

PROPOSAL FOR GROUP INSURANCE

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP.142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You must disclose all facts as you know or ought to know which may affect the insurance cover being applied for. Otherwise, the insurance policy issued may not be valid.

Pursuant to MAS notice 314, all companies are required to submit the following documents:

- a) Copy of Incorporation or Registration certificate.
- b) List of Names, NRICs and Specimen Signatures of authorised signatories on Proposal Form/Application Form.
- c) A photocopy of the NRIC/Passport/employment pass (front and back) of persons appointed to act on behalf of the Company.

Particulars of Proposer

Name	Company Registration No.
Address	Contact No.
	Fax No.
	Email
Type of Business/Trade	Period of Insurance (dd/mm/yyyy) From _____ to _____

The Company is GST Registered. Yes No Are the insurance covers for employees required under any collective agreement? Yes No

Type of Insurance Required

Group Term Life Insurance Group Living Insurance Group Personal Accident Insurance Group Hospital & Surgical Insurance
 Group i-MediCare Managed Healthcare System Group Disability Income Others, please specify: _____
 Employee Benefit Package: Economy (HS only) Standard (HS & TL) Comprehensive (HS, TL & PA)

Please indicate details

Occupation/Category	Plan/Sum Assured	No. of Employees	Premium (Per Member)

* Employee Details to be attached.

Are spouses and children to be included? Yes No

Hospital & Surgical Insurance/i-MediCare <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide data using Group Health Declaration Form.	Managed Healthcare System <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide data using Member Enrolment Form.
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Note: If participation is voluntary, 75% of all married employees' dependants who are eligible for insurance must participate.

Other Information

Total number of employees	Participation by employees <input type="checkbox"/> Compulsory <input type="checkbox"/> Voluntary Note: If participation is voluntary, the number of employees to be covered must be at least 75% of the total number of employees engaged.	Are any employees currently suffering from any illness, injury or undergoing treatment by any doctor or on medical leave? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please give details:
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Declaration By Insured

We hereby declare that the particulars contained in this proposal are true and correct and complete to the best of our knowledge and we have not withheld any material information regarding this proposal.

We warrant that we have an interest in the life or lives of the person(s) to be insured to the extent of the amount(s), if any, payable to us under the Policy.

We agree that this proposal together with the enclosed description and other particulars of each and every eligible employee and any other written statements made by us or on our behalf and any proposals submitted by the eligible employees for the purpose of the proposed insurances shall be the basis of the contract between us and NTUC Income.

It is understood that no employee shall become insured while currently absent from active work, or is suffering from any serious illness or disease which endangers his/her life and only full-time employees shall be eligible. Should a claim occur, NTUC Income reserves the right to request for the medical report from the hospital attending to the employee.

Signature of Proposer & Company Stamp	Date	Signature of Witness	Date
	NRIC/Passport No.		
Name	Designation	Name	NRIC No.

The liability of NTUC Income does not commence until this proposal has been accepted by NTUC Income and the premium paid.

For Office Use Only

Agent/Representative	Code No.	Date
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LIST OF AUTHORISED PERSONNELS

List of Authorised Signatories for Company _____

No.	Name	NRIC/Passport No.	Designation	Specimen Signature
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Please make photocopies of this form if space provided above is insufficient.



NTUC INCOME INSURANCE COOPERATIVE LIMITED

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 TEL: 6336 3322 • FAX: 6338 1500 • EMAIL: email@income.com.sg • WEBSITE: www.income.coop

GROUP HEALTH DECLARATION FORM

STATEMENT PURSUANT TO SECTION 25(5) OF INSURANCE ACT, CAP.142 (OR ANY SUBSEQUENT AMENDMENTS THEREOF)

You are to disclose in this proposal form, fully and faithfully all the facts which you know or ought to know in respect of the risk that is being proposed, otherwise the policy issued hereunder may be void.

Group Policy No.(s)			Name of Policyholder		
NRIC No.			Life Assured (Name in block letters)		Plan/Sum Assured
Height (m)	Weight (kg)	Gender	Occupation	Date of Birth	Contact No.

Particulars of Dependents to Be Insured (only applicable for GHS/i-MediCare)

No.	Relationship	Name	NRIC/BC No.	Gender	Date of Birth	Date of Marriage	Effective Date of Cover
1.	Spouse						
2.	Child						
3.	Child						
4.	Child						

Questionnaire (For Life Assured and/or Dependents)	Yes or No	If "Yes" please give full details including dates, name of hospital/insurer, reasons, descriptions, diagnoses, treatment, still on follow up or fully recovered/cured etc and attach medical reports, if available.
1. Any life, medical or accident insurance has been declined, postponed or accepted on special terms?		
2. In the past 5 years, any medical leave of more than 7 days continuously or any hospitalisation (except normal pregnancy) or surgery?		
3. Currently undergoing any form of treatment?		
4. Ever had or been told to have or been treated for any health condition relating to: a) Heart, lungs, kidney, liver b) Thyroid, nervous system, breasts, reproductive system c) Hereditary or congenital condition d) Cancer or tumour e) Stroke f) Diabetes g) High Blood Pressure h) SLE (Systemic Lupus Erythematosus), HIV (Human Immunodeficiency Virus) infection or STD (Sexually Transmitted Diseases) i) Any other serious illness or injury?		
5. Been advised to have any surgical operation?		
6. Any physical impairment, defect or deformity or mental condition or disorder?		
7. Number of visits to a general practitioner(s) or a specialist(s) in the last 6 months. (For i-MediCare only)	No. of times	

Declaration

I hereby declare that the foregoing statements and answers are true and correct and I have not withheld any material information. I agree that this declaration shall form part of the basis of the contract between my employer and INCOME and if anything contrary to the truth is stated therein my insurance shall be absolutely void. I consent to NTUC INCOME seeking medical information from any doctor who at any time has attended to me concerning anything which affects my physical or mental health and I authorise the giving of such information.

Signature of Life Assured	Signature of Witness
	Name of Witness
Date	NRIC No.