

## APPLICATION 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) Accounting and Corporate Regulatory Authority Singapore (ACRA) Business Profile.
- 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 of Company & Address		Company Registration No.	Nature of Business/Trade
		Email	
Contact Person	Contact No. (O) (H) (Hp) (Fax)	Period of Insurance (dd/mm/yyyy) From to	
The Company is GST Registered. <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the insurance covers for employees required under any collective agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Type of Insurance Required

<input type="checkbox"/> Group Living Insurance (GLV) <input type="checkbox"/> Group Hospital & Surgical Insurance (GHS) <input type="checkbox"/> Group Disability Income	<input type="checkbox"/> Group Term Life Insurance (GTL) <input type="checkbox"/> Group i-MediCare <input type="checkbox"/> Group Incomeshield <input type="checkbox"/> Economy (GHS only)	<input type="checkbox"/> Group Personal Accident Insurance (GPA) <input type="checkbox"/> Others, please specify: _____ <input type="checkbox"/> Standard (GHS & GTL) <input type="checkbox"/> Comprehensive (GHS, GTL, & GPA)
<b>Business Value Pack:</b>		
Please indicate details.		
<b>Occupation/Category</b>	<b>Plan/Sum Assured</b>	<b>No. of Employees<sup>1</sup></b>

For Group Hospital and Surgical Insurance/i-MediCare, are spouses and children to be included?  Yes  No

If "Yes", please provide data using Employee Data Form.

**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 <b>Note:</b> 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 insured members 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:

<sup>1</sup> Employee Details to be attached.

## List Of Authorised Personnel (Not applicable to Group Incomeshield)

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.

### Declaration By Proposer

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.

**If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are satisfied with the information declared in this proposal.**

Name & Signature of Proposer	NRIC/Passport No.	Company stamp
Designation	Date (dd/mm/yyyy)	
Name and Signature of Witness	NRIC/Passport No.	
	Date (dd/mm/yyyy)	

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

### For Official Use

Adviser's Name	Adviser's Code	Date (dd/mm/yyyy)
----------------	----------------	-------------------



## GROUP HEALTH DECLARATION

### 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.

Name of Company	Group Policy No.(s)	Plan/Sum Assured
Name of Employee (Main Insured)	Occupation	Contact No.

### Particulars of Insured(s)

Name (as shown in NRIC/BC)	NRIC/BC No.	Gender	Date of Birth (dd/mm/yyyy)	Height (m)	Weight (kg)	Effective Date of Cover
Main Insured		<input type="checkbox"/> Male <input type="checkbox"/> Female				
Spouse		<input type="checkbox"/> Male <input type="checkbox"/> Female				
Child 1		<input type="checkbox"/> Male <input type="checkbox"/> Female				
Child 2		<input type="checkbox"/> Male <input type="checkbox"/> Female				
Child 3		<input type="checkbox"/> Male <input type="checkbox"/> Female				

### Questionnaire of Lives Insured

Question	Main Insured	Spouse	Child 1	Child 2	Child 3
1. Has any application for life, medical or accident insurance been declined, postponed or accepted on special terms?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 5 years, any medical leave of more than 7 days continuously or any hospitalisation (except normal pregnancy) or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 5 years, have you been examined, received medical advice or treatment, or have been in Hospital/Clinic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been told (by a Doctor) or treated for any health condition relating to:					
a) Heart, lungs or any respiratory disorder, kidney, liver	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Thyroid, nervous system, breasts, reproductive system	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Hereditary or congenital condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Cancer or tumour	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Hypertension, stroke, chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Disorder of the blood, SLE (Systemic Lupus Erythematosus), Hepatitis B or C, HIV (Human Immunodeficiency Virus) infection, AIDS or STD (Sexually Transmitted Diseases)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Any other illness, injury or disability not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been advised to have any surgical operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have any physical impairment, defect or deformity or mental condition or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you visited any General Practitioner(s) or Specialist(s) in the last 6 months. (For i-MediCare only)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you or are you likely to engage in an occupation or any activities which could be considered dangerous? If "Yes", please state the activity.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

GH/1050/Life/09/2009

If you have answered "Yes" to any of the above questions, 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. Please include the respective question number(s) for your answer.

### 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 NTUC 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.

I agree to inform NTUC Income as soon as possible if there is any change in the state of my and/or the life to be insured's health or if I and/or the life to be insured plan to seek any medical consultation, investigation or treatment between the date of this application and before the date the policy is issued by NTUC Income. I understand that NTUC Income may impose terms, including limiting or reducing the insurance cover or sum assured of this proposal according to the information provided by me.

