



Confidential Fact-Finding form for Group Health Insurance

Kindly co	mp	lete fully in BLOCK	LETTER and INK (Tick	boxes [√] when	re appropriate)
			//(dd/mm/yyy		
Request	for	quotation was subm	nitted on / / (c	dd/mm/yyyy)	
Request				-1 11111	
(name of	insu	irance company)			
		formation			
Name of 0	Com	pany:			
Nature of	Bus	iness:			
Presently	insι	red? Yes / No			
		of current insurer:			
Type of Po	olicy	'			
Period of	โทรเ	ırance: From:/	/ (dd/mm/yyyy)	To/	_(dd/mm/yyyy)
Total No.	of E	mployees:	No. of Emplo	oyees to be insu	red:
program	is c	on compulsory basi	assume that participat s unless otherwise state that you like to have a continuous	ted. Please tick	
		•	•		
Benefits		Insuranc	e Coverage	Pa	rticipation
			-	Compulsor	y Voluntary
Medical	1	Group Hospital &	Employee only		
		Surgical (GHS)	Dependant (Spouse and/or Children)		
		Group Major	Employee only		
		Medical (GMM)	Dependant (Spouse		
		Treatear (or ii i)	and/or Children)		
		Group Out-Patient	· , ,		
	Group Out-Patient		I Employee only		
		Group out rutient	Employee only Dependant (Spouse		
		Group out rutions	Dependant (Spouse and/or Children)		
Others	2	Dental I	Dependant (Spouse		
Others	2		Dependant (Spouse and/or Children)		
Others	2		Dependant (Spouse and/or Children) Employee only		
Others	2		Dependant (Spouse and/or Children) Employee only Dependant (Spouse		
		Dental I Maternity	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse)		
Note: Parti	cipa	Dental I Maternity tion is voluntary if emp	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Joyees or dependants are given	ven the choice to d	opt for the cover(s),
Note: Parti	cipa	Dental I Maternity	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Joyees or dependants are given	ven the choice to d	opt for the cover(s),
Note: Parti subject to	cipa a mi	Dental I Maternity tion is voluntary if emp	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Joyees or dependants are givel.		
Note: Parti subject to	cipa a mi	Dental I Maternity tion is voluntary if empnimum participation leverage any members current	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant (Spouse) Doyees or dependants are givel.	s frequent admis	
Note: Parti subject to Q1. Are th admission	cipa a mi nere mo	Dental I Maternity tion is voluntary if emponimum participation level any members currenters than 2 times per years.	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant (Spouse) Dependant (Spouse) Dependant (Spouse) Dependent	s frequent admis	
Note: Parti subject to a Q1. Are th admission If Yes , kin	cipa a mi nere mo	Dental I Maternity tion is voluntary if emploimum participation level any members currentered than 2 times per year provide the following	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant	s frequent admis	ssion (e.g. hospital
Note: Parti subject to a Q1. Are the admission If Yes, kin	cipa a mi nere mo ndly	Dental I Maternity tion is voluntary if emploimum participation level any members currently the provide the following provide the following the second control of the second c	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant (Spouse) Dependant (Spouse) Dependant (Spouse) Dependent	s frequent admis	ssion (e.g. hospital Fotal Sum Insured
Note: Partisubject to a Q1. Are the admission of Yes, king S/N	cipa a mi nere mo ndly # o me	Dental I Maternity tion is voluntary if emploimum participation level any members currentere than 2 times per year provide the following formula illness	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant	s frequent admis	ssion (e.g. hospital
Note: Partisubject to a Q1. Are the admission of Yes, kind S/N	cipa a mi nere mo ndly	Dental I Maternity tion is voluntary if emploimum participation level any members currentere than 2 times per year provide the following formula illness	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant	s frequent admis	ssion (e.g. hospital Fotal Sum Insured
Note: Partisubject to a Q1. Are the admission of Yes, kind S/N	cipa a mi nere mo ndly # o me	Dental I Maternity tion is voluntary if emploimum participation level any members currentere than 2 times per year provide the following formula illness	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant	s frequent admis	ssion (e.g. hospital Fotal Sum Insured
Note: Partisubject to a Q1. Are the admission of Yes, kind S/N	cipa a mi nere mo ndly # o me	Dental I Maternity tion is voluntary if emploimum participation level any members currentere than 2 times per year provide the following formula illness	Dependant (Spouse and/or Children) Employee only Dependant (Spouse and/or Children) Employee only Dependant (Spouse) Dependant	s frequent admis	ssion (e.g. hospital Fotal Sum Insured

