Application Form

PallasHEALTH Individual Medical Plans

YOUR APPLICATION, STEP BY STEP.

This is your application form. Complete it, sign it, send it.

An underwriting offer will be provided in **3 working days or less**.

ONCE OUR OFFER HAS BEEN ACCEPTED, IN 5 WORKING DAYS, YOU WILL RECEIVE:

- Your full member's pack (by email)
  This includes relevant documentation such as claim forms, instructions, terms and conditions, and benefit schedules.
- You will be able to download your member card containing emergency contact numbers for requesting assistance services or before admission to hospital on our Easy Claim app.

1. YOUR DETAILS

IMPORTANT NOTICE

The answers you give to the questions contained in this Application will form the basis of any insurance policy issued, and will be incorporated into the contract. It is essential that you give accurate, truthful, and complete information for all persons to be insured, as inaccuracies may jeopardise coverage or invalidate a claim.

APPLICANT'S DETAILS

Family Name :

First Name(s) :

Date of Birth : DD / MM / YYYY   Gender : Male ◯ Female ◯

Height (cm) :   Weight (kg) :

Occupation :
(Specify nature of duties)

Smoker : Yes ◯ No ◯   Marital Status :

Nationality :   ID/Passport No. :

Residential Address :

Postal Code :   Country :

Usual Country of Residence :

If you wish to use a different mailing address please advise us

Tel. :   Mobile :

Email :

Important : this email will be used for sending your policy documents and claims-related communication which may include sensitive medical information.

FAMILY MEMBERS TO BE INSURED

	FAMILY MEMBER 1	FAMILY MEMBER 2	FAMILY MEMBER 3	FAMILY MEMBER 4
Family Name				
First Name(s)				
Date of Birth	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Gender	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯	Male ◯ Female ◯
Marital Status				
Relationship to Applicant				
Nationality				
Smoker	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯	Yes ◯ No ◯
ID/Passport No.				
Occupation (Specify nature of duties)				
Height & Weight	cm kg	cm kg	cm kg	cm kg

Please use separate sheet if necessary. Please advise us if any Family Members to be insured do not live at the Applicant's Residential Address.

2. YOUR COVER

STEP 1	CHOOSE YOUR AREA OF COVER				
	If dependants will have the same cover as the Applicant, please tick here ◯ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Area of Cover	◯ Worldwide ◯ Worldwide excluding North America and the Caribbean	◯ Worldwide ◯ Worldwide excluding North America and the Caribbean	◯ Worldwide ◯ Worldwide excluding North America and the Caribbean	◯ Worldwide ◯ Worldwide excluding North America and the Caribbean	◯ Worldwide ◯ Worldwide excluding North America and the Caribbean

STEP 2	CHOOSE YOUR ANNUAL DEDUCTIBLE The annual deductible does not apply to Maternity Benefit or Dental & Optical Benefits				
	If dependants will have the same cover as the Applicant, please tick here ◯ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Annual Deductible	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 5,000 ◯ USD 10,000	◯ Nil ◯ USD 500 ◯ USD 1,500 ◯ USD 5,000 ◯ USD 10,000

STEP 3	SELECT ANY COMBINATION OF MODULES				
	Module I - Core Module, Hospital and Surgery, including evacuation and repatriation Module II - Outpatient Benefits Module III - Maternity Benefits Module IV - Dental & Optical Benefits				
	If dependants will have the same cover as the Applicant, please tick here ◯ and complete cover options for the Applicant only.				
MODULES	**APPLICANT**	**FAMILY MEMBER 1**	**FAMILY MEMBER 2**	**FAMILY MEMBER 3**	**FAMILY MEMBER 4**
Combination of Modules	**Module I +** ◯ Module II ◯ Module III ◯ Module IV	**Module I +** ◯ Module II ◯ Module III ◯ Module IV	**Module I +** ◯ Module II ◯ Module III ◯ Module IV	**Module I +** ◯ Module II ◯ Module III ◯ Module IV	**Module I +** ◯ Module II ◯ Module III ◯ Module IV

