PROFESSIONAL INVESTMENT ADVISORY SERVICES

Corporate Financial Planner

(Group Life and Health Insurance)

Name of Organisation _____

Name of Adviser _____

I declare I am authorized to provide advice on the following products:

☐ Advise / arrange contract of insurance in respect of life policies

☐ Advise / market Collective Investment Schemes

Professional Investment Advisory Services Pte Ltd is an affiliate of Aviva group of companies

SECTION 1 - ORGANISATION INFORMATION

A. Organisation Entity Details (NOTE: All fields are mandatory)

Period of Insurance:
From: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Request For Quotation (was submitted on) _____

Full Name of Organisation _____

Incorporation No./ Business Registration No . / Organisation Registration No. _____

Date of Incorporation or Registration _____

Place of Incorporation or Registration _____

Registered Address _____

Type of Business Structure ☐ Sole Proprietor ☐ Partnership ☐ Private Limited ☐ Public Limited ☐ Others _____

SECTION 2 - GENERAL INFORMATION

Nature of Business: _____

Presently Insured? ☐ Yes ☐ No

If **Yes,** name of current Insurer**:** _____

Type of Policy: _____

Period of Insurance: From: _____ (DD/MM/YYYY) to _____ (DD/MM/YYYY)

Total No, of Employees: _____ No. of Employees to be insured: _____

Participation: The insurer will assume that participation of the group insurance program is on compulsory basis unless otherwise stated. Please tick [√] accordingly to the choice of the insurance product that you like to have a quote from us.

Benefits	Insurance Coverage			Participation	
				Compulsory	Voluntary
Life Insurance	3A	Group Term Life (GTL)			
		Group Personal Accident (GPA)			
		Group Critical illness (GCI)			
	3B	Group Disability Income(GDI)			
Medical	3C	Group Hospital & Surgical (GHS)	Employee Only		
			Dependant (Spouse and/or Children)		
		Group Major Medical (GMM)	Employee Only		
			Dependant (Spouse and/or Children)		
Others	3D	Group Outpatient	Employee Only		
			Dependant (Spouse and/or Children)		
		Dental	Employee Only		
			Dependant (Spouse and/or Children)		
	3E	Maternity	Employee Only		
			Dependant (Spouse)		

Note: Participation is voluntary if employees or dependants are given the choice to opt for the cover(s), subject to a minimum participation level

SECTION 2 - General Information

Q1. Are there any members currently in hospital or requires frequent admission (e.g. hospital admission more than 2 times per year) to hospital? ☐ Yes ☐ No

If **Yes**, kindly provide the following details:

S/N	No of Members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

Q2. Has any member suffered or is suffering from any serious condition such as cancer, organ failure, heart disease, stroke, liver disorder, arthritis or any other disorder that causes progressive irreversible functional or physical disability?

☐ Yes ☐ No

If **Yes**, kindly provide the following details:

S/N	No of Members / Age	Reason of hospitalisation / Nature of illness	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

Q3. Is there any member based outside Singapore?

☐ Yes ☐ No

If **Yes**, kindly provide the following details:

S/N	No of Members / Age	Country Based In	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

SECTION 2 - General Information

Q4. Are there any limitations or exclusions imposed on the coverage on any members?

☐ Yes ☐ No

If Yes, kindly provide the following details:

S/N	No of Members / Age	Limitations / Exclusions	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

Q5. Is there any member engaged in hazardous occupation?
(Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

☐ Yes ☐ No

If Yes, kindly provide the following details:

S/N	No of Members / Age	Nature of work	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

Q6. To the best of your knowledge, is there any member engaged in hazardous sports?
(Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.)

☐ Yes ☐ No

If Yes, kindly provide the following details:

S/N	No of Members / Age	Type of Sports	Total Sum Insured / Plan
Note: The insurer will not reimburse the hospital claims for any member in hospital at the time of application.			

SECTION 3A- GROUP TERM LIFE / GROUP PERSONAL ACCIDENT / GROUP CRITICAL ILLNESS INSURANCE

Occupational Classifications

Class 1	Clerical, administrative or other similar non-hazardous occupations
Class 2	Occupations where some degree of risk is involved, e.g. supervision of manual workers, totally administrative job in an industrial environment
Class 3	Occupations involving regular light to medium manual work but no substantial hazard which may increase the risk of sickness or accident
Class 4	High risk occupations involving heavy manual work including hot works

a) Basis of Coverage

		Category of Employees/Occupation (refer to the examples)	Basis of Coverage – Sum Insured (refer to the examples)	No of Employees
Group Term Life	(i)			
	(ii)			
	(iii)			
	(iv)			
Group Personal Accident	(i)			
	(ii)			
	(iii)			
	(iv)			
Group Critical Illness	(i)			
	(ii)			
	(iii)			
	(iv)			

Example 1

Category of Employees / Occupation		Basis of Coverage
(i)	Senior Management (Director, General Manager, Senior Manager)	100,000
(ii)	Manager & Executive	50,000
(iii)	All Others	25,000

Example 2

Category of Employees / Occupation		Basis of Coverage
(i)	All Employees	24 x Basic Monthly Salary*

* Please provide salary information if the basis of coverage is in terms of basic monthly salary.