**If a material fact is not disclosed in this proposal, any policy issued may not be valid. If you are in doubt as to whether a fact is material, you are advised to disclose it. This includes any information that you may have provided to the agent but was not included in the proposal. Please check to ensure you are satisfied with the information declared in this proposal.**

Signature of Main Insured

Signature of Witness

Name of Main Insured

Date (dd/mm/yyyy)

Name & NRIC No. of Witness

Date (dd/mm/yyyy)

**GROUP INSURANCE FACT FINDING FORM**

**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.

Please send/fax completed fact finding form to NTUC Income, Group & Health Dept at 6338 1500.

**Company Information**

Name of Company		Contact No.
Nature of Business		Fax No.
Email	Contact Person	Designation

**General Information**

Proposed Period of Insurance (dd/mm/yyyy)	Total No. of employees	No. of employees to be insured
From To		

**Participation:** We would assume that participation of the group insurance program is on compulsory basis, unless otherwise indicated with a tick under "Participation - Voluntary". Please tick as appropriate to the choice of the insurance product that you would like to have a quote from us.

Insurance Cover Required	Presently Insured?			Participation		Section to Complete
	Yes		No	Compulsory	Voluntary	
	Name of Current Insurer	Period Insured				
Group Term Life (GTL)						1
Group Living (GLV)						1
Group Personal Accident (GPA)						1
Group Disability Income (GDI)						2
Group i-MediCare (IMC) Outpatient	Employee only					3
	Dependant <sup>1</sup>					
Group i-MediCare (IMC) Inpatient	Employee only					4
	Dependant <sup>1</sup>					
Group Hospital & Surgical (GHS)	Employee only					4
	Dependant <sup>1</sup>					
Group Major Medical (GMM)	Employee only					4
	Dependant <sup>1</sup>					
Supplement to Portable Group IncomeShield (PGIS)	Employee only					5
	Dependant <sup>1</sup>					

<sup>1</sup> Refers to Spouse and/or Children

Q1. Is there any member currently in hospital or require frequent admission to hospital (e.g. hospital admission more than 2 times per year)?  Yes  No  
 If "Yes", kindly provide the following details:

S/N	No. of members/Age	Reason for 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.

Q2. Has any member suffered or is suffering from any serious condition such as cancer, organ failure, diabetes, heart disease, stroke, kidney disorder, 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	No. of members/Age	Nature of illness	Total Sum Insured/Plan

Q3. Is there any member based outside Singapore?  Yes  No  
 If "Yes", kindly provide the following details:

S/N	No. of members/Age	Country based in	Total Sum Insured/Plan

Q4. Is there any limitation or exclusion imposed on the cover on any member?  Yes  No

If "Yes", kindly provide the following details:

S/N	No. of members/Age	Limitations/Exclusions	Total Sum Insured/Plan

Q5. Is there any member engaged in hazardous occupation?  Yes  No

(Hazardous occupation e.g. welder, diver, sandblaster, offshore workers etc.)

If "Yes", kindly provide the following details:

S/N	No. of members/Age	Nature of work	Total Sum Insured/Plan

Q6. To the best of your knowledge, is there any member engaged in hazardous sports?  Yes  No

(Hazardous sports e.g. scuba diving, motor racing, bungee jumping etc.)

If "Yes", kindly provide the following details:

S/N	No. of members/Age	Type of sports	Total Sum Insured/Plan

## Section 1

- For: i) Group Term Life (GTL) and/or  
 ii) Group Living (GLV) and/or  
 iii) Group Personal Accident (GPA) Quotation(s) Only.**

**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 Cover

		Category of Employees/Occupation (refer to the examples)	Basis of Cover - Sum Insured (refer to the examples)	No. of Employees
<b>GTL</b>	i)			
	ii)			
	iii)			
	iv)			

<b>GLV</b>	i)			
	ii)			
	iii)			
	iv)			

		Category of Employees/Occupation (refer to the examples)	Basis of Cover - Sum Insured (refer to the examples)	No. of Employees	Total Sum Insured (S\$)
<b>GPA</b>	i)				
	ii)				
	iii)				
	iv)				

**Example:**

Category of Employees/Occupation	Example 1 Basis of Cover - Sum Insured	Example 2 Basis of Cover - Sum Insured
i) Senior Management (Director, General Manager, Senior Manager)	\$100,000	24 x Basic Monthly Salary <sup>2</sup>
ii) All Others	\$25,000	12 x Basic Monthly Salary <sup>2</sup>

<sup>2</sup> Please provide salary information if the basis of cover is in terms of basic monthly salary.

Are there any members with sum insured exceeding S\$2 million?       Yes     No

If "Yes", please provide details on:

(i) No. of members \_\_\_\_\_

(ii) Age of members \_\_\_\_\_

(iii) Individual sum insured \_\_\_\_\_

b) Please provide Current Non Evidence Limit (if applicable)

Group Term Life: S\$ \_\_\_\_\_ up to age \_\_\_\_\_

Group Living: S\$ \_\_\_\_\_ up to age \_\_\_\_\_

c) Group Living: Basis of Cover

Is this an accelerated or additional benefit to the Group Term Life?  Accelerated  Additional

If it is an accelerated benefit, please indicate the percentage of acceleration on the Group Term Life sum insured.  25%  50%  100%

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

d) Details of Employees

Age Band (Age Next Birthday)	GTL				GLV			
	No. of Employees		Total Sum Insured (\$\$)		No. of Employees		Total Sum Insured (\$\$)	
	Male	Female	Male	Female	Male	Female	Male	Female
16-20								
21-25								
26-30								
31-35								
36-40								
41-45								
46-50								
51-55								
56-60								
61-65								
66-70								
<b>Total</b>								

e) Claims Experience for the past 3 years

NTUC Income reserves the right to request for more information.

**GTL**

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		No.	Amount (\$)	No.	Amount (\$)

**GLV**

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		No.	Amount (\$)	No.	Amount (\$)

**GPA**

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		No.	Amount (\$)	No.	Amount (\$)

**Section 2**

**For Group Disability Income (GDI) Quotation Only**

- a) If currently insured, please attach a copy of the definition of Disability.
- b) What is the waiting period required? Please tick as appropriate:  3 months  6 months
- c) What is the benefit duration required? \_\_\_\_\_ (e.g. 2 years, or 5 years, or up to age 60/65)
- d) What is the escalation benefit required? Please tick as appropriate:  0%  3%
- e) Please provide Current Non Evidence Limit (if applicable): S\$\_\_\_\_\_ up to age \_\_\_\_\_
- f) Any requirement for partial disability benefits?  Yes  No

g) Basis of Cover

	Category of Employees/Occupation	Monthly Salary (\$\$)		Basis of Cover i.e. % of monthly salary (e.g. 50%)
		Highest <sup>3</sup>	Average <sup>3</sup>	
i)				
ii)				
iii)				
iv)				

<sup>3</sup> Applicable to the category of employees as stated. Monthly salary will be basic pay + fixed bonus if any. It excludes variable bonus, commissions, etc.

h) Details of Employees

Age Band (Age Next Birthday)	No. of Employees		Total Annual Benefits (\$\$)	
	Male	Female	Male	Female
16-20				
21-25				
26-30				
31-35				
36-40				
41-45				
46-50				
51-55				
56-60				
61-65				
<b>Total</b>				

i) Claims Experience for the past 3 years

NTUC Income reserves the right to request for more information.

Date of Disability _____ (dd/mm/yyyy)	Cause of Disability/ Nature of Illness	Claims Amount (\$\$)	
		Paid	Outstanding

## Section 3

### For Group i-MediCare (IMC) Outpatient Quotation Only

**Note:** Group i-MediCare (IMC) Outpatient must be taken up with either GHS, IMC (Inpatient) or PGIS.

a) Benefit Option

Please tick as appropriate.	Co-insurance
<input type="checkbox"/> Outpatient Primary Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Outpatient Specialist Care (optional rider to Outpatient Primary Care)	<input type="checkbox"/> Yes <input type="checkbox"/> No

b) Details of Employees/Dependants

(If more plans are required, please attach accordingly)

Age Band (Age Next Birthday)	No. of Employees				No. of Dependants			
	Singaporeans/SPR <sup>4</sup>		Foreigners <sup>5</sup>		Singaporeans/SPR <sup>4</sup>		Foreigners <sup>5</sup>	
	Male	Female	Male	Female	Male	Female	Male	Female
1-5								
6-10								
11-15								
16-20								
21-25								
26-30								
31-35								
36-40								
41-45								
46-50								
51-55								
56-60								
61-65								
66-70								
<b>Total:</b>								

<sup>4</sup> Refers to Singapore Permanent Residents

<sup>5</sup> Refers to all foreigners holding Employment Pass, S Pass or Work Permit, working in Singapore

c) Claims Experience for the past 3 years

NTUC Income reserves the right to request for more information.

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Outpatient Primary (GP and A&E)				Outpatient Specialist			
		Paid Claims		Outstanding Claims		Paid Claims		Outstanding Claims	
		No.	Amount (\$\$)	No.	Amount (\$\$)	No.	Amount (\$\$)	No.	Amount (\$\$)

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Specialised Investigations			
		Paid Claims		Outstanding Claims	
		No.	Amount (\$\$)	No.	Amount (\$\$)

d) If currently insured, please attach a copy of the Schedule of Benefits.

e) 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 (\$\$)		Maximum Limit per Policy Year (\$\$)		Co-Payment (\$\$)/ 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
Outpatient Primary (GP & A&E)						
Outpatient Specialist						
Specialised Investigations						

## Section 4

- For: i) Group Hospital & Surgical (GHS) and/or  
 ii) Group i-MediCare (IMC) Inpatient and/or  
 iii) Group Major Medical (GMM) Quotation(s) Only.

a) Basis of Cover

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

**Important Note:**

- 1) Dependants can be covered under the same plan as the employee's cover.  
 2) Please provide the Deductible/Co-insurance for respective employee Category of Employees/Occupation, if applicable.

