This application shall form the basis of the contract between EQ Insurance and myself/ourselves and for corporate policy, on behalf of the individuals under this policy, and agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto, I/we understand that if any of the information is not full or complete or true or correct, the Policy issued hereunder may be void and I/we may receive nothing from the policy.
3. I/We am aware that I/We can seek advice from a qualified advisor before signing this proposal form. Should I/We choose not to, I/We shall take sole responsibility to ensure that this product is appropriate to my/our financial needs and insurance objectives.
4. There is no awareness of any circumstances which is likely to lead to a claim under this policy at the point of this application.
5. I/We declare that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.
6. I/We understand that this Policy shall only be effective following the full annual premium payment and subject to the acceptance and approval of this application by EQ Insurance.
7. I/We confirm that I have been given referred to a copy of "Your Guide to Health Insurance" at https://www.eqinsurance.com.sg/Product/eq-hospital-surgical and read through the Product Summary (as stated in the brochure), the contents of which have been explained to me/us to my/our satisfaction.
8. I/We have agreed and consented (in case of corporate policy, I/we represent the same from the individuals in relation to this policy) that EQ Insurance may collect, use, disclose and/or process my/our personal data and disclose such relevant information to EQ Insurance's group companies, business partners, intermediaries, third party service providers, reinsurers, legal process participants and their advisers, governmental / regulatory authorities, industry associations, courts and other alternative dispute resolution forums, for the purposes and uses described in EQ Insurance's Personal Data Protection Statement at https://www.eqinsurance.com.sg (including the provision of the protection, services related to the insurance application, screening activities in accordance with legal l/regulatory obligations/risk management procedures).

Corporate Status and Validity of Application

The Applicant hereby declares and warrants that it is a validly existing legal entity under the laws of Singapore (or its jurisdiction of incorporation) at the time of this application. The Applicant acknowledges that the subsistence of its legal personality is a fundamental condition for the issuance of the Policy.

In the event the Applicant is dissolved, struck off, or otherwise ceases to exist as a corporate entity prior to the issuance of the Policy, this application shall be deemed null and void. Furthermore, the Applicant agrees that should it cease to exist during the period of insurance, the Policy shall automatically terminate, and the Insurer shall not be liable for any claims occurring after the date of such dissolution.

I hereby confirm that the following documents were given and the contents have been explained to me satisfactory;
a) Your Guide to Health Insurance and;
b) Product Summary

Signature of client (on behalf of all applicants)
Date:

Signature of Advisor
Date:

KEY GENERAL CONDITIONS

The following are some key provisions found in the policy contract of this plan. This is only a brief summary and you are advised to refer to the actual terms and conditions stated in the policy contract. Please consult your insurance advisor should you require further explanation.

1. Eligibility & Age Limit
Any Singaporean, Permanent Resident or foreigner with a valid employment pass residing in Singapore and whose age next birthday is between 18 to 60 years old can be covered. Any children whose age on their next birthday is between 15 days and 17 years and who are unmarried and unemployed, natural children, legal step children and legally adopted children of the insured can also be enrolled in the same policy. If the child is studying full time in an accredited education institution, the age limit will be extended to the child's 24th birthday.

2. Residence Requirement
No benefits shall be payable for any medical treatment provided to any Insured Person who resides outside Singapore for more than ninety (90) consecutive days during the Policy Year.

3 Duty of Disclosure
The accuracy of the information provided over the phone or in Your proposal form will form the basis of and be part of the contract. Before You enter into the Insurance contract and during the Period of Insurance, You must tell Us all material information You know or could reasonably be expected to know which will affect Our decision on the coverage and the terms of the insurance. If You are uncertain about whether a fact is relevant or not, You must tell Us about it. We will acknowledge receipt of acceptance of material information by stating these on the Policy Schedule. If You do not provide this information to Us, We may:

(a) reduce the amount payable for the claim under this Policy; or

(b) refuse to pay the claim that may arise; or

(c) cancel Your insurance policy from inception.

4. Policy Renewal
This Policy is renewable at our option, subject to underwriting requirements being fulfilled and at the premium rates determined at that time by Us. Where at renewal a request is made to hold cover, the maximum period that cover can be held will be 14 days. If at the end of this period the Policy is cancelled or lapses for any reason whatsoever, You must pay Us a premium for the number of days the cover was held which will be calculated pro-rata on the renewal premium.

5. Changes In Circumstances
You must notify Us immediately in writing if there is any change in an Insured Person's country of residence, occupation, pursuits, or health that is likely to affect the risk.

6. Changes of Terms and Conditions
We reserve the right to amend the terms and provisions of this Policy by giving you 30 days prior written notice of such change. No alteration to this Policy shall be valid unless approved by Us in writing and reflected in the schedule or endorsement. No intermediary has the authority to amend or waive any of the terms and conditions of this Policy.

7. Cancellation / Termination of Cover
You may cancel the Policy at any time during the period of insurance by giving written notice to Us and You shall be entitled to a return of premium subject to a minimum premium payment of S$109.00 (inclusive of GST) provided no claim has been submitted prior to the cancellation and subject to any adjustment of premium required by the terms of this Policy.