3. UNDERWRITING QUESTIONNAIRE

INSURANCE DETAILS	
Have you or any person to be insured ever applied for, been covered under, or held a policy administered by APRIL? If Yes, please give details.	
	Yes ◯ No ◯
Do you or any person to be insured currently have health insurance with another company? If Yes, please give details and indicate if it will be continued (and if not, as of what date).	
	Yes ◯ No ◯
Have you or any person to be insured ever had a policy or application for life, sickness, accident disability, critical illness or medical insurance refused or cancelled, or had any special terms imposed? If Yes, please give details.	
	Yes ◯ No ◯

MEDICAL DETAILS AND HISTORY	Please indicate if you or any person to be insured have or have ever had any of the **signs, symptoms, illnesses or disorders** below by ticking the appropriate box.	
1	Cancer, leukemia, tumor or neoplasm, cysts, fibrocystic breast disorder, polyp or growths of any kind	Yes ◯ No ◯
2	Respiratory system: Asthma, bronchitis, allergies, rhinitis or sinusitis, tuberculosis, or other disorder of the respiratory system	Yes ◯ No ◯
3	Circulatory system and blood disorder: Chest pain, raised blood pressure, raised cholesterol, heart condition, or other disorder of the circulatory system or blood	Yes ◯ No ◯
4	Gastrointestinal system: Indigestion, gastric reflux, gastric ulcer, hemorrhoids, hernia, or other disorder of the gastrointestinal system	Yes ◯ No ◯
5	Musculoskeletal: Bone fracture, joint injury, arthritis, back, neck or muscle pain, or other disorder of the spine	Yes ◯ No ◯
6	Tropical illness: Malaria, dengue fever	Yes ◯ No ◯
7	HIV/AIDS	Yes ◯ No ◯
8	Urinary system: Kidney stones or other disorder of the urinary system or prostate	Yes ◯ No ◯
9	Liver: Diabetes, hepatitis, fatty liver, or other disorder of the liver	Yes ◯ No ◯
10	Thyroid: Hypothyroidism, Hashimoto's disease, or other disorder of the thyroid	Yes ◯ No ◯
11	Brain and nervous system: Stroke, aneurysm, seizures, chronic headache, migraine, or other disorder of the brain or nervous system	Yes ◯ No ◯
12	Anxiety, depression, stress, addiction, or other mental, behavioral, developmental disorder	Yes ◯ No ◯
13	Gynecological system: Pregnancy (including any complication), fibroid, endometriosis, irregular periods or bleeding, menstrual pain, HPV infection, or an abnormal smear test result, or other disorder of the gynecological system	Yes ◯ No ◯
14	Skin: Eczema, dermatitis, psoriasis, wart, or other disorder of skin	Yes ◯ No ◯
15	Eyes and ears: Cataract, glaucoma, otitis, hearing loss, or other disorder of eyes or ears	Yes ◯ No ◯
16	Congenital, hereditary conditions, birth defects, deformities, or conditions affecting mobility	Yes ◯ No ◯
17	Any other disorder/ injury	Yes ◯ No ◯

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

If you answered "Yes" to any of the above, please provide details in the table below. You may be required to provide a further medical questionnaire or medical reports, depending on the severity and nature of the condition declared.

Person to be insured			
Question No.			
Disease/ Medical Condition/ Sign & Symptom			
Date of first occurrence of sign & symptom	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Frequency of sign & symptom			
Treatment Details (including name, date, duration of medication, surgery etc.)			
Date of last follow-up medical consultation/ treatment	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Any on-going, regular, planned or preventive treatment required?			
Any on-going sign or symptom?			

MEDICAL DETAILS AND HISTORY - CONTINUED

18 **Except as disclosed elsewhere in this form, have you or any person to be insured ever been admitted to hospital as an inpatient, or undergone any procedures including endoscopy, biopsy whether as an inpatient or outpatient?**
If Yes, please give details.

