PROPOSAL FORM – EQ HOSPITAL & SURGICAL PLAN

A. KNOW YOUR CLIENT

Confidential Fact Form for:	**By your Insurance Advisor:**
(Client's Name)	(Name of Advisor)

IMPORTANT NOTICE TO CLIENTS

For General Agents / Banks
Your insurance advisor is a representative with EQ Insurance and can advise you on the products of :

1) EQ Insurance Company Ltd 2) _____ 3) _____

For Insurance Brokers / Financial Advisers / Bank
Your insurance advisory is a broker with EQ Insurance Company Ltd.

As an insurance broker, your advisor is able to source for and objectively recommend the products of various insurance companies to best meet your insurance needs. Your advisor is required to disclose to you the insurance companies from which he sources the products.

Standard statement applicable to all advisors
Your advisor must have sufficient information before making a suitable recommendation. The information that you provide on your financial situation and your particular needs will be the basis on which advice will be given.

A policy purchased without the proper completion of a "Know Your Client" form may not be appropriate to your needs.

APPLICATION TYPE

Client's Choice

- ☐ I / We wish to disclose all information requested for in this Form. (Please complete and sign "Know Your Client" and all sections of "Our Advice and Reasons Why")
- ☐ I / We wish to receive product advice only. (Please complete and sign "Know Your Client" and Section 2 & 3 of "Our Advice and Reasons Why")
- ☐ I / We do not wish to receive any advice from my / our advisor. (Please complete and sign "Know Your Client")

I / We acknowledge that the insurance advisor has provided me / us with a copy of the completed "Know Your Client" Form.

Advisor's Declaration:
I declare that the information provided to me is strictly confidential and is only to be used for the purpose of fact-finding in the process of recommending suitable insurance products, and shall not be used for any other purposes.

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

B. OUR ADVICE AND REASONS WHY

SECTION 1 - ANALYSIS AND CALCULATION WORKSHEET

(a) **Personal Priorities** (Please Tick)

Your Health Insurance Concerns	**Level of Concerns**		
	Low	**Medium**	**High**
Cover for hospitalisation expenses	☐	☐	☐
Cover for outpatient medical expenses	☐	☐	☐
Cover for major illness (e.g. cancer, kidney dialysis, etc.)	☐	☐	☐
Cover for loss of income due to illness or sickness	☐	☐	☐

(b) Medical Expenses (also known as Hospital / Surgical Expenses)		
(i)	Which type of hospital do you or your family members prefer in the event of hospitalisation?	☐ Private ☐ Public
(ii)	What type of hospital ward do you or your family members prefer in the event of hospitalisation?	☐ 1 ☐ 2 ☐ 4 ☐ 6 Bedded
(iii)	Do you have an existing hospitalisation insurance plan?	☐ Yes ☐ No
(iv)	Do you have an existing Hospital Cash Income plan?	☐ Yes ☐ No
(v)	Is your existing policy an Individual policy or Group Employee Benefits policy?	☐ Individual ☐ Group

SECTION 2 - ADVISOR ANALYSIS AND RECOMMENDATIONS

Total Health Insurance Budget: S$ _____ per year

Advisor's recommendation	Reasons for recommendation	Remarks
Hospital / Surgical / Medical Expenses EQ Hospital & Surgical Plan		Replacement ☐ Yes ☐ No

Note: If this product is intended to replace any existing health insurance policy, advisor should state the reasons for recommending a replacement.

SECTION 3 - ACKNOWLEDGEMENT

Client's Declaration:
I / We understand that the above recommendation(s) is / are based on the facts furnished in the "Know Your Client" Form; and I / **We agree / do not agree** * with the proposed recommendation(s).

Comments (necessary if in disagreement with recommendation): _____

I / We should decide to switch from one health insurance product to another health insurance product, I / We understand that:
a) I / We may not be insurable at standard terms
b) I / We may have to pay a different premium
c) Terms and conditions may defer

Statement by Advisor:
The recommendation in this document are based on your personal information collected in the "Know Your Client" Form, the prevailing healthcare financing system and information on healthcare costs obtained from sources believed to be reliable and accurate to the best of my knowledge. If there has been any change in your circumstances since completing that form, please notify your advisor as it may affect the needs analysis process. The recommendations may not be appropriate in the event of a partial or inaccurate completion of the "Know Your Client" Form.

