GROUP INSURANCE FACT-FINDING FORM

KINDLY COMPLETE FULLY IN BLOCK LETTER AND INK
(Tick boxes [√] where appropriate)

PERIOD OF INSURANCE from: ____________________________ to ________________________________
(dd/mm/yyyy) (dd/mm/yyyy)

REQUEST FOR QUOTATION was submitted on ____
(dd/mm/yyyy)

REQUEST FROM: ____
(Name of Insurance Company)

GENERAL INFORMATION

Name of PEI: ____

Nature of Business: Private Education Institution (PEI)

Presently insured? **Yes / No**

If **Yes**, name of current insurer: ____

Type of Policy: ____

Period of Insurance: From: ______________________________ To __________________________________
(dd/mm/yyyy) (dd/mm/yyyy)

Total No. of Students: _____________________ No. of Students 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**
Personal Accident	**1**	Group Personal Accident (GPA)			
Medical	**2**	Group Hospital & Surgical (GHS)	All Students (incl Local/Non-STP Students)		
			International Students Only		
		Group Major Medical (GMM)	All Students (incl Local / Non-STP Students)	N.A.	
			International Students Only	N.A.	
Others	**3**	Group Outpatient	All Students (incl Local/Non-STP Students)		
			International Students Only		
		Dental	All Students (incl Local/Non-STP Students)	N.A.	
			International Students Only)	N.A.	
	4	Maternity	Employee only	N.A.	
			Dependant (Spouse)	N.A.	

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

1 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	# 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.			

2 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	# 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.			

3 Is there any member based outside Singapore? **Yes / No**

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

S/N	# 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.			

4 Are there any limitations or exclusions imposed on the coverage on any members? **Yes / No**

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

S/N	# 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.			

5 Is there any member engaged in hazardous occupation? **Yes / No**
(Hazardous occupation eg. welder, diver, sandblaster, offshore workers etc.)

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

S/N	# 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.			

6 To the best of your knowledge, is there any member engaged in hazardous sports? **Yes / No**
(Hazardous sports eg. scuba diving, motor racing, bungee jumping etc.)

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

S/N	# 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.			

1 BENEFIT: GROUP PERSONAL ACCIDENT

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 Members (refer to the examples)	Basis of Coverage - Sum Insured (refer to the examples)	# of Students
GPA	(i)			
	(ii)			
	(iii)			
	(iv)			

Example 1

Category of Members / 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 Students	**Basis of Coverage**
(i) All Students/ International Students Only	Per Quotation*

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

b) Claims Experience for the past 3 years

Paid Claims

Period of Coverage From / To _________ (mm/dd/yyyy)	# of Insured as at _______ (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S$)

Outstanding Claims

Period of Coverage From / To _________ (mm/dd/yyyy)	# of Insured as at _______ (dd/mm/yyyy)	GPA	
		# of Claims	Amount (S$)

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

2 BENEFIT: GROUP HOSPITAL & SURGICAL INSURANCE / MAJOR MEDICAL INSURANCE

a) Basis of Coverage

Category of Members		Room & Board Benefit Plan (S$)	Currently with TMIS Yes / No	Proposal with TMIS Yes / No
(i)				
(ii)				
(iii)				
(iv)				

Important Note:
(1) Please provide the Deductible /Co-insurance for respective member category or occupation, if applicable.

Example 1

Category of Member / 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)	# of Members	
	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 Members (Singaporeans & SPRs* & Non-STP*)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Students Only				
Employee & Spouse	N.A.			
Employee & Child(ren)	N.A.			
Employee & Family	N.A.			
** refers to Singapore Permanent Residents & non-Student Pass foreigners holding Employment Pass, S Pass, Dependent Pass etc*				

	# of Members (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Students Only				
Employee & Spouse	N.A.			
Employee & Child(ren)	N.A.			
Employee & Family	N.A.			
** refers to all foreigners holding ICA Student Pass*				

For GMM (if the basis of coverage differs from GHS):

	# of Members (Singaporeans & SPRs* & Non-STP)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only	N.A.			
Employee & Spouse	N.A.			
Employee & Child(ren)	N.A.			
Employee & Family	N.A.			
** refers to Singapore Permanent Residents & non-Student Pass foreigners holding Employment Pass, S Pass, Dependent Pass etc*				

	# of Members (Foreigners* only)			
	Plan 1	**Plan 2**	**Plan 3**	**Plan 4**
Employee Only	N.A.			
Employee & Spouse	N.A.			
Employee & Child(ren)	N.A.			
Employee & Family	N.A.			
** refers to all foreigners holding ICA Student Pass*				

d) Claims Experience for the past 3 years

Period of Coverage From / To _______ (dd/mm/yyyy)	**# of Insured as at _______ (dd/mm/yyyy)**	**Paid Claims**		**Outstanding Claims**	
		# of Claims	**Amount (S$)**	**# of Claims**	**Amount (S$)**
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).

3 BENEFIT: GROUP OUTPATIENT INSURANCE

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

Category of Members		Clinical GP	Specialist	Diag X-Ray/Lab Tests	Dental
(i)					
(ii)					
(iii)					
Dependant (where applicable)		N.A.			
# of Headcount					

b) Age Profile of Members

Age Band (Age Next Birthday)	# of Members	
	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 Tests*		Dental*	
Period of Coverage From / To ____________ (dd/mm/yyyy)	# of Insured as at ______________ (dd/mm/yyyy)	# of Visits	Amt (S$)	# of Visits	Amt (S$)	# 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.

Outstanding Claims

Period of Coverage From / To ___________ (dd/mm/yyyy)	# of Insured as at _____________ (dd/mm/yyyy)	Clinical*		Specialist *		Diagnostic X-Ray / Lab Tests*		Dental*	
		# of Visits	Amt (S$)	# of Visits	Amt (S$)	# 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.

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 Tests						
Dental						
Others						

4 BENEFIT: MATERNITY INSURANCE

a) Basis of Coverage

Category of Employees (refer to the example)		# 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 past 3 years

Period of Coverage From / To _______ (dd/mm/yyyy)	# of Insured as at _______ (dd/mm/yyyy)	Paid Claims		Outstanding Claims	
		# of Claims	Amount (S$)	# of Claims	Amount (S$)
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 per Policy Year (S$)		Deductible / Co-insurance (S$)	
Normal Delivery				
Caesarian Delivery				
Others:				

5 NEEDS ANALYSIS & PRODUCT RECOMMENDATION

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

Company's Priorities	**Low**	**Med**	**High**	**Advisor's Recommendation**
Cover for Outpatient medical expenses	☐	☐	☐	______________
Cover for Hospital & 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 : ____

6 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

Nam Evan Chng/Richard Tay
NRIC/ Fin No.
Designation: Director
Date:

AEGIS Insurance Services Pte Ltd
Agent Code : 04828

Company Stamp (if applicable):