



GLOBALHEALTH ASIA GROUP APPLICATION FORM

Important Notice:

Statement pursuant to Section 25(5) of The Insurance Act (Cap. 142) (or any subsequent amendments thereof): You are to disclose in this Application 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. Neither this enrolment form nor the brochure is a contract of insurance. However, your declarations or disclosures shall form the basis of the contract of insurance. The specified terms, conditions and exclusions applicable to this insurance are set out in the policy, a copy of which is available upon request.

COMPANY DETAILS

Company Name: _____

Specific Nature of Business: _____

LOCATION AND CONTACT DETAILS

Company Address: _____

Country: _____ Postal Code: _____

Telephone (H): _____ (O): _____

Mobile: _____ Facsimile: _____

Email Address: _____

Mailing Address (if different from company address): _____

Country: _____ Postal Code: _____

PLAN SELECTION

1. Level of Cover - Select your plan	<input type="checkbox"/> Advantage 100	<input type="checkbox"/> Advantage 200	<input type="checkbox"/> Advantage 300	<input type="checkbox"/> Advantage 400	<input type="checkbox"/> Advantage 500
	Hospital only cover with sub-limits	Hospital only cover with sub-limits and option to add out-patient	A hospital plan with extensive pre- and post-hospitalisation	Comprehensive hospital and out-patient coverage	Comprehensive hospital and out-patient coverage with Maternity cover
2. Deductible - Select your deductible (in US\$)	<input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000	<input type="checkbox"/> NIL <input type="checkbox"/> 500 <input type="checkbox"/> 1,000 <input type="checkbox"/> 2,000 <input type="checkbox"/> 5,000
3. Area of Cover - Upgrade to a Worldwide plan	NA	NA	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
4. Other Options	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental <input type="checkbox"/> Include out-patient cover	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental	<input type="checkbox"/> Dental

Requested Policy Start Date (dd/mm/yyyy): _____/_____/_____

CONTACT PERSON OF THE COMPANY

Name (last): _____
Name (first): _____
Name (middle): _____
Designation: _____
Residential Address: _____
City: _____ Country: _____ Postal Code: _____
Telephone (H): _____ (O): _____ (F): _____
Email: _____

PAYMENT METHOD

Annual Premium Payable: US\$ _____ (subject to prevailing GST)

Cheque Payment or Money Order.

Please send completed form and your cheque or money order made payable to, **Chartis Singapore Insurance Pte. Ltd.** Chartis Building, 78 Shenton Way #07-16, Singapore 079120 and please indicate on the back of your cheque "Global Health Policy".

Credit Card Payment Authorisation.

I/We, the undersigned, authorise you to charge my credit card for payment of GlobalHealth Advantage Plan premium as stated below:

Please select one only: **Visa** **Mastercard** **Amex** **Diners**

Card Holder's Name: _____

Card Number: - - -

Expiry Date:
m m y y

Signature of cardholder

Date

- Please note:
1. Card payment and effective date of cover is subject to credit card centre's approval.
 2. All charges will be made in Singapore dollars at the exchange rate(s) then in force.
 3. Where a third party Credit Card is used, I/We declare that the card holder has authorised and consented to such use.
 4. Only Singapore Credit Card is accepted.

Have you obtained Health Insurance Certification: Yes No

Producer Name: _____ Producer Code: _____

Address: _____

Phone No.: _____ Facsimile No.: _____

Email Address: _____

GlobalHealth Asia Advantage Plans are underwritten by Chartis Singapore Insurance Pte. Ltd.

DECLARATION BY APPLICANT

1. I/We hereby apply for a policy to be issued based on the statements contained herein and declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete and true. Except as declared herein, all persons to be insured are currently in good health. **I/We agree that if the health status of the above intended insured person changes after this application is signed and before Chartis Singapore Insurance Pte. Ltd. ("Chartis") issues a policy, I/We shall immediately notify Chartis of the change.** I/We agree that the policy as issued including all schedules, endorsements, and this application shall form the whole contract and that no insurance shall be in force until and unless the application has been accepted, and the appropriate premium is paid.
2. I/We hereby agree on behalf of myself/ourselves and any person(s), firm or corporation, that any information collected or held by Chartis (whether contained in this Proposal or otherwise obtained) may be used and disclosed by Chartis, its associated individuals/companies or any independent third parties (within or outside Singapore) for any matters relating to this Proposal, any Policy issued and to provide advice or information concerning products and services which Chartis believes may be of interest to me/us, and to communicate with me/us for any purposes.
3. If I/We are switching policy, I/We should consider whether this will result in any cost and whether the benefits under the new policy are more suitable.
4. I am aware that I can seek advice from a qualified advisor before I sign this enrolment form. Should I choose not to, I take sole responsibility to ensure that this product is appropriate to my financial needs and insurance objectives.
5. I/We hereby declare that I/We have received, read and understood, or have been advised of and understand, the contents of the brochure and any information material relating to this insurance product.
6. Direct Billing Facility (Applicable only to the following plans with nil deductible: Advantage 200 with out-patient option, Advantage 400 and Advantage 500) -please delete this section if this facility is not taken up.

I/We authorise Chartis/GlobalHealth to release the names, dates of birth, sex, passport and/or identification number, any information provided on the Application and any records Chartis/GlobalHealth may have regarding the Insured person(s) shown on the Namelist to hospitals, clinics, laboratories, physicians, specialists, dentists, chiropractors, acupuncturists, physiotherapists, or other medical practitioners for the purpose of providing direct bill paying services for the Insured Person(s).

By signing this **Authority and Release Form**, I/We also acknowledge the specific Policy term listed below:

Right of Recovery: In the event that authorisation for payment and/or payment is made by Chartis for a claim which is not covered under this Policy or when the limit of liability of this insurance is exceeded, Chartis reserves the right to recover the said sum or excess from you. This recovery includes but is not limited to deducting the payments owed from other claims made by you during the Policy period. If the amount owed remains outstanding for more than 90 days, then Chartis/GlobalHealth reserves the right to suspend the direct billing service to you without further notice.

Applicant's Name/Designation

Signature and Company Stamp

Date

Intermediary's access to online records:

- In the event that our family is represented by an insurance intermediary, I hereby accept that our intermediary will gain access to our GlobalHealth policy's documents online on his/her personal and password protected Producer Corner.

EMPLOYEES TO BE INSURED

Kindly list all employees to be insured. Please specify if any of the persons to be insured works or takes part in any activities involving offshore, underwater, underground, or manual work, or works in a remote location? If yes, please give details.

Employee 1

Last Name: _____

First Name: _____

Date of Birth (dd/mm/yy): _____

Gender (M/F): _____

