GROUP INSURANCE FACT-FINDING FORM

KINDLY COMPLETE FULLY IN BLOCK LETTER AND INK
(Tick boxes [√] where appropriate)

PERIOD OF INSURANCE from: _____ to _____
(dd/mm/yyyy) (dd/mm/yyyy)

REQUEST FOR QUOTATION was submitted on _____
(dd/mm/yyyy)

REQUEST FROM: _____
(Name of Insurance Company)

GENERAL INFORMATION

Name of Company: _____

Nature of Business: _____

Presently insured? **Yes** / **No**

If **Yes**, name of current insurer: _____

Type of Policy: _____

Period of Insurance: From: _____ To _____
(dd/mm/yyyy) (dd/mm/yyyy)

Total No. of Employees: _____ No. of Employees to be insured: _____

Participation: The insurer will assume that participation of the group insurance program is on compulsory basis unless otherwise stated. Please tick [√] accordingly to the choice of the insurance product that you like to have a quote from us.

Benefits	**Insurance Coverage**			**Participation**	
				Compulsory	**Voluntary**
Personal Accident	**1**	Group Personal Accident (GPA)			
Medical	**2**	Group Hospital & Surgical (GHS)	Employee only		
			Dependant (Spouse and/or Children)		
		Group Major Medical (GMM)	Employee only		
			Dependant (Spouse and/or Children)		
Others	**3**	Group Outpatient	Employee only		
			Dependant (Spouse and/or Children)		
		Dental	Employee only		
			Dependant (Spouse and/or Children)		
	4	Maternity	Employee only		
			Dependant (Spouse)		

Note: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s), subject to a minimum participation level.

1 Are there any members currently in hospital or requires frequent admission (e.g. hospital admission more than 2 times per year) to hospital? **Yes** / **No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

2 Has any member suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that causes progressive irreversible functional or physical disability? **Yes** / **No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

3 Is there any member based outside Singapore? **Yes** / **No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Country based in	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

4 Are there any limitations or exclusions imposed on the coverage on any members? **Yes** / **No**

If **Yes**, kindly provide the following details:

S/N	# of members / Age	Limitations / Exclusions	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

5 Is there any member engaged in hazardous occupation? **Yes** / **No**
(Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

If **Yes,** kindly provide the following details:

S/N	# of members /Age	Nature of work	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

6 To the best of your knowledge, is there any member engaged in hazardous sports? **Yes** / **No**
(Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.)

If **Yes,** kindly provide the following details:

S/N	# of members / Age	Type of sports	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

1 BENEFIT: GROUP PERSONAL ACCIDENT

Occupational Classifications

Class 1	Clerical, administrative or other similar non-hazardous occupations
Class 2	Occupations where some degree of risk is involved, e.g. supervision of manual workers, totally administrative job in an industrial environment
Class 3	Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident
Class 4	High risk occupations involving heavy manual work including hot works

a) Basis of Coverage

		Category of Employees/Occupation (refer to the examples)	Basis of Coverage - Sum Insured (refer to the examples)	# of Employees
GPA	(i)			
	(ii)			
	(iii)			
	(iv)			

Example 1

Category of Employees / Occupation	**Basis of Coverage**
(i) Senior Management (Director, General Manager, Senior Manager)	100,000
(ii) Manager & Executive	50,000
(iii) All Others	25,000

Example 2

Category of Employees / Occupation	**Basis of Coverage**
(i) All Employees	24 X Basic Monthly Salary*

** Please provide salary information if the basis of coverage is in terms of basic monthly salary.*

b) Claims Experience for the past 3 years

Paid Claims

Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S$)

Outstanding Claims

Period of Coverage From / To _____ (mm/dd/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S$)

Note: The insurer reserves the right to request for more information.

2 BENEFIT: GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

a) Basis of Coverage

Category of Employees / Occupation		Room & Board Benefit Plan (S$)	Currently with TMIS Yes / No	Proposal with TMIS Yes / No
(i)				
(ii)				
(iii)				
(iv)				

Important Note:
(1) Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.
(2) Please provide the Deductible /Co-insurance for respective employee category or occupation, if applicable.