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Note: The	insurer will not rei	mburse the hospital claims for any member in hospi	ital at the time of
application			
		ered or is suffering from any serious condition	such as cancer.
		se, stroke, liver disorder, arthritis or any other	
		rsible functional or physical disability? Yes / N e	
•	_	following details:	G
	# of	Reason of hospitalisation / Nature of	Total Come Incomed
S/N	-	• · · · · · · · · · · · · · · · · · · ·	Total Sum Insured
	members /	illness	/Plan
	age		
		<u> </u>	
Note: The	insurer will not rei	mburse the hospital claims for any member in hospi	tal at the time of
application	n.		
Q.3 Is th	ere any member	based outside Singapore? Yes / No	
		following details:	
S/N	# of	Country based in	Total Sum Insured
- ,	members /		/Plan
	age		,a
	age		
		mburse the hospital claims for any member in hospi	tal at the time of
application			
_		ons or exclusions imposed on the coverage on a	any members?
Yes / No		provide the following details:	
S/N	# of	Limitations/Exclusions	Total Sum Insured
	members /		/Plan
	age		
1			
Note: The	insurer will not rei	mburse the hospital claims for any member in hospi	ital at the time of
		mburse the hospital claims for any member in hospi	ital at the time of
application	n.		ital at the time of
<i>application</i> Q.5 Is th	<i>n.</i> ere any member	engaged in hazardous occupation? Yes / No	
application Q.5 Is th (Hazardo	<i>n.</i> ere any member ous occupation e	engaged in hazardous occupation? Yes / No g. welder, diver, sandblaster, offshore workers	
application Q.5 Is th (Hazardo If Yes , k	n. ere any member ous occupation eq kindly provide the	engaged in hazardous occupation? Yes / No g. welder, diver, sandblaster, offshore workers e following details:	etc.)
application Q.5 Is th (Hazardo	n. ere any member ous occupation equivalently provide the # of	engaged in hazardous occupation? Yes / No g. welder, diver, sandblaster, offshore workers	etc.) Total Sum Insured
application Q.5 Is th (Hazardo If Yes , k	ere any member ous occupation exindly provide the # of members /	engaged in hazardous occupation? Yes / No g. welder, diver, sandblaster, offshore workers e following details:	etc.)
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application Q.5 Is th (Hazarde If Yes, k S/N Note: The application	ere any member ous occupation exindly provide the # of members / age insurer will not rein.	engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers following details: Nature of work mburse the hospital claims for any member in hospi	etc.) Total Sum Insured /Plan tal at the time of
application Q.5 Is th (Hazarde If Yes, k S/N Note: The application	ere any member ous occupation exindly provide the # of members / age insurer will not rein.	engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers following details: Nature of work mburse the hospital claims for any member in hospi	etc.) Total Sum Insured /Plan tal at the time of
Application Q.5 Is th (Hazard If Yes, H S/N Note: The application Q.6 To th	ere any member ous occupation exindly provide the work of members / age insurer will not rein. ne best of your kr	engaged in hazardous occupation? Yes / No g. welder, diver, sandblaster, offshore workers e following details: Nature of work Imburse the hospital claims for any member in hospital claims for any member engaged in haz	etc.) Total Sum Insured /Plan ital at the time of ardous sports?
Application Q.5 Is th (Hazarde If Yes, k S/N Note: The application Q.6 To th Yes / No	ere any member ous occupation exindly provide the work of members / age insurer will not rein. The best of your known (Hazardous spo	engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers of following details: Nature of work mburse the hospital claims for any member in hospital claims for any member of hos	etc.) Total Sum Insured /Plan ital at the time of ardous sports?
Application Q.5 Is th (Hazarde If Yes, k S/N Note: The application Q.6 To th Yes / No If Yes, k	ere any member ous occupation exindly provide the following members / age insurer will not rein. The best of your known (Hazardous spoindly provide the	engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers e following details: Nature of work mburse the hospital claims for any member in hospital claims for any member in hospital engaged in hazerts eg. scuba diving, motor racing, bungee jum following details:	etc.) Total Sum Insured /Plan ital at the time of ardous sports? pping etc.)
Application Q.5 Is th (Hazarde If Yes, k S/N Note: The application Q.6 To th Yes / No	ere any member ous occupation exindly provide the following members / age insurer will not rein. The best of your known (Hazardous spoindly provide the	engaged in hazardous occupation? Yes / Nog. welder, diver, sandblaster, offshore workers of following details: Nature of work mburse the hospital claims for any member in hospital claims for any member of hos	etc.) Total Sum Insured /Plan ital at the time of ardous sports?





		/Plan
Note: The application	mburse the hospital claims for any member in hospital	al at the time of

Benefit: Group Hospital & Surgical Insurance/Major Medical Insurance								
a. Basis of C	a. Basis of Coverage							
Category of Employees / Occupation	Employees / Benefit Plan 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.

