# GROUP INSURANCE FACT-FINDING FORM

**Important Notice**

1. 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.
2. Please note that this insurance is subject to the premium being paid and received in full by the Company (a) before the inception date here 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.
3. The liability of the Company does not commence until this Application is accepted and the premium is paid in accordance with the clause 2 above.

**KINDLY COMPLETE FULLY IN BLOCK LETTERS AND INK**

| Period of Insurance | |
|---|---|
| From D D / M M / Y Y Y Y | To D D / M M / Y Y Y Y |
| Request for Quotation was submitted on | Request From |
| D D / M M / Y Y Y Y | |
| Agent Name/Code | |
| | |

## 1 General Information

| Name of Applicant/Company | | |
|---|---|---|
| | | |
| Company Address | | |
| | | |
| Country: | Postal Code: | |
| Contact Details | | |
| Tel No.: | Email Address: | |
| Nature of Business | | |
| | | |
| Presently insured under other medical, hospitalisation, accident, life or critical illness insurance | Yes | No |
| If **Yes**, Name of Current Insurer: ............ | | |
| Type of Policy/Name of Plan: | | |
| | | |
| Period of Insurance | | |
| From D D / M M / Y Y Y Y | To D D / M M / Y Y Y Y | |
| Total Number of Employees | No. of Employees to be insured | No. of Dependants to be insured |
| | | |
| **Eligibility:** Date of Employment/Confirmation* (*delete where appropriate) | | |



China Taiping Insurance (Singapore) Pte. Ltd. (Co. Reg. No. 200208384E)
3 Anson Road #16-00 Springleaf Tower Singapore 079909 ✆6389 6111 6222 1033 www.sg.cntaiping.com

## 1 General Information (continued)

**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 |
| **Life Insurance** | 1 | Group Term Life (GTL) | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |
| | | Group Critical Illness (GCI) | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |
| **Personal Accident** | 2 | Group Personal Accident (GPA) | | | |
| **Medical** | 3 | Group Hospital & Surgical (GHS) | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |
| | | Group Major Medical (GMM) | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |
| **Others** | 4 | Group Outpatient | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |
| | | Dental | Employee only | | |
| | | | Dependant (Spouse and/or Children) | | |

**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? *If **Yes**, kindly provide the following details:* Yes No

| 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

| 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? *If **Yes**, kindly provide the following details:* Yes No

| 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.



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## 1 General Information (continued)

4 Are there any limitations or exclusions imposed on the coverage on any members? *If* **Yes**, *kindly provide the following details:* Yes No

| 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? (Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.). *If* **Yes**, *kindly provide the following details:* Yes No

| 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? (Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.). *If* ***Yes***, *kindly provide the following details:* Yes No

| 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.

## 2 Benefit: Group Term Life/Group Personal Accident/Critical Illness Insurance

| 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 |
|---|---|---|---|---|
| **Group Term Life** | (i) | | | |
| | (ii) | | | |
| | (iii) | | | |
| | (iv) | | | |
| **Group Personal Accident** | (i) | | | |
| | (ii) | | | |
| | (iii) | | | |
| | (iv) | | | |
| **Group Critical Illness** | (i) | | | |
| | (ii) | | | |
| | (iii) | | | |
| | (iv) | | | |



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## 2 Benefit: Group Term Life/Group Personal Accident/Critical Illness Insurance (continued)

**Important Note:**
1. Dependants can be covered under Group Term Life (GTL) and Group Critical Illness (GCI). Their cover cannot exceed the employee's cover.
2. GCI is an optional supplementary benefit to GTL, i.e. GTL must be chosen before GCI can be chosen.

**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 and All Dependants | 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) Please provide Current Non-Medical Limit (if applicable)**

Group Term Life: S$ ____________________ up to age ____________________

Group Critical Illness: S$ ____________________ up to age ____________________

**c) Group Critical Illness: Basis of Coverage**

This benefit is an advance amount to the Group Term Life.

** We do not offer this benefit as an additional amount to Group Term Life.*

As it is an advance benefit, what percentage on the Group Term Life sum insured you want us to quote? Please circle as appropriate:
25% / 50% / 100%

Please provide a list of critical illnesses covered (if currently insured).

**d) Details of Employees and Dependants**

| Age Band (Age Next Birthday) | Group Term Life | | | | Group Critical Illness | | | |
|---|---|---|---|---|---|---|---|---|
| | # of Employees | | Total Sum Insured (S$) | | # of Employees | | Total Sum Insured (S$) | |
| | Male | Female | Male | Female | Male | Female | Male | Female |
| **16-30** | | | | | | | | |
| **31-35** | | | | | | | | |
| **36-40** | | | | | | | | |
| **41-45** | | | | | | | | |
| **46-50** | | | | | | | | |
| **51-55** | | | | | | | | |
| **56-60** | | | | | | | | |
| **61-65** | | | | | | | | |
| **66-70** | | | | | | | | |
| **Total** | | | | | | | | |

| Age Band (Age Next Birthday) | Group Term Life | | | | Group Critical Illness | | | |
|---|---|---|---|---|---|---|---|---|
| | # of Dependants | | Total Sum Insured (S$) | | # of Dependants | | Total Sum Insured (S$) | |
| | Male | Female | Male | Female | Male | Female | Male | Female |
| **16-30** | | | | | | | | |
| **31-35** | | | | | | | | |
| **36-40** | | | | | | | | |
| **41-45** | | | | | | | | |
| **46-50** | | | | | | | | |
| **51-55** | | | | | | | | |
| **56-60** | | | | | | | | |
| **61-65** | | | | | | | | |
| **66-70** | | | | | | | | |
| **Total** | | | | | | | | |