Example 1

Category of Employees / Occupation	**R&B Benefit Plan (S$)**
(i) Senior Management (Director, General Manager, Senior Manager)	360
(ii) Manager & Executive	200
(iii) All Others	100

b) Age Profile of Employees

Age Band (Age Next Birthday)	# of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) Details of Insured Members

For GHS and GMM:

	# of Employees (Singaporeans & SPRs*)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

	# of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore*				

For GMM (if the basis of coverage differs from GHS):

	# of Employees (Singaporeans & SPRs*)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to Singapore Permanent Residents*				

	# of Employees (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
** refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore*				

d) Claims Experience for the past 3 years

Period of Coverage From / To _____ (dd/mm/yyyy)	**# of Insured as at _____ (dd/mm/yyyy)**	**Paid Claims**		**Outstanding Claims**	
		# of Claims	**Amount (S$)**	**# of Claims**	**Amount (S$)**
Note: The insurer reserves the right to request for more information.					

e) Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis (i.e. currently insured).

3 BENEFIT: GROUP OUTPATIENT INSURANCE

a) Category of Employees to be insured (please tick as appropriate)

Category of Employees		Clinical GP	Specialist	Diag X-Ray/Lab Tests	Dental
(i)					
(ii)					
(iii)					
Dependant (where applicable)					
# of Headcount					

b) Age Profile of Employees

Age Band (Age Next Birthday)	# of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) Claims Experience for the past 3 years

Paid Claims

		Clinical*		Specialist *		Diagnostic X-Ray / Lab Tests*		Dental*	
Period of Coverage From / To _____ (dd/mm/yyyy)	**# of Insured as at _____ (dd/mm/yyyy)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**

- *inclusive of visits to non-panel clinics*

Note: The insurer reserves the right to request for more information.

Outstanding Claims

		Clinical*		Specialist *		Diagnostic X-Ray / Lab Tests*		Dental*	
Period of Coverage From / To _____ (dd/mm/yyyy)	**# of Insured as at _____ (dd/mm/yyyy)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**	**# of Visits**	**Amt (S$)**
** inclusive of visits to non-panel clinics* *Note: The insurer reserves the right to request for more information.*									

d) Kindly attach a copy of the Schedule of Benefits if the benefits are on insured basis.

If currently self-insured, kindly provide the following details:

Please indicate "Unlimited" if there is no cap and "NA" if it is not applicable.

Benefits	**Maximum Limit per Visit (S$)**		**Maximum Limit per Policy Year (S$)**		**Co-Payment (S$) / Co-Insurance (%)**	
	Clinic on Company's panel	**Non-panel Clinic**	**Clinic on Company's panel**	**Non-panel Clinic**	**Clinic on Company's panel**	**Non-panel Clinic**
Clinical GP						
Specialist						
Diagnostic X-Ray / Lab Tests						
Dental						
Others						

4 BENEFIT: MATERNITY INSURANCE

a) Basis of Coverage

Category of Employees (refer to the example)		# of Headcount
(i)		
(ii)		
(iii)		

Example 1
Category of Employees/Occupation
(i) Senior Management (Director, General Manager, Senior Manager)
(ii) Manager & Executive
(iii) All Others
Example 2
(i) All Employees

b) Claims Experience for past 3 years

Period of Coverage From / To _____ (dd/mm/yyyy)	# of Insured as at _____ (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		# of Claims	Amount (S$)	# of Claims	Amount (S$)
Note: The insurer reserves the right to request for more information.					

c) Kindly attach a copy of the Schedule of Benefits if the benefits are on insured basis.

If currently self-insured, kindly provide the following details:

Please indicate "Unlimited" if there is no cap and "NA" if it is not applicable.

Benefits	Maximum Limit per Policy Year (S$)		Deductible / Co-insurance (S$)	
Normal Delivery				
Caesarian Delivery				
Others:				

5 NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box to indicate the priority of your company's needs:

Company's Priorities	Low	Med	High	Advisor's Recommendation
Cover for Outpatient medical expenses	☐	☐	☐	
Cover for Hospital & Surgical expenses	☐	☐	☐	
Cover for Dental expenses	☐	☐	☐	
Cover for Major illnesses (e.g. cancer, kidney failure, etc.)	☐	☐	☐	
Cover for Loss of Income due to sickness or accident	☐	☐	☐	
Cover for long term medical treatment	☐	☐	☐	

Others : _____

6 DECLARATION

I / We hereby declare that, to the best of my / our knowledge and belief, the information given here are true and complete, and agree that if a contract of insurance is effected, all information submitted in connection with this application shall form the basis of such contract between the Company and the Insurer.

_____
Signature of Authorised Officer

Name:
NRIC/ Fin No.
Designation: Company Stamp (if applicable):
Date:

I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the requirements of this Fact-Finding form to him / her.

_____
Signature of Insurance Representative

Name
NRIC/ Fin No.
Designation: Company Stamp (if applicable):
Date: