



# STU PAL Plan Proposal Form

Statement pursuant to Section 25(5) of the Insurance Act (Cap 142) or any subsequent amendments thereof, you are to disclose in this enrolment form, fully and faithfully, all the facts which you know or ought to know in respect of the risk that is being proposed, otherwise the Policy issued hereunder may be void and you may receive nothing from the Policy.

Please refer to attached brochure, "STU PAL Plan" for a summary of the benefits and exclusions. Specific terms, conditions and exclusions are set out in the policy, a copy of which is available upon request.

## Yes! I / We would like to enroll in this Plan.

Plan Details				
Summary of Benefits	Sum Insured (S\$)			
	Plan 1	Plan 2	Plan 3	Plan 4
1. Accidental Death or Permanent Disablement	Up to 50,000	Up to 100,000	Up to 150,000	Up to 200,000
2. Additional Accidental Death or Permanent Total Disablement due to				
(a) School Activities	25,000	50,000	75,000	100,000
or	or	or	or	or
(b) Public Conveyance	N/A	N/A	75,000	100,000
(Benefit 2 is applicable to Member only)				
3. Fractures / Dislocations / Burns (per Accident)	Up to 500	Up to 1,000	Up to 1,500	Up to 2,000
4. Accident Medical Reimbursement (per Accident)	Up to 1,000	Up to 2,000	Up to 3,000	Up to 4,000
5. Daily Hospital Income due to Illness/Injury (up to 90 days)	50 per day	100 per day	150 per day	200 per day
Please indicate your choice of coverage – Monthly Premium* (S\$)				
Member	<input type="checkbox"/> 6.25	<input type="checkbox"/> 12.50	<input type="checkbox"/> 18.75	<input type="checkbox"/> 25.00
Member & Child(ren) <sup>^</sup>	<input type="checkbox"/> 7.50	<input type="checkbox"/> 15.00	<input type="checkbox"/> 22.50	<input type="checkbox"/> 30.00
Member & Spouse	<input type="checkbox"/> 11.90	<input type="checkbox"/> 23.75	<input type="checkbox"/> 35.65	<input type="checkbox"/> 47.50
Member, Spouse & Child(ren) <sup>^</sup>	<input type="checkbox"/> 13.00	<input type="checkbox"/> 26.00	<input type="checkbox"/> 39.00	<input type="checkbox"/> 52.00
Each Parent <sup>#</sup>	<input type="checkbox"/> 5.90	<input type="checkbox"/> 11.85	<input type="checkbox"/> 17.75	<input type="checkbox"/> 23.75

\* All premiums quoted are inclusive of GST. Premiums will be adjusted with subsequent change of GST.

<sup>^</sup>Benefit 2 is applicable to Member only.

<sup>^</sup> Each dependent child will enjoy 15% coverage on all benefits except Benefit 2 as stated in the Summary of Benefits table. There is no limit on the number of children provided they are between 15 days to 25 years old unemployed and/or unmarried who are dependent upon Member for at least 50% of his/her maintenance and support.

<sup>#</sup>Parent means parent(s) and/or parent(s)-in-law of the Member who must be an Insured Person under this Policy.

Under this Policy, no increase in sum insured is allowed upon attainment age of 65 years (at last birthday) and the sum insured for all benefits will be reduced by 50% upon attainment age of between 76 to 80 years.

My Personal Particulars ("Policyholder")		
Name (Mr / Ms / Mdm / Mrs / Dr):		NRIC / FIN No.:
Date of Birth (dd/mm/yy):	Gender: Male/ Female	Occupation:
Address:		Postal Code:
Telephone No.	Home:	Office:
		Mobile:
My Spouse's Particulars (if applicable)		
Name (Mr / Ms / Mdm / Mrs / Dr):		NRIC / Passport No.:
Date of Birth (dd/mm/yy):	Gender: Male/ Female	Occupation:
My Child(ren)'s Particulars (if applicable)		
	Name	Date of Birth (dd/mm/yy)
		Gender
1.		Male / Female
2.		Male / Female
3.		Male / Female
4.		Male / Female
5.		Male / Female

<b>For Official Use</b> Staff Code: _____
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My Parent's Particulars (if applicable)			
Name (Mr / Ms / Mdm / Mrs / Dr) Please underline surname:		NRIC / Passport No.:	
Date of Birth (dd/mm/yy):	Gender: Male / Female	Relationship: Father / Mother	Occupation:

My Parent's Particulars (if applicable)			
Name (Mr / Ms / Mdm / Mrs / Dr) Please underline surname:		NRIC / Passport No.:	
Date of Birth (dd/mm/yy):	Gender: Male / Female	Relationship: Father / Mother	Occupation:

My Parent-in-law's Particulars (if applicable)			
Name (Mr / Ms / Mdm / Mrs / Dr) Please underline surname:		NRIC / Passport No.:	
Date of Birth (dd/mm/yy):	Gender: Male / Female	Relationship: Father-in-law / Mother-in-law	Occupation:

My Parent-in-law's Particulars (if applicable)			
Name (Mr / Ms / Mdm / Mrs / Dr) Please underline surname:		NRIC / Passport No.:	
Date of Birth (dd/mm/yy):	Gender: Male / Female	Relationship: Father-in-law / Mother-in-law	Occupation:

**Declaration**  
 I am a member with **Singapore Teachers' Union** attach to (name of school) and make the declarations below for **STU PAL Plan**

(1) I and /or my spouse\* am / are\*:  
 (i) between the ages of 16 and 65 years (at last birthday);  
 (ii) residing in Singapore / Malaysia\*; and  
 (iii) in good health and free from any physical impairment or deformity.

(2) \*my dependent child(ren) is / are\*:  
 (i) between the ages of 15 days to 25 years if he/she/they\* are unemployed and/or unmarried  
 (ii) residing in Singapore / Malaysia\*; and  
 (ii) in good health and free from any physical impairment or deformity.

(3) \*my Parent(s) and/or Parent(s)-in-law is / are\*:  
 (i) between the ages of 45 days to 65 years (at last birthday);  
 (ii) residing in Singapore / Malaysia\*; and  
 (iii) in good health and free from any physical impairment or deformity.

\* delete whichever is inapplicable.

Please tick the answers as appropriate.			
1	Have you and/or your Spouse and/or Dependent child(ren) and/or Parent ever been diagnosed or treated for:-	Yes	No
(a)	Cancer (including skin cancer, ulcerated moles or chronic lesions) or leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
(b)	Any condition of the circulatory system or ever had a stroke?	<input type="checkbox"/>	<input type="checkbox"/>
(c)	Any conditions affecting the kidneys or ever been a diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
(d)	Alcoholism or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you or your spouse received, taken or been advised to take medicine for a continuous period of more than 4 weeks or been on a diet prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>
3	Have you or your spouse been absent from work for a total of more than 4 weeks due to an injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
If you answer "YES" to any of the above, please give details:			
_____			
_____			

**Authorization of premium payment through GIRO / Credit Card**  
 I / We agree to pay the premiums according to the plan chosen and I hereby authorise American Home Assurance Company, Singapore (AHAC) to charge the stated monthly premium to the following credit card/bank account. Where a third party credit card is used, I/We declare that the cardholder has authorised and consented to its use.

Visa  
 Mastercard

Name of Bank : \_\_\_\_\_ Name of Cardholder : \_\_\_\_\_

Credit Card No.: \_\_\_\_\_ Expiry Date: \_\_\_\_\_(mm/yyyy)



I understand that the **STU PAL Plan** is a personal accident policy and benefits (except for Benefit 5) shall be payable upon the occurrence of an Accident subject to applicable terms and conditions. I also understand that I and/or my Spouse and/or Parent and/or Dependent Child can only be covered for one personal accident policy issued by Employee Care. I confirm that I am / we are currently not covered under any one such policy. In the event that I am / we are already covered under any one such policy prior to this application, please cover me / us under the policy which provides for the higher sum insured.

I / We hereby declare and agree on behalf of myself / ourselves and any person(s), firm or corporation, that any information collected or held by American Home Assurance Company, Singapore (the "Company") (whether contained in this application or otherwise obtained) may be used and disclosed by the Company to its associated individuals / companies or any independent third parties (within or outside Singapore) for the purposes of processing this application and providing subsequent services (including provision of advice or information) in relation to the **STU PAL Plan**, and to communicate with me / us for any purposes.

I do not wish to be contacted for subsequent services (including provision of advice or information, direct marketing, data matching) for products and services which the Company believes may be of interest to me / us, and to communicate with me / us for any purposes. I declare that the above information provided is true and complete, and understand that this enrolment form is not a contract of insurance until accepted by the Company. However, such information or declaration herein will form the basis of the contract of insurance with the Company.

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Underwritten By:

**American Home Assurance Company, Singapore**



Incorporated in the United States with liability limited.