**Example:**

Category of Employees/Occupation	Room & Board Benefit Plan (\$\$)
i) Senior Management (Director, General Manager, Senior Manager)	515
ii) Manager & Executive	350
iii) All Others	190

b) Age Profile of Employees

Age Band (Age Next Birthday)	No. of Employees	
	Male	Female
16-20		
21-25		
26-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
<b>Total</b>		

c) Details of Insured Members

**For GHS, IMC (Inpatient) and GMM:**

	No. of Employees (Singaporeans & SPRs <sup>4</sup> )			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				

	No. of Employees (Foreigners <sup>5</sup> only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				

**For GMM (if the basis of cover differs from GHS) or IMC (Inpatient):**

	No. of Employees (Singaporeans & SPRs <sup>4</sup> )			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				

	No. of Employees (Foreigners <sup>5</sup> only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				

<sup>4</sup> Refers to Singapore Permanent Residents

<sup>5</sup> Refers to all foreigners holding Employment Pass, S Pass or Work Permit, working in Singapore

d) Claims Experience for the past 3 years

NTUC Income reserves the right to request for more information.

Period of Insurance From/To (dd/mm/yyyy)	No. of Insured as at (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		No. of Claims	Amount (\$\$)	No. of Claims	Amount (\$\$)

e) If currently insured, please attach a copy of the Schedule of Benefits.

## Section 5

### For Supplement to Portable Group IncomeShield (PGIS) Quotation Only

a) Basis of Cover

	Category of Employees/Occupation	Pegged to Enhanced IncomeShield (EIS) Plan	Room & Board Benefit Plan (\$\$)	No. of Employees	No. of Dependants
i)					
ii)					
iii)					
iv)					

**Example:**

**Category of Employees/Occupation**

**Pegged to Enhanced IncomeShield (EIS) Plan**

**Room & Board Benefit Plan (\$\$)**

- i) Senior Management (Director, General Manager, Senior Manager)
- ii) Manager & Executive
- iii) All Others

- EIS Preferred
- EIS Advantage
- EIS Basic

- 515
- 350
- 190

b) Details of Employees/Dependants

Age Band (Age Next Birthday)	No. of Employees				No. of Dependants			
	Singaporeans/SPR <sup>4</sup>		Foreigners <sup>5</sup>		Singaporeans/SPR <sup>4</sup>		Foreigners <sup>5</sup>	
	Male	Female	Male	Female	Male	Female	Male	Female
<b>1-18</b>								
<b>19-30</b>								
<b>31-40</b>								
<b>41-50</b>								
<b>51-60</b>								
<b>61-65</b>								
<b>66-70</b>								

<sup>4</sup> Refers to Singapore Permanent Residents

<sup>5</sup> Refers to all foreigners holding Employment Pass, S Pass or Work Permit, working in Singapore

c) Claims Experience for the past 3 years

NTUC Income reserves the right to request for more information.

Period of Insurance From/To _____ (dd/mm/yyyy)	No. of Insured as at _____ (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		No. of Claims	Amount (\$\$)	No. of Claims	Amount (\$\$)

d) If currently insured, please attach a copy of the Schedule of Benefits.

## Needs Analysis & Product Recommendation

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

Company's Priorities	Low	Medium	High	Adviser's Recommendation
Cover for outpatient medical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for hospital & surgical expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for dental expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for major illnesses (e.g. cancer, kidney failure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for loss of income due to sickness or accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cover for long term medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Declaration

I/We hereby declare that, to the best of my/our knowledge and belief, the information given here is 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 NTUC Income.

The following information has been attached.

- Copy of renewal/current benefits schedule.     Claims history report from current insurer for past 3 years.

\_\_\_\_\_  
Signature of Authorised Officer

\_\_\_\_\_  
Company Stamp (if applicable)

Name: \_\_\_\_\_ NRIC/Passport No.: \_\_\_\_\_

Date: \_\_\_\_\_ Designation: \_\_\_\_\_

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 Authorised Officer Signature of Intermediary/  
Broker/Agent (if any as appropriate) as a witness

\_\_\_\_\_  
Company Stamp (if applicable)

Name: \_\_\_\_\_

Date: \_\_\_\_\_ Designation: \_\_\_\_\_

Representative Code: \_\_\_\_\_ Contact No.: \_\_\_\_\_