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

C. DECLARATION FOR PRODUCT SUMMARY

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)	Signature of Advisor
Date:	Date:

FOR OFFICIAL USE ONLY - INTERNAL

I understand that the recommendation(s) is / are based on the facts furnished in the "Know Your Client" Form; and I **agree / do not agree** * with the proposed recommendation(s).

Comments (necessary if in disagreement with recommendation):

Remedial Action

Signature	Name	Position	Date

*Delete where appropriate

D. APPLICATION DETAILS (PROPOSAL FORM)

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

Full Name:	
Address:	Postal Code ( )
NRIC / Passport 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 / PP 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: _____

Note: Proposal for child(ren) must be accompanied by at least one parent.

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	☐	☐	☐	☐
Spouse	☐	☐	☐	☐
Child(ren)	☐	☐	☐	☐

Note: Child(ren)'s plan must not be higher than that of the parent's.

QUESTIONAIRE

		YES	NO
1.	Has any one of the applicants ever had any Health or Life Insurance application declined, postponed, accepted on special terms or had a Health or Life Insurance policy's renewal refused?	☐	☐
2.	Is any one of the applicants currently undergoing any medical treatment or medication, medical follow-up or routine checkup?	☐	☐
3.	Has any one of the applicants ever had a surgery or been advised to have any diagnostic test, hospital confinement or surgical operation which has yet to be performed?	☐	☐
4.	Has any one of the applicants during the last 5 years, had any treatment, examination or advice for a re-current complaint by a physician or a medical practitioner, at a clinic, hospital, dispensary or sanitorium?	☐	☐
5.	Has any one of the applicants suffered from or are suffering from any disease, ailment, injury or any other medical conditions?	☐	☐
6.	**For Female Only:** Is any one of the applicants now pregnant? If "Yes", please state number of months of pregnancy.	☐	☐
7.	If any of the answer above is "Yes", please provide details below, noting the question number.		

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)	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).

E. PRODUCT SUMMARY FOR EQ HOSPITAL & SURGICAL PLAN

(I) PRODUCT INFORMATION

Coverage & Benefit Schedule
This is a yearly renewable hospital and surgical plan which will compensate the benefits described below, depending on the plan chosen, for the charges which are made to you or your covered family members in connection with a hospital confinement or surgery, which results directly from an illness or injury.

BENEFITS (PER DISABILITY UNLESS OTHERWISE INDICATED)

	Platinum (SGD)	Gold (SGD)	Silver (SGD)	Basic (SGD)
1. In-Patient & Accidental Outpatient Benefits				
- Daily Room & Board	As Charged Overall Maximum Limit $50,000	As Charged Overall Maximum Limit $30,000	As Charged Overall Maximum Limit $20,000	As Charged Overall Maximum Limit $10,000
- Intensive Care Unit				
- Hospital Miscellaneous Expenses				
- Surgeon's Fee				
- In-Hospital Physician's Visit				
- Pre-Hospitalisation Treatment				
- Post-Hospitalisation Treatment				
- Emergency Accidental Outpatient Treatment				
- Emergency Accidental Dental Treatment				
2. Other Outpatient Benefits (Per Policy Year)				
- Outpatient Kidney Dialysis Treatment	$50,000	$30,000	$20,000	$10,000
- Outpatient Cancer Treatment	$50,000	$30,000	$20,000	$10,000
3. Miscellaneous Benefits				
- Major Organ Transplant (Per Policy Year)	$50,000	$30,000	$20,000	$10,000
- Surgical Implant	$5,000	$3,000	$2,000	$1,000
- Accidental Miscarriage	$1,000	$1,000	$1,000	$1,000
- Medical Report	$100	$100	$100	$100
- Daily Hospital Cash Income (Per Day, up to 30 days) (if admitted to Singapore Government Restructured Hospital)	$150	$100	$50	$50
- Special Grant	$5,000	$5,000	$5,000	$5,000

Per Disability shall mean all medical conditions resulting from the same cause, including any and all complications arising therefrom or closely related thereto, except that after 30 days following the latest discharge from Hospital or Surgery, any subsequent Disability from the same cause shall be considered as a new Disability.

