Liberty Pte Limited
One Raffles Quay #40-01 North Tower
Singapore 048583
Tel: 1800-LIBERTY (5423 789)
UEN | GST Reg. No. 201538069C
libertyinternational.com/sg

Proposal Form – proMediCare

Please complete all sections to facilitate the processing of your application.

Statement pursuant to Section 23(5) of the Insurance Act 1966 or any subsequent amendments thereof. You are to disclose in the proposal form fully and faithfully all facts which you know or ought to know, otherwise the Policy issued hereunder may be void.

Name of Producer & Producer Code: _____

Particulars of Proposer

☐ **Corporate**

Name of Proposer: _____	Contact No.: _____
Mailing Address: _____	Postal Code ( )
Email: _____	Nature of Business: _____

☐ **Individual**

Name of Proposer: _____	Occupation: _____
Name of Employer: _____	Nature of Employer's Business: _____

Particulars of Insured Person

Name of Insured Person: _____		NRIC/FIN No.: _____	
Mailing Address: _____		Postal Code ( )	
Email: _____		Contact No.: _____	
Nationality: _____	Country of Residence: _____	Gender: Please select	
Date of Birth: _____	Marital Status: Please select	Height (m): _____m	Weight (kg): _____kg

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Name of Proposer:	_____
Occupation: _____	

Particulars of Additional Insured Person(s) (Spouse/Children/Employee)

Name	Relationship	Date of Birth	NRIC/FIN No.	Country of Residence	Gender	Occupation	Weight (kg)/ Height (m)
					Please selec		
					Please selec		
					Please selec		
					Please selec		

Selection of Plan

Period of Insurance: From _____ To _____	Selection of Plan: Please select
Total Annual Premium excluding prevailing GST:	S$
plus prevailing GST:	S$
Total Annual Premium including prevailing GST:	S$ 0.00

Health Statement

1. Have you or any of your Additional Insured Person(s) ever had any physical defects or infirmity? If 'Yes', please provide details: _____	Please select
2. Have you or any of the Additional Insured Person(s) ever:	
a) had surgical operation?	Please select
b) been advised to have any diagnostic test, hospital confinement or surgical operation which has not yet been performed? If "Yes", please provide particulars in Question 5 below.	Please select
3. Are you or any of the Additional Insured Person(s) currently undergoing any medical treatment, ever been treated, under observation for, or told that you or they had, any disorder or disease of the following:	
a) Skin, ears, nose, throat, eyes, cataracts, glaucoma, detached retina, sinusitis, otitis media, hearing problems?	Please select
b) Stomach, intestines, liver, kidney, gallbladder, pancreas, bladder, prostrate, genio urinary system, cirrhosis, hernia, piles, diabetes, protein in urine or used drugs for any other reason?	Please select

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c) Lungs, bones, joints, ligament, asthma, bronchitis, pneumonia, tuberculosis, slipped disc, back trouble, fractures, arthritis, rheumatism, polio, muscular dystrophy?	Please select
d) Heart, brain, mental, psychiatric disorders, or nervous disorder, low or high blood pressure, stroke, fits, paralysis, migraine?	Please select
e) Lymphatic system, goiter, thyroid?	Please select
f) Any enlarge glands or any form of Cancer, tumors, AIDS or disorders of the blood?	Please select
g) Female reproductive system (for female insured), breast lumps, fibroids, cysts, menorrhagia?	Please select
h) Any other ailment, impairment, Bodily Injury, Accident, condition(s) or medical investigations not mentioned above? If your answer to any of the above is "Yes", please provide particulars in Question 5.	Please select
4. Have you or any of your Additional Insured Person(s) during the past 5 years, had any treatments, examinations or advices for a complaint by a Physician or other Medical Practitioners, at a clinic, hospital, dispensary, or sanitorium? If your answer to any of the above is "Yes", please provide particulars in Question 5.	Please select

5. State full particulars of any affirmative answers to Questions 2, 3 and 4.

Question No.	Name of Person(s)	Nature of Illness/ Disability	Date of Illness/ Disability	Duration of Illness/ Disability	Results of Treatment	Name & Address of Doctors and/or Hospital

6. Do you have any other medical insurance? If 'Yes', please provide details:	Please select

Name of Insurer(s)	Period of Insurance	
	From	To
	From	To
	From	To

7. Has any Accident or Health policy covering you or any of the Additional Insured Person(s) ever been declined or its renewal refused? If 'Yes', please provide details:	Please select

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Name of Proposer: _____				
Name of Insurer(s)	Period of Insurance		Renewal Declined	Refused due to
	From	To		
	From	To		
	From	To		
8. Has any application made by you or any of the Additional Insured Person(s) for Life, Accident and Health insurance been declined, postponed, withdrawn or subject to special terms and conditions? If 'Yes', please provide details:				Please select
Name of Insurer(s)	Period of Insurance		Application declined/ postponed/ withdrawn due to	Application subject to following special terms/conditions
	From	To		
	From	To		
	From	To		
9. Have you ever made a claim against any insurer in respect of Bodily Injury or sickness during the last 3 years? If 'Yes', please provide details:				Please select
Name of Insurer(s)	Date of Claim	Nature of Claim		Claim Amount (S$)
				S$
				S$
				S$