Yes ◯ No ◯

19 **In the last five years, have you or any person to be insured been notified of any abnormal test results or awaiting results for any scans or tests performed (e.g. blood or urine test, ECG, endoscopy, X-ray, ultrasound, CT scan, MRI, PET scan etc.)?** Please also answer "yes" if there are any inconclusive or uncertain results (retesting or follow up test required) and abnormal findings that may not require treatment at present (e.g. cyst, joint degeneration, calcification, etc.)

Yes ◯ No ◯

20 **In the last five years, have you or any person to be insured currently taking or been prescribed any medications for a continuous period of more than one month?** If Yes, please state the medicine name, dosage and the approximate cost.

Yes ◯ No ◯

21 **Please enter the following details about the usual/family doctor for each person to be insured. If you do not have a usual/family doctor, please provide the names, addresses and contact information of medical providers you and your family members to be insured have seen in the last 3 years. Use a separate sheet if necessary.** If you have never seen a doctor in the past 3 years, please indicate that below.

Name			
Address			
Telephone		Fax	
Email			

Please provide more details on a separate sheet if required.

3. UNDERWRITING QUESTIONNAIRE - CONTINUED

ADDITIONAL SPACE FOR FURTHER REMARKS	You may use this space for any further comments about any medical conditions you have or have suffered from. Please remember to enclose any supporting documents with your application.

COMMENCEMENT DATE	
◯ On Acceptance	◯ Another Date : DD / MM / YYYY

We cannot backdate cover to a date earlier than the date you accept our final offer.

INTERMEDIARY ACCESS			
Would you like your insurance intermediary to have access to your policy details and claims transactions through their online account at healthbyapril.com/portal?			Yes ◯ No ◯
Do you authorise us to discuss and/or share claims and medical information with your insurance intermediary?			Yes ◯ No ◯
Intermediary Name		Intermediary Code	
Company Name		Telephone	
Email			

CLAIM REIMBURSEMENT	Please provide your banking details for claim reimbursement.		
Bank Name			
Bank Address			
A/C Name		A/C No.	
Currency	◯ SGD ◯ USD ◯ EUR ◯ GBP	For all other currencies, please check with APRIL Singapore. For international transfers to a foreign bank, note that your bank may charge you fees for each transaction which will be your responsibility to bear.	
The following information must be provided for bank accounts outside of Singapore:			
Sort Code		BIC (Swift) Code	
Corresponding Bank Details (if applicable)			

4. PAYMENT METHODS

PREMIUM PAYMENT

Please select the payment method in which you wish to pay your premiums.

	CREDIT CARD (Visa / Mastercard)	CHEQUE OR BANK DRAFT	BANK TRANSFER
Annual	◯	◯	◯

If you choose to pay your premiums by credit card, you will receive a payment link by email sent to the address you provided on this form.

CHEQUE OR BANK DRAFT

- Cheques should be drawn on a Singapore clearing bank and made payable to **"Liberty Insurance Pte Ltd"**. Kindly indicate **(1) Name of Applicant or policyholder; (2) Contact No.; (3) Name of Product; (4) Producer Code at the back of your cheque**

BANK TRANSFER

- Transfers can be made in USD or SGD.

- Relating to payment for SGD Singapore-related risks policies:

US Dollar (USD) Account

Beneficiary Name :	Liberty Insurance Pte Ltd
Beneficiary Address :	51 Club Street, Liberty House, #03-00, Singapore 069428
Bank Name :	UOB
Bank Code :	7375
Branch Code :	001
Account Number :	451-904-130-2
Swift Code :	UOVBSGSG
Bank Address :	80 Raffles Place, #29-03 UOB Plaza 1 Singapore 048624
Correspondent Bank:	The Bank of New York Mellon, New York
Swift Code :	IRVTUS3N
Currency :	USD

