SAFETYNET
HEALTH INSURANCE SPECIALIST

FAMILY HEALTH PROTECT
APPLICATION FORM (A)
INITIAL ☐ ADDITION ☐

Forte

KEY PRODUCT FEATURES

COVERS:
- This product is primarily designed to cover hospital and surgical treatment
- Cover up to some limits Out-patient treatment, Vaccination and Health Check-up

DOES NOT COVER:
- This product does not cover routine dental and vision care

OTHER:
- Annual Maximum Coverage benefits is progressive for the first 2 years
- This product requires the insured to bear a co-payment as shown in the Benefits Table
- We can upgrade or downgrade our coverage but only at policy anniversary and upgrade is subject to rules detailed in the Member's booklet
- All terms and conditions are included in the Member's booklet

CHIEF OF COMMUNITY PARTICULARS

FAMILY NAME:		FIRST 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 (KGS):

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 (ADDITION ONLY)

POLICY NO.:	
FAMILY NAME:	FIRST NAME:
TOTAL OF MEMBERS ADDITION:	COMMENCEMENT DATE: (DD/MM/YY)

CHOOSE YOUR PLAN

H&S including Essential OP	OPTIONAL OP PLUS
☐ Silk ☐ Jade ☐ Bronze ☐ Silver ☐ Gold ☐ Diamond ☐ Lotus	☐ YES ☐ NO

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): ☐

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HEALTH INSURANCE SPECIALIST

FAMILY HEALTH PROTECT

APPLICATION FORM (A)

INITIAL ☐ ADDITION ☐

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ACKNOWLEDGMENT

For and on behalf of all members included in this application:

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 and upon commencement of the policy.
- That none of the members in this application (Form A or B) is currently hospitalized.
- That the information provided shall form the basis of the contract of insurance (Policy).
- To authorize any physicians, hospital 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 claims on FORTE's behalf, for the purpose of a claim enquiry.
- Once you have passed the 15 days free look period, a minimum 6 months premium will be due if you choose to terminate any member or the whole policy before its expiry date, even if there is no claim.
- There won't be any refund of premium if any claim is made on our policy.

I/WE UNDERSTAND:

- That this policy shall only be effective following full annual premium payment and is subject to approval by FORTE.
- That in the event of a claim enquiry, FORTE or any authorized partners reserve the right to request for a copy of my/our latest medical report(s) at my/our own expense should further medical information be required.
- That members of my community can include and is limited to Spouse, Child, Great Child, Sibling, Parent, Parent-in-law, Sister-in-law, Brother-in-law, Grand-parent, Grand-parent-in-law, Niece, Nephew, Cousin, Uncle, Aunt, Great Uncle, Great Aunt or Others (Subject to approval).
- That no liability will be accepted until full payment is received and policy is accepted by FORTE.
- That any change of information should immediately be reported when available. Failure to do so may result in withdrawal of claims and/or benefits.

Signature of Chief of Community (for and on behalf of all 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:

- INTENTIONALLY LEFT BLANK. -

SAFETYNET
HEALTH INSURANCE SPECIALIST

FAMILY HEALTH PROTECT

MEMBERS LIST (B)

INITIAL ☐ ADDITION ☐

Forte

MEMBER'S INFORMATION

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FAMILY NAME:	FIRST NAME:	
FEMALE/MALE	NATIONALITY:	IDENTIFICATION TYPE:
SINGLE/MARRIED/WIDOW	DATE OF BIRTH:	IDENTIFICATION NO.:
MOBILE NO.:	EMAIL:	

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