We also have the right to cancel this Policy by giving You 7 days written notice and upon cancellation, You will be granted a pro-rated refund of the total premium paid corresponding to the unexpired Period of Insurance.

8. Free Look Period
In the event that the Insured is not satisfied with this Policy for any reason and there are no claims on the Policy, it may be returned to Us for cancellation with effect from inception, within fourteen (14) working days upon receipt of the Policy documents. Any premium billed will be refunded without interest.

9. Other Insurance
If at the time of any incident which results in a claim under this policy and the Insured Person has another insurance covering the same loss, We will only be liable for the excess of the amount recoverable from such other source or insurance.

Policy Owners' Protection Scheme: *This policy is protected under the Policy Owners' Protection 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 the Company or visit the GIA / LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).*

IMPORTANT NOTE
This is only a product summary and is not a contract of insurance. You are advised to read the policy contract for full details of the benefits, exclusions and other terms and conditions. You have a "Free Look" period of 14 working days from the date you receive the policy. Please inform Us within the "Free Look" period if you are not satisfied with the policy for whatever reason and we will cancel it from its commencement date. Full refund will be granted provided no claim has risen.

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reg no. 1978-00490-N

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IMPORTANT NOTICE ON GST FOR MEDICAL, ACCIDENT & MOTOR CAR INSURANCE

(Effective for policies commencing 1st October 2021 onwards)

Regulations 26 and 27 of the GST (General) Regulations **(Strictly applicable to a GST-registered Company)**

- If you are a GST-registered company, please complete a "**YES**" answer on IRAS prescribed Declaration Form below and submit it with your confirmation instruction to commence this policy coverage with us.
- By your answering "**YES**", you are reaffirming your awareness that you are **NOT ALLOWED** to claim input tax incurred on the accident & medical insurance premium and motor car insurance premiums - as stipulated by the said Regulations.

Applicable to Policy Type: **Medical / Accident / Motor Car Insurance**

GST Registered Company, please complete the declaration below:

Declaration of Entitlement to Claim Input Tax on Insurance Policy by GST Registered Policyholders

To : **EQ INSURANCE COMPANY LIMITED**

Date : _____

As a GST-registered person at the effective date of the insurance policy, I hereby confirm the following:

	YES	NO
1) Am I blocked, by virtue of Regulation 26 and 27 of the Goods and Services Tax (General) Regulations*, from claiming the GST incurred on the insurance premiums?	☐	☐

** The blocked input tax claims under Regulation 26 and 27 would include (but not limited to) the following:*

a) ***Medical and accident insurance*** *premiums incurred for your staff, unless the insurance or payment of compensation is mandatory under the Work Injury Compensation Act ("WICA") or under any collective agreement within the meaning of the Industrial Relations Act; and*

b) ***Motor car insurance premiums****.*

Please click on the links or scan the QR code provided above if more information is required on the particular legislation(s) concerned.

Name of GST-registered company/person:	
Name & Signature of Authorised Person:	
Designation of Authorised Person:	
Email address and contact number of Authorised Person:	

CREDIT CARD AUTHORISATION FORM

IMPORTANT NOTICE TO THE PROPOSER:

1. *I hereby authorise EQ Insurance to charge my credit card (details below) for the Total Insurance Premium due.*
2. *I agree that no reversal is allowed under any circumstances whatsoever, once the payment is charged to my credit card.*

PAYMENT INSTRUCTION

Name of Policy Holder:	NRIC / FIN / UEN No.:
Contact No.: (Home) (Office) (Mobile)	Email:

Policy Type / Policy No. / Cover Note No. / Invoice No.: | Amount to be charged:

1. _____ _____
2. _____ _____
3. _____ _____

Total Insurance Premium: _____

PERSONAL DATA COLLECTION STATEMENT

I agree and consent that EQI may collect, use and process my personal information obtained in this Credit Card Authorisation Form and disclose such information to third party service vendors and financial institutions for the purpose of processing and making payments to EQI.

Note: Please refer to the full version of EQI's Data Privacy Policy found at https://www.eqinsurance.com.sg/CorporatePolicies before providing your consent.

CREDIT CARD DETAILS (APPLICABLE TO AMEX/ MASTERCARD/ VISA)

Premium (including GST): S$ _____

☐ Visa / MasterCard*
☐ AMEX

Name on Credit Card: _____ Tel No.: _____
(Cardholder must be the Policyholder, Spouse, Parent, Child or Sibling)

Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date ☐☐ - ☐☐☐☐ CVV ☐☐☐☐

Credit Card Issuing Bank: _____

All refunds due during policy period shall be issued to the Name of Insured. EQI shall not be held responsible or liable in anyway, should there be any dispute arising with regard to such deduction or refund.

_____ _____
Signature of Cardholder *(As in Credit card)* | Date (dd/mm/yyyy)

(Delete where appropriate)*

FOR OFFICIAL USE

Accepted By:	Verified by:	Date:

Submit your COMPLETED APPLICATION form to distribution@eqinsurance.com.sg.

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reg no. 1978-00490-N

A Member of Citystate