Singapore Dollar (SGD) Account

Beneficiary Name :	Liberty Insurance Pte Ltd.
Beneficiary Address :	51 Club Street, Liberty House, #03-00, Singapore 069428
Bank Name :	UOB
Bank Code :	7375
Branch Code :	001
Account Number :	451-304-455-5
Swift Code :	001
Bank Address :	80 Raffles Place, #29-03 UOB Plaza 1, Singapore 048624
Currency :	SGD

1. All bank charges will be borne by the remitter.
2. Please indicate your Policy Number and Debit Note number as a payment detail to your banker.
3. Please email pallas@april.com the bank remittance advice or instruction slip with your Policy Number, name and debit note number to us for our accounting records and to issue an Official Receipt.

5. ACKNOWLEDGEMENT & PERSONAL DATA PROTECTION ACT (PDPA)

PERSONAL DATA PROTECTION STATEMENT

I give consent to Liberty Insurance Pte Ltd and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to myself or other individuals that I have furnished via any means in the past, present & in the future, for one or more of the purposes described in Liberty's Data Protection Policy, including but not limited to considering whether to provide insurance, carrying out due diligence, pricing, administering and servicing policies, communications, renewals, reinsurance, collections, claims, accounting, audit, legal, compliance, research, analysis, information-sharing, surveys, data storage & backups. I have read and agreed to the full Policy at www.libertyinsurance.com.sg/data-protection-policy/. If there is any personal data relating not to myself but to other individuals that I have furnished via any means in the past, present & in the future, I warrant that I have obtained prior consent from these data subjects (or if they are lacking in legal capacity, from their legal representatives, guardians or parents as the case may be) for Liberty Insurance Pte Ltd and its Appointees to collect, use and disclose their personal data for the abovementioned purposes and on the same terms herewith. I warrant that all personal data I have provided are accurate and complete, and I shall inform Liberty of any changes to the personal data to my knowledge as soon as practicable.

DECLARATION BY APPLICANT

I/We do hereby declare and warrant that:

a. All information provided by me/us in connection with this application is true, accurate and complete. I/We have not withheld any material fact and except as declared herein all persons to be insured are currently in good health to the best of my/our knowledge and belief.

b. I/We understand that any inaccurate, incomplete or false information given or any omission of information required, may at Liberty Insurance Pte Ltd's ("Liberty", the "Company") discretion, render this application invalid.

c. I/We agree that this application and declaration shall be the basis of the contract between Liberty and myself.

d. I/We agree to accept the Company's policy subject to the terms, exclusions and conditions to be expressed therein, endorsed thereon or attached thereto. I understand that no insurance shall be in force until and unless the application has been accepted and the appropriate premium paid.

e. I/We agree to inform if there is any change in any of the details I have provided to Liberty in this application. I understand and agree that it is my sole responsibility to inform and update Liberty of any changes to the health or personal information of any person to be insured. I hereby agree to indemnify and absolve Liberty of any liability arising out of any use and/or disclosure by Liberty of any inaccurate or incomplete information due to my failure to update Liberty promptly of any changes to the health or personal information of any person to be insured.

SIGNATURE

Name : ______________________

Title : ______________________

Date : ______________________

Important : The application form must be sent to us **within 30 days** from this date for your application to be valid.

Underwritten by:

Liberty Insurance Pte Ltd
Registration No. 199002791D
GST Registration No. M2-0093571-3
51 Club Street #03-00 Liberty House
Singapore 069428
Tel: 1800-LIBERTY(5423 789)

Arranged by:

APRIL Singapore Pte Ltd
Co. Reg. No. 200613924G
2A McCallum Street
Singapore 069043
Tel: (+65) 6736 0057
Email: pallas@april.com

PH SG 2022/07

SUBMIT YOUR APPLICATION

SUBMIT ELECTRONICALLY

SUBMIT

Save this file and
send it to
asia.app@april.com

OR

PRINT, SIGN, EMAIL

PRINT

Send the scanned copy to
asia.app@april.com

Mail to
APRIL Singapore Pte Ltd
2A McCallum Street
Singapore 069043