

Pre-contract disclosure for medical insurance plans for Work Permit and S Pass Holders

PRODUCT NAME: GROUP MEDIWELL CLASSIC INSURANCE

This product provides coverage for the following features that comply with the Ministry of Manpower’s (MOM) enhanced Medical Insurance requirements¹:

| | Yes/No |
|--|--------|
| Annual claim limit of at least \$60,000, inclusive of a first-dollar cover of \$15,000 | Yes |
| For portion of the bill above \$15,000, the employer must co-pay up to 25% (to the hospital) | Yes |
| Exclusions are in line with MOM’s list of allowable exclusions ² | Yes |
| Age-differentiated premiums are in 2 age bands: (1) ≤50 years old and (2) >50 years old | Yes |
| Insurers will reimburse our portion of the hospital bill to hospitals directly upon admissibility of the medical claim | No |



¹ Scan the QR code for MOM’s press release on the enhanced medical insurance.

² Refer to link below for the list of allowable exclusions.

4. Coverage Required Plan 1 (Co-Payment) Plan 2 (No Co- Payment)

| S/N | Name of Employee to Be Insured | Work Permit / S Pass No. | Gender | Date of Birth | Occupation |
|-----|--------------------------------|--------------------------|--------|---------------|------------|
| 1 | | | | | |
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DECLARATION

I/We hereby declare to the best of my/our knowledge and belief that all the employees listed are in good health and free from physical defects or infirmity and that the statements and answers given in this enrolment form and health declarations are true, accurate and complete and that I/We have not withheld any information or material facts that may influence the assessment and acceptance of this insurance. I/We understand that any misstatement of fact, whether by commission or omission may be grounds for the Sompo Insurance Singapore Pte. Ltd. ("Sompo") in its absolute and sole discretion to decline to pay any benefit which might otherwise have been payable.

I/We agree that if a contract of insurance is effected, all information submitted in connection with this application, including the proposal and health declaration forms completed by the respective insured persons, shall form the basis if such contract between me/us and Sompo and shall be deemed to be incorporated in such contract. I/We understand that this insurance if accepted will be an annual contract renewable at the discretion of Sompo.

I/We acknowledge and agree (in case of corporate policy, I/we represent that I/we have obtained the consent of the individuals in relation to this policy) that Sompo may collect, use, disclose and/or process my/our personal data (in case of corporate policy, personal data of individuals in relation to this policy) in accordance with the Personal Data Protection Act 2012 for the purposes and uses described in Sompo's Privacy Policy (including the provision of protection, services related to this insurance policy, screening activities in accordance with legal/regulatory obligations/risk management procedures). This may include disclosure to Sompo's business partners, intermediaries, third party service providers and industry associations. Sompo's Privacy Policy can be found at www.sompo.com.sg

I/We consent to receive marketing and promotional information from Sompo (e.g. via email, mail, SMS, etc.). I/We understand that I/we can withdraw or manage my/our consent to receive marketing and promotional information at www.sompo.com.sg

 Signature of Authorized Personnel
 Name of Authorized Signatory:
 Designation:
 Company Stamp (if applicable):

 Date

I/We declare and acknowledge that I/We have reviewed this Group Hospital & Surgical Insurance application with the authorized officer of the Company, and that I/We have explained all requirements of this application form to him/her.

 Signature of Insurance Representative
 Name:
 Designation:
 Company Stamp (if applicable):

 Date