SECTION 3A- GROUP TERM LIFE / GROUP PERSONAL ACCIDENT / GROUP CRITICAL ILLNESS INSURANCE

b) Please provide Current Non-Medical Limit (if applicable)

Group Term Life S$_____ up to age _____

Group Critical Illness S$_____ up to age _____

c) Group Critical Illness: Basis of Coverage

Is this benefit an accelerated of or an additional amount to the Term Life? ☐ Accelerated ☐ Additional

If it is an accelerated benefit, what percentage on the Term Life sum insured you want us to quote?

☐ 25% ☐ 50% ☐ 100%

Please provide a list of critical illnesses covered (if currently insured).

d) Details of Employees

Age Band (Age Next Birthday)	Group Term Life				Group Critical Illness			
	No of Employees		Total Sum Insured (S$)		No of employees		Total Sum Insured (S$)	
	Male	Female	Male	Female	Male	Female	Male	Female
16-30								
31-35								
36-40								
41-45								
46-50								
51-55								
56-60								
61-65								
66-70								
Total								

e) Claims Experience for the past 3 years

Paid Claims

Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	Group Term Life		Group Personal Accident		Group Critical Illness	
		No of Claims	Amount (S$)	No of Claims	Amount (S$)	No of Claims	Amount (S$)
Note: The insurer reserves the right to request for more information.							

SECTION 3A- GROUP TERM LIFE / GROUP PERSONAL ACCIDENT / GROUP CRITICAL ILLNESS INSURANCE

Outstanding Claims

Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	Group Term Life		Group Personal Accident		Group Critical Illness	
		No of Claims	Amount (S$)	No of Claims	Amount (S$)	No of Claims	Amount (S$)
Note: The insurer reserves the right to request for more information.							

SECTION 3B- GROUP DISABILITY INCOME INSURANCE

a) If currently insured, please attach a copy of the definition of Disability.

b) What is the waiting period required? ☐ 3 Months ☐ 6 Months ☐ _____Months

c) What is the benefit duration required? ☐ _____Years ☐ Up to Retirement age _____

d) What is the escalation benefit required? ☐ 0% ☐ 3% ☐ 5% ☐ _____ %

e) Please provide Current Non-Medical Limit (if applicable): S$_____ up to age _____

f) Any requirement for partial disability benefits? ☐ Yes ☐ No

g) Basis of Coverage

Category of Employees / Occupation		Monthly Salary (S$)		Basis of Coverage i.e. % (e.g. 50%) of monthly salary
		Highest*	Average *	
(i)				
(ii)				
(iii)				
(iv)				
* Applicable to the category of employees as stated. Monthly salary will be basic pay + fixed bonus if any. It excludes variable bonus, commissions, etc.				

SECTION 3B- GROUP DISABILITY INCOME INSURANCE

h) Details of Employees

Age Band (Age Next Birthday)	No of Employees		Sum Insured (S$)	
	Male	Female	Male	Female
16-30				
31-35				
36-40				
41-45				
46-50				
51-55				
56-60				
61-65				
66-70				
Total				

i) Claims Experience for the past 3 years

Date of Disability (dd/mm/yyyy)	Cause of Disability / Nature of Illness	Claim Amount (S$)	
		Paid	Outstanding
Note: The Insurer reserves the right to request for more information.			

SECTION 3C- GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

a) Basis of Coverage

Category of Employees / Occupation		Room & Board (R&B) Benefit Plan (S$)	Currently with TMIS* Yes / No	Proposal with TMIS* Yes / No
(i)				
(ii)				
(iii)				
(iv)				

Important Note:

(1) Dependants can be covered under Group Hospital & Surgical Plan. Their cover should be the same as the employee's cover.

(2) Please provide the Deductible /Co-insurance for respective employee category or occupation, if applicable.