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## 2 Benefit: Group Term Life/Group Personal Accident/Critical Illness Insurance (continued)

e) **Claims Experience for the past 3 years**

**Paid Claims**

| Period of Coverage From / To<br>____________<br>(dd/mm/yyyy) | # of Insured as at<br>____________<br>(dd/mm/yyyy) | Group Term Life | | Group Personal Accident | | Group Critical Illness | |
|---|---|---|---|---|---|---|---|
| | | # of Claims | Amount (S$) | # of Claims | Amount (S$) | # of Claims | Amount (S$) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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

**Outstanding Claims**

| Period of Coverage From / To<br>____________<br>(dd/mm/yyyy) | # of Insured as at<br>____________<br>(dd/mm/yyyy) | Group Term Life | | Group Personal Accident | | Group Critical Illness | |
|---|---|---|---|---|---|---|---|
| | | # of Claims | Amount (S$) | # of Claims | Amount (S$) | # of Claims | Amount (S$) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

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

## 3 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** | | |



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## 3 Benefit: Group Hospital & Surgical Insurance/Major Medical Insurance (continued)

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$) |
| | | | |
| | | | |
| | | | |

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

e) **Kindly attach a copy of the Schedule of Benefits at the end of this form, if the benefits are on insured basis (i.e. currently Insured).**



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## 4 Benefit: Group Outpatient/Dental 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 | Amount (S$) | # of Visits | Amount (S$) | # of Visits | Amount (S$) | # of Visits | Amount (S$) |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

* 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 | Amount (S$) | # of Visits | Amount (S$) | # of Visits | Amount (S$) | # of Visits | Amount (S$) |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

* inclusive of visits to non-panel clinics
**Note:** The insurer reserves the right to request for more information.



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## 4 Benefit: Group Outpatient/Dental Insurance (continued)

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 | | | | | | |

## 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: ............................................................... | | | | |

Company's budget provided for this Fact-finding and Need Analysis: SGD ........................................................ per annum



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## 6 Personal Data Collection Statement

**A. Consent to Privacy Policy**

I / We further confirm that I / we have read and understood and hereby consent to the collection, use, disclosure and processing of my / our personal data in accordance with and agree to be bound by CTPIS Privacy Policy which is made available on CTPIS website at www.sg.cntaiping.com/en/privacypolicy, as may be amended from time to time.

I / We agree on my / our behalf and on behalf of every insured person that in addition to the release of information to any medical source, or other entity mentioned in this Application Form, CTPIS is authorised to collect, retain, use and / or disclose as it reasonably deems fit, any information in respect of me / us / any insured person, that is received by CTPIS to its Representatives and relevant third parties, companies within China Taiping Insurance Group, reinsurers, medical organisations, my / our Representatives, financial institutions, credit agencies, investigators, service providers (who may have to disclose my / our data to their service providers such as medical providers, reinsurers, medical evacuation agencies), judicial, regulatory, government, statutory authorities, dispute resolution parties and industry entities) whether within or outside Singapore. As far as reasonably possible, CTPIS will release such information to such parties on the understanding that the information will be kept strictly confidential and be used, disclosed and retained in accordance with relevant law.

**B. Marketing Consent** (please tick the relevant boxes to indicate consent)

I / We hereby consent to CTPIS (including Representatives of China Taiping), China Taiping group of companies and their service providers to contact me / us (even though my / our telephone number(s) are already registered or may be registered on the National Do Not Call Registry), by way of:

Voice Call    Mail    Email / Any other avenues of marketing activities    SMS

for marketing purposes and provide me / us with marketing, advertising and promotional information, materials and / or documents relating to products and services marketed by China Taiping or its related companies.

I / We am / are aware that the consent provided by me in this form is an addition to and does not supersede, vary or qualify any consent which I / we may have provided previously in respect of the above purposes, unless my / our consent is withdrawn through the withdrawal form.

| Signature of Authorised Officer | Company Stamp (if applicable): |
|---|---|
| Name: | |
| NRIC/Fin No. | |
| Designation: | |
| Date (DD/MM/YYYY): | |

## 7 Declaration by Insurance Representative

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 | Company Stamp (if applicable): |
|---|---|
| Name: | |
| NRIC/Fin No. | |
| Designation: | |
| Date (DD/MM/YYYY): | |



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