

Group E-Care Application Form
(to be completed by policyholder)

Note:

Section 25(5) of the Insurance Act states that: You are to disclose in this application form, fully and faithfully all the facts which you know or ought to know, otherwise the Policy issued hereunder may be void.

A. Particulars of policyholder
1. Name of policyholder
2. Address
3. Nature of business
B. Particulars of insurance applied for
Commencement date of insurance: _____
C. Basis of insurance
The insurance applied for is <input type="checkbox"/> Non-contributory (Paid by employer only) <input type="checkbox"/> Contributory (Paid by employer and employee)
D. Eligibility requirements
Eligibility period
<input type="checkbox"/> After probation of _____ months
<input type="checkbox"/> Date of employment
<input type="checkbox"/> Others, please specify: _____
If a Member is not actively at work on the day he is otherwise eligible in accordance with the above requirements, his eligibility date shall then be deferred to the first day immediately following the date of his complete recovery from sickness or return to active full-time work, whichever is later.
E. Your Choice of Benefits (Please tick where applicable)
<input type="checkbox"/> [GTL] Group Term Life Benefit
<input type="checkbox"/> [GCI] Group Critical Illness Benefit (additional/acceleration)*
<input type="checkbox"/> [GPA] Group Personal Accident Benefit
<input type="checkbox"/> [GHS] Group Hospital & Surgical Benefit
<input type="checkbox"/> [EMM] Group Extended Major Medical Benefit
<input type="checkbox"/> [GCB] Group CliniCare Benefit
<input type="checkbox"/> [OPSC/XL] Group Outpatient Specialist Benefit
<input type="checkbox"/> [DEN] Group Dental Benefit

F. Group Term Life Benefit		
<u>Plan</u>	<u>Sum Insured</u>	<u>Plan classification (category of employees / occupation)</u>
1	\$300,000	_____
2	\$200,000	_____
3	\$150,000	_____
4	\$100,000	_____
5	\$ 50,000	_____

G. Group Critical Illness Benefit (additional/acceleration)*		
<u>Plan</u>	<u>Sum Insured</u>	<u>Plan classification (category of employees / occupation)</u>
1	\$150,000	_____
2	\$100,000	_____
3	\$ 75,000	_____
4	\$ 50,000	_____
5	\$ 25,000	_____

H. Group Personal Accident Benefit		
<u>Plan</u>	<u>Sum Insured</u>	<u>Plan classification (category of employees / occupation)</u>
1	\$300,000	_____
2	\$200,000	_____
3	\$150,000	_____
4	\$100,000	_____
5	\$ 50,000	_____

I. Group Hospital & Surgical Benefit		
<u>(Restructured/Government Hospital)</u>		
<u>Plan</u>	<u>Room & board</u>	<u>Plan classification (category of employees / occupation)</u>
1	<u>Single Bed</u>	_____
2	<u>Four Bed</u>	_____
<u>(Private Hospital)</u>		
<u>Plan</u>	<u>Room & board</u>	<u>Plan classification (category of employees / occupation)</u>
3	<u>Single Bed</u>	_____
4	<u>Double Bed</u>	_____
5	<u>Four Bed</u>	_____

J. Group Extended Major Medical BenefitRestructured/Government Hospital)

<u>Plan</u>	<u>Room & board</u>	<u>Plan classification (category of employees / occupation)</u>
1	<u>Single Bed</u>	_____
2	<u>Four Bed</u>	_____

(Private Hospital)

<u>Plan</u>	<u>Room & board</u>	<u>Plan classification (category of employees / occupation)</u>
3	<u>Single Bed</u>	_____
4	<u>Double Bed</u>	_____
5	<u>Four Bed</u>	_____

K. Group CliniCare Benefit

<u>Plan</u>	<u>Plan Limits</u>	<u>Plan classification (category of employees / occupation)</u>
1	Non-panel \$25	_____
2	Non-panel \$40	_____

L. Group Outpatient Specialist Benefit

<u>Plan</u>	<u>Plan Limits</u>	<u>Plan classification (category of employees / occupation)</u>
1	\$1,000	_____
2	\$ 800	_____
3	\$ 500	_____

M. Group Dental Benefit

<u>Plan</u>	<u>Plan classification (category of employees / occupation)</u>
1	_____

N. Existing insurance programs

1. Is your company currently insured with another insurance company on the above insurance programs? Yes / No

If yes, please furnish the following information:

The insurance company: _____

Commencement date of insurance: _____

2. Is there any member seriously ill or in hospital? Yes / No

If Yes, kindly provide the following details

Number of member(s): _____

Reason for hospitalisation / Nature of illness:

On behalf of the policyholder stated in this application, I / we hereby apply for group insurance policy to provide insurance coverage to the members of the policyholder under the terms and benefits as herein stated and those stated in the policy.

I / we agree that if a contract is effected, all information submitted in connection with this application shall form the basis of such contract between the policyholder and HSBC Insurance (Singapore) Pte. Limited.

Authorised signature / date

Name / title / NRIC or Passport number

Company stamp

Name of broking firm : _____

Name of agent / broker : _____

Company Stamp : _____
(if applicable)

You are advised to read the Product Summary. The Product Summary contains a summary of the product information and key terms and conditions. In the event that you do not receive a copy, you may request for a copy directly from Your Financial Services Consultant or HSBC Insurance (Singapore) Pte. Limited.

HSBC Insurance (Singapore) Pte. Limited.

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