Name of Doctor(s)

Family Doctor	Last Doctor Consulted	Company's Doctor
Name of Clinic: _____	Name of Clinic: _____	Name of Clinic: _____
Name of Doctor: _____	Name of Doctor: _____	Name of Doctor: _____

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Name of Proposer: _____

Mode of Payment (Mastercard/Visa/Amex/UOB IPP/DBS IPP)

Total annual premium including prevailing GST: S$ 0.00

☐ Credit Card

1. The Proposer will receive a payment link from the Producer/Liberty via email. Please ensure the Proposer's email address is provided in this Proposal Form.
2. Upon clicking on the link, the Proposer will be directed to our authorized third-party payment gateway, 2C2P, for secure credit card payment.
3. The Policy will be issued upon successful payment of premium.
4. For information regarding other payment methods, please refer to https://www.libertyinternational.com/sg/footer/finance

PAYMENT BEFORE COVER WARRANTY (INDIVIDUAL)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) on or before the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and no benefits whatsoever shall be payable by the Company.

PREMIUM PAYMENT WARRANTY (CORPORATE)

Please note that the total premium must be paid and actually received in full by the Company (or the intermediary through whom this Policy was effected) within 60 days of the inception date of the coverage, failing which the Policy shall be deemed to be automatically cancelled and a pro-rata premium is to be charged for the period that the Company is on risk.

DECLARATION

I, the Proposer, declare and warrant that:

a) All information provided by me/us in connection with this application are true, accurate and complete
b) I agree that this application and declaration shall be the basis of the contract between Liberty and myself
c) I agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto
d) If I do not fully and faithfully give the facts as I know them or ought to know them, I may receive nothing from the policy
e) I agree to the policy terms, exclusions and conditions as expressed in the brochure, proposal form, policy wordings and endorsements
f) By signing this form, I/we consent to Liberty Pte Limited ("Liberty") and its authorised service providers, related entities, and partners (collectively, "Appointees") collecting, using, and disclosing my/our personal data, and any personal data of other individuals provided by me/us, for purposes including: assessing and providing insurance products and services; policy administration, renewals, claims, and payments; compliance, audit, and regulatory reporting; research, analytics, and service improvement; and communication and customer support. I/we confirm that I/we have read and agree to Liberty's Privacy Policy, which explains how Liberty manages personal data, including cross-border transfers. If I/we provide personal data of other individuals, I/we warrant that I/we have obtained their consent (or consent from their legal representatives, where applicable) for these purposes. I/we understand that I/we may access, correct, or withdraw consent for my/our personal data at any time by contacting Liberty's Data Protection Officer at privacy.officer.ap@libertymutual.com, subject to legal and contractual obligations

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Name of Proposer: _____

IMPORTANT NOTICE TO SUBMITTER

If you, the submitter of this form, are submitting this form for another person who is the actual Proposer; and in consideration for Liberty processing this application upon your request:

a) You agree that you have been validly & legally authorised by the Proposer to do so; and
b) You warrant that you have shown this entire completed document to the intended Proposer and had obtained his/her agreement to everything; and
c) You, in your personal capacity, agree to indemnify and keep Liberty Pte Limited indemnified against all proceedings, costs, expenses, claims, liabilities, losses or damages if any part of this Notice turns out to be false, howsoever whatsoever, on a strict liability basis, that is, even if your state of mind was unintentional, intentional, negligent, inadvertent, accidental, unknowing, etc

_____ _____

Date Signatory of Proposer

This policy is protected under the Policy Owners' Protection Scheme which is administered by the Singapore Deposit Insurance Corporation (SDIC). Coverage for your policy is automatic and no further action is required from you. For more information on the types of benefits that are covered under the scheme as well as the limits of coverage, where applicable, please contact us (sgservicecenter@libertymutual.com) or visit the GIA/LIA or SDIC websites (www.gia.org.sg or www.lia.org.sg or www.sdic.org.sg).

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Name of Proposer: _____

Declaration for Product Summary – proMediCare

Please complete all sections to faciliate the processing of your application.

A duly signed copy must be filed with Liberty Pte Limited for record purpose.

Presented to: Name of Proposer: _____	Expiry Date of Cover: _____

I/We, the Proposer, acknowledge that the Insurance Adviser has given me/us a copy of the "Product Summary" and "Your Guide to Health Insurance" and the contents of which have been explained to my/our satisfaction.

Name of Insured Person(s)	Gender	Age Next Birthday	Selected Plan
	Please select		Please select
	Please select		Please select
	Please select		Please select
	Please select		Please select
	Please select		Please select
	Please select		Please select
	Please select		Please select
	Please select		Please select

_____
Date

_____
Signatory of Insured Person
(for and on behalf of all persons to be insured)

_____
Date

_____
Name and Signatory of Proposer or Company's Authorized Person and Company Stamp (for corporate proposer)

_____
Date

_____
Name and Signatory of Insurance Adviser