# 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 suf cient 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 Bene ts 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 | Position |
|---|---|---|---|
| | | | |

*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<br>No. of sticks / day: _____ Years of smoking: _____ |
| Contact No.:<br>(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 |

### DETAILS OF EMPLOYER (COMPANY) [COMPLETE THIS SECTION ONLY IF PREMIUM IS PAID BY EMPLOYER AND POLICY TO BE ISSUED TO EMPLOYER]

| 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 con nement 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:**<br>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: _____

## PERSONAL DATA COLLECTION STATEMENT

To evaluate, process and administer this application or transaction, it is necessarily for us to collect, use, disclose and/or process your personal data or personal information about you. Such personal data includes information collected in this form, or in any document provided, or to be provided to us by you or from other sources.

**A. Purpose of Collection**

The personal data belonging to you and your insured/s may be collected, used and disclosed for the purposes of:

a. carrying out identity checks;
b. deciding whether to insure or continue to insure you and your insured persons;
c. providing advice for product recommendation based on your profile;
d. processing any claims under your policy, including the settlement of claims and any necessary investigations relating to the claims;
e. communicating on any matters relating to the services and/or products which you are entitled to under this policy;
f. responding to your inquiries or instructions and providing ongoing services, under your policy;
g. making or obtaining payments and recovering any debt owed to us;
h. detecting and preventing fraud, unlawful or improper activities;
i. conducting market research and statistical analysis;
j. coaching employees for customer service quality assurance;
k. reinsuring risks and for reinsurance administration; and
l. complying with all applicable laws, including reporting to regulatory and industry entities.

**B. Disclosure of Data**

The personal data belonging to you and your insured/s may be disclosed for the purposes set out in Section A above to the parties below:

a. Third party service vendors, suppliers, agents, reinsurers, or intermediaries;
b. Medical Professionals and Institutions;
c. Local or overseas service third party vendors that provide us with services such as printing, mail distribution, data storage, data entry, marketing and research, disaster recovery or emergency assistance services;
d. Debt collection agencies;
e. Dispute resolution parties;
f. Parties that assist us to investigate, administer and adjudicate claims;
g. Financial institutions;
h. Credit reference agencies;

i. Industry associations; and

j. To any regulatory, government and statutory body to comply with applicable, laws or regulation or upon their valid request.

**C. Personal Data Access and Amendments**

You can request access to your personal data collected by us, and to make any corrections to your personal data so as to keep it updated. We may charge you a reasonable fee for providing you with the service.

**D. Marketing Option**

Please indicate if you wish to receive marketing or promotional materials on our products or services via the following modes of communication. ;

☐ Telephone call ☐ Text Message ☐ Mail ☐ Email

If you do not indicate your option here, we will follow any existing option you may have indicated previously.

**E. Withdrawal Option of the collection and use of your personal data**

You may make your request to withdraw your consent, access or correct your personal data by writing to: The Data Protection Officer, EQ Insurance, 5 Maxwell Road, #17-00 Tower Block, MND Complex, Singapore 069110. Alternatively, you can email to dpo@eqinsurance.com.sg.

Neither EQ Insurance nor any of its employees shall be liable for any loss or damage suffered by you or any user as a result of any disclosure of any personal data which you have consented to us and/or any of its employees disclosing.

Altering on this "Personal data collection statement" is strictly prohibited. Any attempt to do so will be of no effect.

## DECLARATION

I / We hereby declare and warrant the answers given above in every respect are true and correct and I have not withheld any information likely to affect acceptance of this Proposal, and agree that this Proposal Declaration shall be the basis of the Contract between EQ Insurance and myself, and I further agree to accept the EQ Insurance Policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto.

I / We declared that no such insurance has been terminated in the last 12 months due to breach of any premium payment condition.

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.

I hereby authorize any hospital, medical practitioner, clinic or other medical facility, insurance company or other organizations or persons to release to EQ Insurance any information concerning my medical condition or history.

I confirm that I have been given a copy of the booklet "Your Guide to Health Insurance" and read through the Product Summary (as stated in the brochure), the contents of which have been explained to me to my satisfaction.

I am aware that I can seek advice from a qualified advisor before I sign this proposal form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.

**WARNING:** 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 insurance advisor / agent but was not included in the proposal. Please check to ensure that you are fully satis ed with the information declared in this proposal.

| Signature of Proposer (for and on behalf of all applicants to be insured) | Date Signed (dd/mm/yyyy) | Signature of Witness<br><br>Name & NRIC No.: |
|---|---|---|

## PAYMENT METHOD

☐ Cash ☐ Cheque crossed & payable to "EQ Insurance Company Limited" (Bank & Cheque No.: _____ )

## CREDIT CARD DETAILS (APPLICABLE TO MASTERCARD/ VISA/JCB/AMEX)

Premium: S$ _____ (including GST)

**I agree that no reversal is allowed under any circumstances whatsoever, once the payment is charged to my credit card**

☐ Visa / MasterCard*
☐ JCB
☐ AMEX

Name on Credit Card: _____ Tel No.: _____
*(Cardholder must be the Policyholder, Spouse, Parent, Child or Sibling)*

Card No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry Date ☐☐ - ☐☐☐☐ Security Code ☐☐☐☐

☐ Instalment Plan (only for participating banks with total premiums exceeding S$500)
Participating Bank: ☐ DBS ☐ UOB ☐ Citibank Instalment Period: ☐ 6 Months ☐ 12 Months

_____ Signature of Cardholder *(As in Credit card)*

_____ Date (dd/mm/yyyy)

*(* Delete where appropriate)*

HSI1702-Ver2.1 (PF)

## 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<br>Overall Maximum Limit<br>$50,000 | As Charged<br>Overall Maximum Limit<br>$30,000 | As Charged<br>Overall Maximum Limit<br>$20,000 | As Charged<br>Overall Maximum Limit<br>$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 Bene ts (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 | $353.10 | $353.10 | $303.88 | $303.88 | $282.48 | $282.48 | $235.40 | $235.40 |
| 19 - 30 | $529.65 | $624.88 | $425.86 | $502.90 | $367.01 | $433.35 | $282.48 | $333.84 |
| 31 - 40 | $635.58 | $782.17 | $516.81 | $624.88 | $451.54 | $541.42 | $353.10 | $417.30 |
| 41 - 50 | $776.82 | $948.02 | $637.72 | $765.05 | $564.96 | $666.61 | $447.26 | $518.95 |
| 51 - 60 | $1,200.54 | $1,083.91 | $1,003.66 | $906.29 | $904.15 | $817.48 | $729.74 | $660.19 |
| 61 - 65 (renewal only) | $1,906.74 | $1,563.27 | $1,580.39 | $1,295.77 | $1,412.40 | $1,157.74 | $1,129.92 | $926.62 |
| 66 - 70 (renewal only) | $2,471.70 | $2,187.08 | $2,066.17 | $1,863.94 | $1,863.94 | $1,678.83 | $1,506.56 | $1,369.60 |

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 domicile in Singapore and whose age on the next birthday is between 18 to 60 years old can enrol. Any natural children, legal step children and legally adopted children of the Insured, whose age on the next birthday is between 15 days and 17 years and who are unmarried and unemployed 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$80.25 (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 bene ts 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.*



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