APPLICATION FOR UPGRADE BENEFITS

Important Notice
Disabilities existing prior to this Upgrade Application shall be covered according to the Terms & Conditions of the preceding medical plan unless the Company has been notified on this application of the Disabilities and said Disabilities are accepted at the higher benefit level in writing by the Company.

Policy Number: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Name of Insured: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Job Title: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Date of Birth (dd/mm/yy): |___|___|/|___|___|/|___|___| Gender (M/F): |___| Height (cm): |___|___|___| Weight (kg): |___|___|___|

Upgrade to: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

DEPENDANTS

Name	Date of Birth	Gender	Height/Weight	Relationship

1. Have you or any of your dependants consulted a physician in the past 2 years?

   ☐ Yes (please explain): ______________________________

   ☐ No

2. Are you or any of your dependants under treatment, special diet, or medication for any illness, injury, or medical condition?

   ☐ Yes (please explain): ______________________________

   ☐ No

3. Have you or any of your dependants been advised to undergo any test, treatment, special diet, medication, procedure, check-up, or hospitalisation that has not yet been completed?

   ☐ Yes (please explain): ______________________________

   ☐ No

4. Disabilities that you and/or your dependant(s) have suffered from prior to this upgrade application.

____

5. Is there any current pregnancy? ☐ Yes ☐ No. If "Yes" please give expected due date.

____

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true.

______________________________ ______________________________

Signature of the Insured / Main Applicant
(Signature by Policyholder if the insured person is a Minor)

Date

Chartis Singapore Insurance Pte. Ltd.
CHARTIS Building
78 Shenton Way #07-16
Singapore 079120
Email: membercare@globalhealthasia.com
Web: www.globalhealthasia.com
www.chartisinsurance.com/sg
Co. Reg. No. 201009404M

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