Archipelago SYNERGY Plan
Group Employees/Members Declaration

Medical History Disregarded (MHD)
3 to 30 employees/members

Please complete this declaration clearly in BLOCK CAPITALS and tick the boxes where needed.

You must tell us about all material facts before we accept an application or renew the plan. A material fact is information likely to influence us in assessing and accepting the insurance. If you do not tell us all material facts or if you misrepresent any material facts, this may render the insurance voidable from inception (the start of the contract) and enable us to repudiate liability (entitle us not to pay your claims). If there is any doubt about whether a fact is material, for your own protection, you must tell us.

SECTION A GROUP PLANHOLDER DETAILS

Company registered full name :

SECTION B YOUR PERSONAL DETAILS

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

☐ Non-manual, administrative or clerical work
☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
☐ Involve occasional or regular manual work or use of manual tools
☐ Involves in the use of power tools
☐ Involves in operating heavy equipment
☐ Off-shore related work or air crew or ship crew
☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Mobile : Phone :

Email address :

SECTION C DEPENDANTS TO BE COVERED

You do not need to fill in the height and weight sections for dependants aged 17 years or younger.

Dependant 1

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

- ☐ Non-manual, administrative or clerical work
- ☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
- ☐ Involve occasional or regular manual work or use of manual tools
- ☐ Involves in the use of power tools
- ☐ Involves in operating heavy equipment
- ☐ Off-shore related work or air crew or ship crew
- ☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

Dependant 2

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Occupation : Gender : ☐ M ☐ F

Company name :

Job description :

Please also tick the relevant box below :

- ☐ Non-manual, administrative or clerical work
- ☐ Work of a supervisory nature or work which involves frequent travelling but not involve in manual work
- ☐ Involve occasional or regular manual work or use of manual tools
- ☐ Involves in the use of power tools
- ☐ Involves in operating heavy equipment
- ☐ Off-shore related work or air crew or ship crew
- ☐ Member of the armed forces or uniformed personnel

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

Dependant 3

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Others, please specify :

Family name (surname) : First name(s) :

Current residential address :

Postcode : Country :

NRIC / Passport No : Date of Birth (dd/mm/yyyy) :

Nationality on passport : Home country :

Gender : ☐ M ☐ F

Height : (cm) or (inches) Weight : (kg) or (pounds)

Relationship to you :

If you have any more dependants to be covered, please give us details on a separate sheet of page 2 of this declaration and send it to us with the other declaration forms.

SECTION D MEDICAL QUESTIONNAIRE

1.	Have you or any of your dependants ever had a past history of cancer (including benign brain tumours), a heart condition or stroke, joint replacement, psychiatric or mental illness?	☐ Yes	☐ No
2.	In the last 12 months, have you or any of your dependants had any signs or symptoms that may require a visit to a medical professional or are you or any of your dependants awaiting any reviews, treatment or investigation for any current or past medical problems?	☐ Yes	☐ No
3.	Do you or any of your dependants have any long-term, ongoing or chronic condition for which you have regular appointments or need a review or treatment for?	☐ Yes	☐ No
4.	If the plan includes maternity cover, are you or any of your dependants currently pregnant?	☐ Yes	☐ No
5.	In the last 2 years, have you or any of your dependants on this application had any other problems or concerns about their health which are not dealt with in questions 1-4 above?	☐ Yes	☐ No

If you answer yes to any of the above questions, please provide details in Section E Medical details.

SECTION E MEDICAL DETAILS

Name of applicant			
Question number			
Symptom(s) and/or medical condition or symptom and when did it start? (dd/mm/yyyy)			
What treatment, medication or special diet have you been given? Please specify names of drugs and dosage required.			
What follow-up consultations, medical investigations, diagnostic tests or procedures are needed or have been recommended?			
Do you still have this medical condition or symptom?			
What date did you last see any health care professional for this medical condition or symptom? (dd/mm/yyyy)			

SECTION F DATA PROTECTION

We are committed to protecting your personal data and privacy. Any personal information that we collect from you will be kept confidential and will be processed in accordance with the Personal Data Protection Act 2010.

We will use any personal data to process your claims, administer your plan, service our relationship with you, provide you with products and services and evaluate their effectiveness, provide you with better customer services and for statistical analysis.

We may also, in carrying out your instructions, processing and administering claims, transfer your personal data to other Archipelago Insurance Limited entities and its associates for the purposes of performance of the contract. Such personal data shall be governed by the personal data protection laws of that country. The Group Planholder is responsible for ensuring that all data provided to the Insurer is accurate at all times and is obliged to inform the Insurer of any changes.

Your information may also be used for fraud prevention and audit purposes. If you give us false or inaccurate information and we suspect fraud, we will record this. We may pass such information to law enforcement or other legal agencies, governmental or judicial bodies, or to regulators.

Your medical information will only be disclosed to those involved with your treatment or care, including your medical practitioner, or their agents. If you ask us to, we will also send your medical information to any person or organization that may be responsible for meeting your treatment expenses, or their agents. Your information may be discussed with your Group Planholder’s agent or broker if the Group Planholder have requested the broker for assistance in handling your claims and you have authorised us to provide them with such medical information.

If you want us to disclose your medical information to another individual or next of kin, you must tell us in writing. In exceptional emergency situations and in accordance with medical confidentiality guidelines and relevant law, we may be required to disclose such information to relatives, family members or other third parties.

To help us ensure that your personal information remains accurate and up to date, please inform us of any changes. All policy documents will be sent to the Group Planholder.

We may, from time to time, provide you with marketing information about Archipelago Insurance Limited, our products and services and those of any associated companies which may be of interest to you. If you do not want us to use your details in this way, please tick the box. ☐

SECTION G DECLARATION

I have read, understood and agree to keep to the terms and conditions shown in the Policy Wordings, along with all eligible dependants included in this declaration or any dependants I enroll in the future after the start date of the plan. I confirm that I have authority to give Archipelago Insurance Limited information about my dependants referred to in this declaration and where necessary that I have checked with them that the information I have provided is correct. I confirm that to the best of my knowledge, the information I have provided on this declaration is complete and accurate and that it contains all the information required.

I consent to any personal data, including medical information, that you may collect about me and my dependants, being processed by Archipelago Insurance Limited.

I read, understand and agree that should I or one of my dependants attend a hospital/clinic/medical facility where direct billing or cashless arrangements are in place and the claim is subsequently found to be ineligible, Archipelago Insurance Limited has the right to recover the full amount of the ineligible claim from myself, the dependant/s or the Group Planholder.

I declare that the information I have provided in this declaration is correct in all respects.

I have read carefully, agreed and understood the terms and conditions shown in the Policy Wordings.

Signature:

Name of signatory:

Date (dd/mm/yyyy):

Archipelago Insurance Limited does not provide care or guarantee access to health services. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a health care professional. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Information is believed to be accurate as of the production date; however, it is subject to change. For more information, refer to **www.archipelagogrp.com**.

If coverage provided by any insurance policy violates or will violate any UN or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Archipelago Insurance Limited cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the UN or other applicable economic or trade sanctions, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

All plans are underwritten by Archipelago Insurance Limited.

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