



EMPLOYEE AND FAMILY ENROLMENT 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.

PROPOSER

Company Name: _____

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

EMPLOYEE DETAILS

Name (last): _____

Name (first): _____

Name (middle): _____

ID/Passport No.: _____ Citizen of: _____

Date of Birth (dd/mm/yy): ____/____/____ Social Security No. (If U.S. Citizen): _____

Gender (M/F): ____ Smoker: Yes No Height (cm): _____ Weight (kg): _____

Occupation (specify nature of duties): _____

Country of Residence: _____

LOCATION AND CONTACT DETAILS

Email: _____

Telephone (Home): _____ (Work): _____

Mobile: _____ Fax: _____

Residential Address:

Line 1: _____

Line 2: _____

Line 3: _____ City: _____

Country: _____ Postal Code: _____

FAMILY MEMBERS TO BE INSURED

Details	Dependent 1	Dependent 2	Dependent 3	Dependent 4
Last Name				
First, Middle Name				
Relationship to Applicant				
Marital Status				
Citizen of				
ID Number/Passport				
Date of Birth (dd/mm/yy)				
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> M <input type="checkbox"/> F
Height (cm) & Weight (kg)				
Smoker	<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
Occupation				

Important Note about filling in this form:

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

1. Does any of the persons to be Insured reside outside the Usual Country of Residence as shown above? If "Yes", please state which country.
- Yes No
-
2. Does the occupation of any of the persons to be Insured include any activities involving offshore, underwater, underground, or manual work, or work in a remote location? If "Yes", please give details.
- Yes No
-
3. Have any of the persons to be Insured previously applied for or held a GlobalHealth policy? If "Yes", please provide policy number.
- Yes No
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4. Do any of the persons to be Insured have health insurance with another company? If "Yes", please attach a copy of the policy and benefit schedules, and indicate if the other coverage will be continued if the GlobalHealth application is approved.
- Yes No
-
5. Have any of the persons to be Insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused, postponed, declined, withdrawn, or had any special terms (including extra premium or exclusions) imposed? If "Yes", please provide full details.
- Yes No
-
6. Have any of the persons to be Insured experienced, been treated for, sought advice on, or had symptoms relating to any of the following conditions?
- Yes No
-

If the answer is "Yes" to any of the following, please write the medical condition and complete the relevant questionnaire where indicated. For other medical conditions, please provide details in the table on page 3.

- a) Cancer, leukemia, tumours, cysts or a growth of any kind? (If "Yes", please complete the **Tumour/Cyst** Questionnaire)
- Yes No
-
- b) Asthma, persistent cough, coughing of blood, pneumonia, chest or breathing complaints, chronic bronchitis, chronic sinusitis, allergies, deviated nasal septum, tuberculosis, or any disease or disorder of the lungs? (If "Yes", please complete the **Respiratory** Questionnaire)
- Yes No
-
- c) Chest pain, raised blood pressure, raised cholesterol, heart murmur or heart condition, breathlessness, abnormal heart rate, rheumatic fever, varicose veins, or circulatory disorder? (If "Yes", please complete the **Cardiovascular** Questionnaire)
- Yes No
-
- d) Indigestion, gastritis, gastric or duodenal ulcer, blood in stools, fistula, hernia, haemorrhoids or any disease or disorder of the bowel?
- Yes No
-
- e) Kidney stones, urinary tract infections or complaint, blood, protein or sugar in urine, or any disease or disorder of the kidney, bladder, prostate or genito-urinary tract?
- Yes No
-

- f) Jaundice, hepatitis of any form or any disease or disorder of the gall bladder, pancreas or liver? Yes No
-
- g) Diabetes, thyroid disorders or any other endocrine disorders? Yes No
-
- h) Anaemia, thalassaemia, haemophilia, or any other disease or disorder of the blood? Yes No
-
- i) Disease of the brain or nervous system, stroke, epilepsy, paralysis, weakness of a limb or prolonged headache? (If "Yes", please complete the **Cerebrovascular/Nervous System** Questionnaire) Yes No
-
- j) Mental health disorder, depression, anxiety, nervous condition, stress, post traumatic stress disorder, behavioural problem, alcohol or drug addiction? Yes No
-
- k) Back or neck pain or strain, spinal condition, sciatica, slipped disc, whiplash, gout, arthritis, bone fracture, joint injury e.g. knee, elbow, wrist, shoulder, hallux valgus (hammer toes) or any symptoms of a muscle disorder? (If "Yes", please complete the **Musculo-Skeletal** Questionnaire) Yes No
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- l) Malaria, dengue fever, typhoid or any other tropical disease? Yes No
-
- m) HIV, AIDS (Acquired Immuno Deficiency Syndrome), AIDS related condition or had any positive blood test for HIV (also called AIDS or HTLV-III) virus? Yes No
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- n) Psoriasis, eczema, dermatitis, acne or any other skin condition? Yes No
-
- o) Ear discharge, nose bleeds, double vision, impaired sight, hearing or speech or any other disease or disorder of the ear, eye, nose or throat? Yes No
-
- p) Any other ailment, impairment, injury, accident, condition(s), medical investigations, or hospital treatments not mentioned above? Yes No
-
- q) **(Females only)** Pregnancy or any complications of pregnancy, abnormal smear test or any gynaecological disorder e.g. fibroid &/or cyst of the female reproductive system? If "Yes", please complete the Gynaecological Questionnaire) Yes No
-

Address:

Line 1: _____

Line 2: _____

Line 3: _____ City: _____

Country: _____ Postal Code: _____

How long has this person been under this physician's care: _____

Date of last attendance & reason: _____

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.

Important Notes regarding the medical questionnaires:

Take Note That, all information requested in this form must be completed fully and accurately. Failure to provide all information, requested herein, may adversely affect the acceptance of any claim(s) you may make in the future.

Our acceptance of an incomplete Application Form shall not be construed howsoever as a waiver by Chartis, of the strict requirements for full disclosure of all relevant information requested herein.

 **DECLARATION BY EMPLOYEE**

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 in full.

Pre-existing conditions may not be covered if not declared and accepted by Chartis.

I/We agree that any information collected or held by Chartis (whether contained in the Application or otherwise obtained) may be used and disclosed by Chartis to its associated individuals/companies or any independent third parties (within or outside Singapore) for any matters relating to this application, 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 purpose.

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

If 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.

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.

Direct Billing (Applicable only to the following plans with nil deductible: Advantage 200 with Out-patient option, Advantage 400 and Advantage 500): 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 of authorisation of payment and/or payment is made by Chartis for a claim which is not covered under this Policy or when the limit of liability for 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 reserves the right to suspend the direct billing service to you without further notice.

I / We are aware and acknowledge that the failure to provide all relevant details in each of the Sections of this Application Form may prejudice any claim(s) that may be made by Me / Us in the future.

I / We are aware and have been duly advised that an acceptance of an incomplete Application Form by Chartis, does not amount to a waiver by Chartis, of the strict requirements for a full disclosure of all relevant information requested herein.

Printed Name/Title

Signature

Date

Chartis Singapore Insurance Pte. Ltd.

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Singapore 079120

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Web: www.globalhealthasia.com

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