Example 1

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

b. Age profile of employees						
Age band (Age next birthday)		# 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 GHS and GMM:						
		# of employees (Sin	gaporeans & SPRs*)			
	Plan 1	Plan 2	Plan 3	Plan 4		
Employee Only						
Employee &						
Spouse						





Employee & Child(ren)					
Employee &					
Family					
	re Permanent Resider	 nts			
rerers to emigape	re remainemente de la contracti	700			
		# of emplo	yees (Foreigner	rs* onlv)	
	Plan 1	Plan 2		an 3	Plan 4
Employee Only	-				-
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family					
* refers to all foreight	gners holding Employi	ment Pass, S Pass	s and Work Permi	t, working in S	Singapore
For GMM (if the	basis of coverage				
			es (Singaporear		
	Plan 1	Plan 2	Pl	an 3	Plan 4
Employee Only					
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family	yra Parmanant Basidar				
Teleis to Siligapo	re Permanent Resider	ILS			
		# of emplo	yees (Foreigner	rs* only)	
	Plan 1	Plan 2		an 3	Plan 4
Employee Only	i idii 1	Tidii Z	1.1	an 5	TIGHT
Employee &					
Spouse					
Employee &					
Child(ren)					
Employee &					
Family					
	gners holding Employi	ment Pass, S Pass	and Work Permi	t, working in S	Singapore
d. Claims ex	xperience for the	past 3 years			
Period of	# of Insured as	Paid (Claims	Outsta	nding Claims
coverage	at	# of Claims	Amount (S\$)	# of Claims	Amount (S\$)
From/To	(dd/mm/yyyy)				
(dd/mm/yyyy)					
Note: The insurer r	reserves the right to re	equest for more i	nformation.		





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

Benefit: G	Benefit: Group Outpatient Insurance									
	ory of employee				e tick a	ıs ap	propr	iate)		
Category of E	mployees	Clinica	l GP	Specia	alist		iag X- ests	Ray/Lab	Denta	al
(i)										
(ii)										
(iii)										
	vhere applicable)									
# of headcou										
	e profile of empl	oyees								
Age band (A	ge next birthday)				# of e	empl	oyees			
				Male				Fen	nale	
	16-30									
	31-35									
	36-40									
	11-45									
	16-50									
	51-55									
	56-60 51-65									
	56-70									
	Total									
	ims experience f	or the	past 3	vears						
	-			,						
Pai	d Claims	1				1				
			inical	-	ialist*	ra	iagnost ay/lab t	ests*		ital*
Period of coverage	# of Insured as at	# of visits	Amt (S\$)	# of visits	Amt (S\$)	# of visit		nt (S\$)	# of visits	Amt (S\$)
From/T (dd/mm/yyyy)	o (dd/mm/yyyy)									
(44,11111,7,7,7)										
* inclusive of v	isits to non-panel cl	inics Not	e: The in	surer rese	erves the	right	to req	uest for r	nore info	rmation.
Outs	tanding Claims	•		1		-				
			nical	-	cialist*		ray/la	ostics X- b tests*		ntal*
Period of coverage From/To (dd/mm/yyyy)		# of visits	Amt (S\$)	# of visits	Amt (Ss		of visits	Amt (S\$)	# of visits	Amt (S\$)





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

c. Kindly attach a copy of the Schedule of Benefits, if the benefits are on insured basis. If currently 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 lin (S\$)	nit per policy	Co-payment (S\$)/Co-insurance (%)	
	Clinic on	Non-panel	Clinic on	Non-panel	Clinic on	Non-panel
	Company's	clinic	Company's	clinic	Company's	clinic
	panel		panel		panel	
Clinical GP						
Specialist						
Diagonistic						
X-Ray/Lab						
Tests						
Dental						
Others						

Benefit: Maternity Insurance							
a. Ba	a. Basis of coverage						
Category	of Employees (refer to the example)	# of headcount					
(i)							
(ii)							
(iii)							

Example 1

Example 2

(i) All Employees

- (i) Senior Management (Director, General
- Manager, Senior Manager)
 (ii) Manager & Executive
- (II) Mariager & Executi
- (iii) All Others

b. Claims experience for past 3 years							
Period of	# of Insured as	Paid C	Claims	Outstanding Claims			
coverageFrom/To (dd/mm/yyyy)	at (dd/mm/yyyy)	# of Claims	Amount (S\$)	# of Claims	Amount (S\$)		
At the Thirty							

Note: The insurer reserves the right to request for more information.

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 p (S\$)	er Policy Year	Deductible / Co-insurance (S\$)		
Normal Delivery					
Caesarian Delivery					

Now Health International (Singapore) Pte. Ltd.(No.201317502C)) is the appointed underwriting agent for Tenet Sompo Insurance Pte. Ltd. and is registered with the Agents' Registration Board of the General Insurance Association of Singapore (GIA). Registered at 16 Raffles Quay #33-03 Hong Leong Building Singapore 048581.





Others											
Needs analysis & product recommendation											
Please tick the appropriate box to indicate the priority of your company's needs:											
Company's Priorities		Low	Med	High	A	dvisor's recommendation					
Cover for Outpatient medical expenses											
Cover for Hospital & Surgical expenses											
Cover for Dental ex	penses										
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:											
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 Company and the Insurer.											
Signature of Authorised Officer:											
Name: NRIC/ Fin No. Designation: Date:				Company stamp (if applicable):							
I / We declare and acknowledge that I / we have reviewed this Group Insurance Fact-Finding Form with the authorised officer of the Company, and that I / we have explained all the requirements of this Fact-Finding form to him / her.											
Signature of Insurance Representative:											
Name: NRIC/ Fin No. Designation: Date:				Company stamp (if applicable):							