

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

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								
Social Security No. (If U.S. Citizen)								
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								

MEDICAL QUESTIONNAIRE

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

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 4.

- 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
-
- 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
-
- 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
-

If you answered "Yes" to any of the above questions that did not require a Medical Questionnaire, please give details of the condition in the table below.

Applicant's Name	Q.No.	Date of first consultation	Details of Medical condition, including nature of treatment, results and if you have fully recovered?	Name & Address of doctor, hospital or health professional consulted	Do you require any follow up treatment or consultation, if so when?

(please use an extra sheet if more space is required)

7. Other than for those medical conditions mentioned above, has this person been admitted to hospital for treatment or observation or undergone any surgical procedure? If Yes, please provide full details, including the date, diagnosis and nature of treatment or surgical procedure. Yes No
-
8. Is this person taking any medication or receiving any form of treatment at the present time? If Yes, please provide the medical condition, name of medication and dosage, and/or treatment. Yes No
-
9. Has this person been advised to have or do they intend to seek any medical advice, test, investigation, surgical procedure, hospitalisation, or treatment in the near future? If Yes, please provide the medical condition, attending physician and recommended treatment. Yes No
-

DECLARATION BY PROPOSER

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.

I/We hereby declare that I am/We are ordinarily resident in Singapore as defined by "Insurance Act (Cap. 142) (Amendment of First Schedule) Order 2010"

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.

*Insurance Act (Chapter 142) (the "Act")

This Policy is issued in Singapore and is subject to the Insurance Act (Chapter 142) (the "Act").

A policy may be regarded as a Singapore policy or an off-shore policy. For this Policy to be regarded as a Singapore policy, You should be ordinarily resident in Singapore at the date of Your application for this Policy. The Act provides that You are treated as being ordinarily resident in Singapore if

- (i) You are a citizen of Singapore, unless You have resided outside Singapore continuously for 5 or more years preceding the application date of the policy and are not currently residing in Singapore;
- (ii) You are a permanent resident, unless You have resided in Singapore for less than a total of 183 days in the 12 months preceding the application date of the policy;
- (iii) You have a work pass or permit required under the Employment of Foreign Manpower Act(Cap. 91A), unless You have resided in Singapore for less than a total of 183 days in the 12 months preceding the application date of the policy; or
- (iv) You have a pass or permit required under the Immigration Act (Cap. 133) that has duration longer than 90 days and You have resided in Singapore continuously for at least 90 days in the 12 months preceding the application date of the policy.

If You do not satisfy any one of the aforesaid definitions of being "ordinarily resident in Singapore", You must notify Us immediately.

Printed Name/Title

Signature

Date

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

Please select payment method and provide details, where relevant:

Cheque Payment or Money Order.

Please make cheque/money order payable to **Chartis Singapore Insurance Pte. Ltd.** and indicate at the back of your cheque/money order "Global Health Policy". Send cheque/money order together with this duly completed form to : Chartis Singapore Insurance Pte. Ltd., Chartis Building, 10 Hoe Chiang Road, #04-01 Keppel Towers, Singapore 089315

Credit Card (For Full Payment of Premium).

I/We, the undersigned, authorize 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

Credit Card (For 0% Interest Installment Payment of Premium).

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

Please select one only: **DBS** **POSB** **UOB**

Please select payment period : 6 monthly interest-free payment 12 monthly interest-free payment

Card Holder's Name: _____

Card Number: - - -

Expiry Date:
m m y y

Notes for 0% interest installment payment:

1. For UOB 0% interest installment plan (IP) an administrative fee of S\$100 is payable in the event of premature cancellation or termination of the IP and/or credit card account.
2. 0% interest installment plans are not applicable for Corporate Cards, American Express Credit Cards and DBS Black Cards.
3. No mid term cancellation is allowed if Credit Card 0% Interest Installment Payment of Premium option is chosen.
4. 0% interest installment plans are available only if premium exceeds US\$ 500.

Declarations:

1. Where a third party credit card is used, I/We declare that the card holder has authorized and consented to such use.
2. If I have opted for 0% interest installment payment, I agree to be bound by DBS/POSB or UOB Terms and Conditions governing Installment Payment Plan posted at www.dbs.com and www.uob.com.sg respectively.

Signature of Cardholder

Date

- Notes:
 1. Credit card payment and effective date of cover is subject to credit card center's approval.
 2. All charges will be made in Singapore dollars at the exchange rate(s) then in force.
 3. Only Singapore credit cards are accepted.

Have you obtained Health Insurance Certification: Yes No

Producer Name: _____ Producer Code: _____

Address: _____

Phone No.: _____ Facsimile No.: _____

Email Address: _____

Chartis Singapore Insurance Pte. Ltd.

10 Hoe Chiang Road, #04-01
Keppel Towers, Singapore 089315

Email: membercare@globalhealthasia.com

Web: www.globalhealthasia.com
www.chartisinsurance.com/sg

Co. Reg. No. 201009404M