*TMIS - Transferable Medical Insurance Scheme

SECTION 3C- GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

Example 1

Category of Employees / Occupation	R&B Benefit Plan (S$)
(i) Senior Management (Director, General Manager, Senior Manager)	360
(ii) Manager & Executive	200
(iii) All Others	100

b) Age Profile of Employees

Age Band (Age Next Birthday)	No of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) Details of Insured Members

For Group Hospital & Surgical and Group Major Medical:

	No of Employees (Singaporeans & SPRs*)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
* refers to Singapore Permanent Residents				

	No of Employees (Foreigners* only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
* refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore				

SECTION 3C- GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

For Group Major Medical (if the basis of coverage differs from Group Hospital & Surgical):

	No of Employees (Singaporeans & SPRs*)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
* refers to Singapore Permanent Residents				

	No of Employees (Foreigners* only)			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only				
Employee & Spouse				
Employee & Child(ren)				
Employee & Family				
* refers to all foreigners holding Employment Pass, S Pass and Work Permit, working in Singapore				

d) Claims Experience for the past 3 years

Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	Paid claims		Outstanding Claims	
		No of Claims	Amount (S$)	No of Claims	Amount (s$)
Note: The Insurer reserves the right to request for more information.					

e) Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis (i.e. currently insured).

SECTION 3D- GROUP OUTPATIENT INSURANCE

a) Category of Employees to be insured (please tick as appropriate)

Category of Employees		Clinical GP	Specialist	Diagnostic X-Ray/ Lab tests	Dental
(i)					
(ii)					
(iii)					
Dependent (where applicable)					
No of headcount					

SECTION 3D- GROUP OUTPATIENT INSURANCE

b) Age Profile of Employees

Age Band (Age Next Birthday)	No of Employees	
	Male	Female
16-30		
31-35		
36-40		
41-45		
46-50		
51-55		
56-60		
61-65		
66-70		
Total		

c) Claims Experience for the past 3 years

Paid Claims

		Clinical *		Specialist *		Diagnostic X- Ray/ Lab Test*		Dental *	
Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	No of Visits	Amount (S$)	No of Visits	Amount (S$)	No of Visits	Amount (S$)	No of Visits	Amount (S$)

*inclusive of visits to non-panel clinics
Note: The insurer reserves the right to request for more information

Outstanding Claims

		Clinical *		Specialist *		Diagnostic X- Ray/ Lab Test*		Dental *	
Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	No of Visits	Amount (S$)	No of Visits	Amount (S$)	No of Visits	Amount (S$)	No of Visits	Amount (S$)

*inclusive of visits to non-panel clinics
Note: The insurer reserves the right to request for more information

SECTION 3D- GROUP OUTPATIENT INSURANCE

d) Kindly attach a copy of the Schedule of Benefits if the benefits are on insured basis. If currently self-insured, kindly provide the following details: Please indicate "Unlimited" if there is no cap and "NA" if it is not applicable.

Benefits	Maximum Limit per visit (S$)		Maximum Limit per policy Year (S$)		Co- Payment (S$) / Co- Insurance (%)	
	Clinic on Company's panel	Non- panel Clinic	Clinic on Company's panel	Non- panel Clinic	Clinic on Company's panel	Non- panel Clinic
Clinical GP						
Specialist						
Diagnostic X-Ray / Lab Test						
Dental						
Others						

SECTION 3E- MATERNITY INSURANCE

a) Basis of coverage

Category of Employees (refer to example)		No of Headcount
(i)		
(ii)		
(iii)		

Example 1

Category of Employees/ Occupation

(i) Senior Management (Director, General Manager, Senior Manager)

(ii) Manager & Executive

(iii) All Others

Example 2

(i) All Employees

b) Claims Experience for the past 3 years

Period of Coverage From / To (dd/mm/yyyy)	No of Insured as at (dd/mm/yyyy)	Paid claims		Outstanding Claims	
		No of Claims	Amount (S$)	No of Claims	Amount (S$)
Note: The Insurer reserves the right to request for more information.					

SECTION 3E- MATERNITY INSURANCE

c) Kindly attach a copy of the Schedule of Benefits if the benefits are on insured basis.If currently self-insured, kindly provide the Following details: Please indicate "Unlimited" if there is no cap and "NA" if it is not applicable

Benefits	Maximum Limit per Policy Year (S$)	Deductable/ Co- Insurance (S$)
Normal Delivery		
Caesarian Delivery		
Others		

SECTION 4 - NEEDS ANALYSIS & PRODUCT RECOMMENDATION

Please tick the appropriate box to indicate the priority of your company's needs:

Company's Priorities	Low	Medium	High	Adviser's Recommendation
Cover for outpatient medical expenses	☐	☐	☐	
Cover for Hospitals & Surgical expenses	☐	☐	☐	
Cover for Dental expenses	☐	☐	☐	
Cover for Major illnesses (e.g. cancer, kidney failure, etc.)	☐	☐	☐	
Cover for Loss of income due to sickness or accident	☐	☐	☐	
Cover for long term medical treatment	☐	☐	☐	
Others				

