SAFETYNET
HEALTH INSURANCE SPECIALIST

PRIVATE HEALTH PROTECT

APPLICATION FORM (A) ☐

MEMBER ADDITION (A) ☐

Forte

MEDICAL QUESTIONNAIRE FOR PRIVATE HEALTH PROTECT PLANS ONLY

	Member #1 (CHIEF)	Member #2	Member #3	Member #4	Member #5	Member #6	Member #7
1. Has any of the member ever suffered and/or been diagnosed with? (question refers to A, B, C, D below)	Tick the right answer: Y for Yes and N for No						
A. Any form of cancer, carcinoma, leukemia?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
B. Coronary disease, heart disease, stroke, diabetes?	Y N	Y N	Y N	Y N	Y N	Y N	Y N
C. Sclerosis, SLE (Lupus), chronic obstructive pulmonary disease (COPD) or brain tumor	Y N	Y N	Y N	Y N	Y N	Y N	Y N
D. Major organ failure or disease (Heart, Lung, Kidney, Liver, Pancreas)	Y N	Y N	Y N	Y N	Y N	Y N	Y N
2. Has any of the member been treated or advised to undergo organ transplant (Bone Marrow, Heart, Lung, Kidney, Liver)?	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Please note that a Yes answer (Y) above will lead to rejection of application for the concerned member.
If there are more than 7 members in the application, please attach an additional form.

INSURANCE TRANSFER ONLY

1. Have you been continuously insured for at least 3 years (no break-in-cover in 3 years) under one similar international Health Insurance plan (proof of reference required)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
2. Do you certify there is not any time gap of coverage between the previous Health Insurance plan and Us?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
3. Do you certify you do not have any PLANNED or PENDING surgery or Hospitalization at this time of -transfer of insurance-?	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Please clarify the exclusion of your current Health Insurance plan (Previous certificates of insurance required)														

Please note that a "No" answer (N) above will lead to rejection of INSURANCE TRANSFER application for the concerned member.

POLICYHOLDER OR CHIEF OF COMMUNITY PARTICULARS

FULL NAME:

FEMALE / MALE | NATIONALITY: | IDENTIFICATION TYPE:

SINGLE / MARRIED / WIDOW | DATE OF BIRTH: | IDENTIFICATION NO.:

PERMANENT ADDRESS:
(Please provide full address)

TELEPHONE NO.: | MOBILE NO.:

EMAIL:

OCCUPATION: | HEIGHT (CM): | WEIGHT (KG):

Please provide details of the doctor you most frequently used, if any:

NAME OF CLINIC / HOSPITAL:

NAME AND OFFICE ADDRESS OF THE DOCTOR:

Please provide details of other personal or group health insurance policies you have subscribed, if any:

NAME OF INSURER AND POLICY:

DESCRIBE COVER PLAN:

POLICYHOLDER OR CHIEF OF COMMUNITY PARTICULARS (MEMBER ADDITION ONLY)

POLICY NO.:

FULL NAME:

TOTAL OF NEW MEMBERS: | COMMENCEMENT DATE:
(DD/MM/YY)

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KEY PRODUCT FEATURES

COVERS:

- This product is primarily designed to cover hospital and surgical treatment.
- The plans under the label "Personal Accident Protect" cover only treatment arising from accident.
- The plans under the label "Private Health Protect" cover treatment arising from illness and accident.

DOES NOT COVER:

- This product does not cover out-patient primary care whether given by a Specialist or a General Practitioner.
- This product does not cover routine dental care.
- This product does not cover preventative treatment including health check-ups.
- This product does not cover medical conditions which were existing, Pre-Existing Conditions, before the policy commencement date. This exclusion is waived after three consecutive years of cover.

OTHER:

- This product is annually renewable. Premiums are not guaranteed and are likely to change with attained age every year.
- This product requires the insured to bear a co-payment for all treatment claimed, subject to a maximum out of pocket in the hospital network, as shown in the benefit table.
- A list of medical conditions are excluded during the first twenty four (24 months) months of cover. Refer to policy wording.
- You can upgrade your level of cover, but only at policy anniversary. Upgrade is subject to satisfactory individual health declaration.
- A list of severe conditions are covered only partially if diagnosed during the first six 6 months from the policy commencement date.
- All definitions, terms and conditions are included in the policy wording.

CHOOSE YOUR PLAN

PERSONAL ACCIDENT PROTECT

☐ Basic ☐ Standard ☐ Deluxe ☐ Premium

PRIVATE HEALTH PROTECT

☐ Basic ☐ Standard ☐ Standard+ ☐ Deluxe ☐ Premium

CHOOSE YOUR PAYMENT OPTION

☐ **One time Off**

☐ **3 Instalments**
First instalment (35%) is due on commencement date.
Second instalment (35%) is due after 3 months.
Third instalment (30%) is due after 6 months. 2% additional premium apply.

WHEN TO START

TOTAL NO. OF MEMBERS INCLUDED IN THIS APPLICATION ☐

EXPECTED COMMENCEMENT DATE DD/MM/YY

ACKNOWLEDGMENT

I/WE DECLARE:
I/WE AGREE:

- That the answers provided in this Form A and in the accompanying Form(s) B are complete and true at the time of application.
- That the information provided shall form the basis of the contract of insurance (Policy).
- To authorize any physicians, hospitals, or any person(s) who attended to us, examined us, or is authorized to maintain a medical record, to disclose any information with regards to any illness, injury or treatment to FORTE or FORTE'S partner managing claim on FORTE'S behalf, for the purpose of a claim enquiry.
- There won't be any refund of premium if any claim is made on our policy.

I/WE UNDERSTAND:

- That this policy cannot cover a child below 6 years old on standalone basis.
- That this policy shall only be effective subject to approval by FORTE and payment of any premium due.
- That no liability will be accepted until full payment is received by FORTE.
- That the policy may be terminated if FORTE discovers that this application contains any false information.

Signature of the Policyholder or Chief of Community (for and on behalf of all the members of the community)	**Date:**

Agent/ Intermediate/ Broker

I hereby certify that I have duly explained to the -Policyholder or Chief of Community-: the Key Benefits, Terms and Conditions and Major Exclusions of this product.

Full name:	Signature of the Agent/ Intermediate/ Broker	Date:

SAFETYNET
HEALTH INSURANCE SPECIALIST

PRIVATE HEALTH PROTECT

APPLICATION FORM (B) ☐

MEMBER ADDITION (B) ☐

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INFORMATION OF MEMBER #2

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

INFORMATION OF MEMBER #3

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

INFORMATION OF MEMBER #4

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

INFORMATION OF MEMBER #5

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

INFORMATION OF MEMBER #6

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

INFORMATION OF MEMBER #7

MEMBER NO.:	RELATIONSHIP TO CHIEF OF COMMUNITY:	
FULL NAME:		
FEMALE / MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE / MARRIED / WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	