Premium Rate and Premium Warranty
The annual premium rates (inclusive of GST) set out below are based on the Insured Person's age next birthday. They are applicable only if (i) the usual country of residence is in Singapore and (ii) you are in standard health in either Class I or II occupations.

ANNUAL PREMIUM (INCLUSIVE OF GST)	Platinum (SGD)		Gold (SGD)		Silver (SGD)		Basic (SGD)	
	Male	Female	Male	Female	Male	Female	Male	Female
Child	$359.70	$359.70	$309.56	$309.56	$287.76	$287.76	$239.80	$239.80
19 - 30	$539.55	$636.56	$433.82	$512.30	$373.87	$441.45	$287.76	$340.08
31 - 40	$647.46	$796.79	$526.47	$636.56	$459.98	$551.54	$359.70	$425.10
41 - 50	$791.34	$965.74	$649.64	$779.35	$575.52	$679.07	$455.62	$528.65
51 - 60	$1,222.98	$1,104.17	$1,022.42	$923.23	$921.05	$832.76	$743.38	$672.53
61 - 65 (renewal only)	$1,942.38	$1,592.49	$1,609.93	$1,319.99	$1,438.80	$1,179.38	$1,151.04	$943.94
66 - 70 (renewal only)	$2,517.90	$2,227.96	$2,104.79	$1,898.78	$1,898.78	$1,710.21	$1,534.72	$1,395.20

The annual premium (inclusive of GST) due must be paid in full on or before the inception or renewal date.

Class I – Persons engaged in indoor and non-manual work in non-hazardous places.

Class II – Persons engaged in work of an outdoor or supervisory nature or involves occasional manual work whose duties do not involve the use of tools and machinery or exposed to any special hazards.

Please refer to our office for occupations involving manual work and not within the above definitions.

(II) KEY PRODUCT PROVISIONS

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. **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.

4. **Changes In Circumstances**
If there is any change in the Country of Residence, occupation, pursuits or health of any Insured Person, which is likely to affect the risk, the Insured must give Us immediate written notice.

5. **Changes of Terms and Conditions**
We reserve the right to amend the terms and provisions of this Policy on any Policy Anniversary date by giving the Insured 30 days' written notice of such change.

6. **Cancellation / Termination of Cover**
This insurance may be cancelled at any time at the request of the Insured by giving us 30 days' written notice prior to the termination date. If no claims have been made during the current Period of Insurance, We will grant the Insured a short period refund, subject to a minimum premium of S$81.75 (inclusive of GST)

   We also have the right to cancel this Policy by giving You 30 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.

7. **Right to Return Policy**
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 after receipt of the Policy by the Insured. Any premium billed will be refunded without interest.

8. **Other Insurances and Third Party Liability**
If at the time of claim the Insured Person shall hold other medical insurance which makes provision for payment of medical expenses, You shall advise Us of the details of such other insurance and We shall be liable only for the balance of the amount recoverable from such other insurance.

   In the event of any claim or right of action against any third party arising from a claim paid under this Policy, You must notify Us in writing immediately of all developments and take all steps that We may reasonably require to include all benefits claimed for under this Policy in any claims against the third party with the objective of recovering the claim paid.

9. **Exclusions**
There are certain conditions under which no benefits will be payable. These are stated as exclusions in the contract. The following is a list of some of the exclusions for this Policy. The exclusions for this Policy, include, but not limited to, the following conditions:
(a) Pre-existing conditions which existed before the effective date, whether known or unknown to the Insured.
(b) Any illness or sickness which commences within the first thirty (30) days from the effective date of the Insured Person.
(c) Pregnancy, childbirth, investigation and treatment relating to birth control, congenital conditions or birth defects.
(d) Emotional, stress, psychiatric or psychological disorders.
(e) Participation in any sports in a professional capacity, dangerous activities or sports.

__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.

EQ Insurance Company Limited
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tel (65) 6223 9433 | distribution@eqinsurance.com.sg | www.eqinsurance.com.sg
reg no. 1978-00490-N

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.

EQ Insurance Company Limited
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tel (65) 6223 9433 | distribution@eqinsurance.com.sg | www.eqinsurance.com.sg
reg no. 1978-00490-N

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