SECTION 5 - ORGANISATION ACKNOWLEDGEMENT AND DECLARATION

1. Personal Data Notice and Consent Clause

a) I/We understand, acknowledge and consent to PIAS processing, collecting and using my/our corporate data provided to me/us in this form and from time to time, to PIAS and disclosing my/our corporate data to Permitted Parties for the following Purposes:

i) administering, servicing or dealing with the financial advisory services provided by PIAS (including processing my/our applications for financial products);

ii) managing with my/our financial products that I/we have purchased pursuant to the financial advisory services provided by PIAS;

iii) observing any legal, governmental or regulatory requirements of any relevant jurisdiction (including any disclosure or notification requirements to which PIAS is subject to);

iv) carrying out due diligence, monitoring or other screening activities in accordance with PIAS' legal or regulatory obligations or risk management procedures; and

v) providing me/us with marketing, advertising and promotional information, materials and / or documents relating the financial advisory services provided by PIAS (including the financial products of PIAS' business partners and product providers) that PIAS may be selling, marketing, offering or promoting (whether such products or services exist now or are created in the future) which in the opinion of PIAS may be of interest or benefit to me/us, by way of postal mail and electronic transmission to my/our email and postal address(es)*. For withdrawal of consent for marketing via email and / or postal mail, please contact PIAS Data Protection Officer for more information at dataprotection@pias.asia.

SECTION 5 - ORGANISATION ACKNOWLEDGEMENT AND DECLARATION

b) ☐ (Please tick √ the box if you wish to provide your consent)

By ticking the box, I/We hereby consent to PIAS providing me/us with marketing, advertising and promotional information, materials and / or documents relating the financial advisory services provided by PIAS (including the financial products of PIAS' business partners and product providers) that PIAS may be selling, marketing, offering or promoting (whether such products or services exist now or are created in the future) which in the opinion of PIAS may be of interest or benefit to me/us, by way of telephone calls, SMS / MMS and facsimile to me/us, to the telephone number(s) provided by me/us to PIAS in this form and any other telephone number(s) provided by me/us to PIAS from time to time.

I understand that if my/our consent is not provided, PIAS will be unable to provide me/us with such marketing and promotional information using such modes of communication.*

c) I/We hereby represent and warrant that I/We am/are the user and / or subscriber of all the telephone number(s) provided by me/us to PIAS from time to time (including without limitation the telephone number(s) provided by me/us to PIAS in this consent form and on all other forms, or documents from time to time), and that I/We have read and understood PIAS' Personal Data Notice and Consent Policy and the above provisions.

d) I/We represent and warrant that for any personal data of my/our employees and employees' dependant(s) that I/We disclose to PIAS, that I/We am/are validly acting on behalf of my/our employees and employees' dependant(s) and that, prior to disclosing my/our employees and employees' dependant(s)' personal data to PIAS, I/We have informed my/our employees and employees' dependant(s) that their personal data will be disclosed to, and obtained the consent from my/our employees and employees' dependant(s) for their personal data to be disclosed to, PIAS so that PIAS can process, collect and use my/our employees and employees' dependant(s)' personal data for one or more of the Purposes and PIAS can disclose my/our employees and employees' dependant(s)' personal data to the Permitted Parties for one or more of the Purposes.

* For details about PIAS' Personal Data Notice and Consent Policy, please visit http://www.proinvest.com.sg/about-pias/pdpa.

2. I acknowledge receipt and I have read and understood the following documents (where applicable)

- Important Notice To Client
- Corporate Financial Planner (Group Life and Health Insurance) Form

3. Source of Funds

☐ Company Cheque
☐ Third Party Cheque (Please specify the Payer's Name, NRIC / Passport and Relationship with organisation)

_____

☐ Others _____

4. Declaration

I/We hereby declare that, to the best of my / our knowledge and belief, the information given here are true and complete, and agree that if a contract of insurance is effected, all information submitted in connection with this application shall form the basis of such contract between the Organisation and the Insurer.

_____
Signature of Organisation Authorised Officer
Co Stamp (Where applicable)

Name: _____

NRIC/Passport: _____

Designation: _____

Date: _____

_____
Signature of Organisation Authorised Officer
Co Stamp (Where applicable)

Name: _____

NRIC/Passport: _____

Designation: _____

Date: _____

SECTION 6 - ADVISER'S DECLARATION

I declare and acknowledge that I have reviewed this Corporate Financial Planner (Group Life and Health Insurance) with the Authorised Officer of the Organisation, and that I have explained all the requirements of this Corporate Financial Planner to him/her. The information will be treated as confidential and shall not be used for any other purposes without Organisation's consent.

Name of Adviser	Adviser's Signature	Date